Application For Employment

Jio Home Health Care, Inc.

42835 Delphinium Cir.,
Leesburg, VA 20176
Ph: 571-416-7004
Fax:833-223-4439

We are an Equal Opportunity Employer and is committed to excellence through diversity.

Please print or type. The application must be fully completed to be considered. Please complete each section, even if you attach a resume.

Personal Information

Name

Address	City	State	Zip

Phone Number	Mobile Number	Email Address

Are You A U.S. Citizen?
Yes ☐ No ☐

Have You Ever Been Convicted Of A Felony?
Yes ☐ No ☐

If Selected For Employment Are You Willing To Submit to a Pre-Employment Drug Screening Test?
Yes ☐ No ☐

Date Of Birth :

SS Number :

Position

Position You Are Applying For	Available Start Date	Desired Pay

Employment Desired

☐ Full Time ☐ Part Time ☐ Seasonal/Temporary

Education

School Name	Location	Years Attended	Degree Received	Major

References

Name	Title	Company	Phone

Employment History

Employer (1)	Job Title		Dates Employed
Work Phone	Starting Pay Rate		Ending Pay Rate
Address	City	State	Zip
Employer (2)	Job Title		Dates Employed
Work Phone	Starting Pay Rate		Ending Pay Rate
Address	City	State	Zip
Employer (3)	Job Title		Dates Employed
Work Phone	Starting Pay Rate		Ending Pay Rate
Address	City	State	Zip
Employer (4)	Job Title		Dates Employed
Work Phone	Starting Pay Rate		Ending Pay Rate
Address	City	State	Zip
Employer (5)	Job Title		Dates Employed
Work Phone	Starting Pay Rate		Ending Pay Rate
Address	City	State	Zip

Signature Disclaimer

I certify that my answers are true and complete to the best of my knowledge.
If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

Name (Please Print)	Signature
Date	

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Email ID: jiohomehealthcare@gmail.com

HIPAA EMPLOYEE CONFIDENTIALITY AGREEMENT

THIS AGREEMENT entered into this ___ day of _____, 20___, by and between Jio Home Health Care, Inc., and _____, known as the "Employee", and known collectively as the "Parties", set forth the terms and conditions under which information created or received by or on behalf of this Healthcare Facility (known collectively referred to as protected health information, or "PHI") may be used or disclosed under State law and the Health Insurance Portability and Accountability Act of 1996 and updated through HIPAA Omnibus Rule of 2013 and will also uphold regulations enacted there under (hereafter "HIPAA").

THEREFORE, in consideration of the premises and the covenants and agreements contained herein, the Parties hereto, intending to be legally bound hereby, covenant and agree as follows:

1. Confidential Information. The Parties acknowledge that meaningful employment may or will necessitate disclosure of Confidential Information by this Healthcare Facility to the Employee and use of Confidential Information by the Employee. The term "Confidential Information" includes, but is not limited to, PHI, any information about patients or other employees, any computer log-on codes or passwords, any patient records or billing information, any patient lists, any financial information about this Healthcare Facility or its patients that is not public, any intellectual property rights of Practice, any proprietary information of Practice and any information that concerns this Healthcare Facility's contractual relationships, relates to this Healthcare Facility's competitive advantages, or is otherwise designated as confidential by this Healthcare Facility.

2. Disclosure. Disclosure and use of Confidential Information includes oral communications as well as display or distribution of tangible physical documentation, in whole or in part, from any source or in any format (e.g., paper, digital, electronic, internet, social networks, magnetic or optical media, film, etc.). The Parties have entered into this Agreement to induce use and disclosure of Confidential Information and are relying on the covenants contained herein in making any such use or disclosure. This Healthcare Facility, not the Employee, is the records owner under state law and the Employee has no right or ownership interest in any Confidential Information.

3. Applicable Law. Confidential Information will not be used or disclosed by the Employee in violation of applicable law, including but not limited to HIPAA Federal and State records owner statute; this Agreement; the Practice's Notice of Privacy Practices, as amended; or other limitations as put in place by Practice from time to time. The intent of this Agreement is to ensure that the Employee will use and access only the minimum amount of Confidential Information necessary to perform the Employee's duties and will not disclose Confidential Information outside this Healthcare Facility unless expressly authorized in writing to do so by this Healthcare Facility. All Confidential Information received (or which may be received in the future) by Employee will be held and treated by him or her as confidential and will not be disclosed in any manner whatsoever, in whole or in part, except as authorized by this

Healthcare Facility and will not be used other than in connection with the employment relationship.

4. Log-on Code and Password. The Employee understands that he or she will be assigned a log-on code or password by Practice, which may be changed as this Healthcare Facility, in its sole discretion, sees fit. The Employee will not change the log-on code or password without this Healthcare Facility's permission. Nor will the Employee leave Confidential Information unattended (e.g., so that it remains visible on computer screens after the Employee's use). The Employee agrees that his or her log-on code or password is equivalent to a legally-binding signature and will not be disclosed to or used by anyone other than the Employee. Nor will the Employee use or even attempt to learn another person's log-on code or password. The Employee immediately will notify this Healthcare Facility's HIPAA Privacy Officer upon suspecting that his or her log-on code or password no longer is confidential. The Employee agrees that all computer systems are the exclusive property of Practice and will not be used by the Employee for any purpose unrelated to his or her employment. The Employee acknowledges that he or she has no right of privacy when using this Healthcare Facility's computer systems and that his or her computer use periodically will be monitored by this Healthcare Facility to ensure compliance with this Agreement and applicable law.

5. Returning Confidential Information. Immediately upon request by this Healthcare Facility, the Employee will return all Confidential Information to this Healthcare Facility and will not retain any copies of any Confidential Information, except as otherwise expressly permitted in writing signed by this Healthcare Facility. All Confidential Information, including copies thereof, will remain and be the exclusive property of this Healthcare Facility, unless otherwise required by applicable law. The Employee specifically agrees that he or she will not, and will not allow anyone working on their behalf or affiliated with the Employee in any way, use any or all of the Confidential Information for any purpose other than as expressly allowed by this Agreement. The Employee understands that violating the terms of this Agreement may, in this Healthcare Facility's sole discretion, result in disciplinary action including termination of employment and/or legal action to prevent or recover damages for breach. Breach reporting is imperative.

6. Breach. The Parties agree that any breach of any of the covenants or agreements set forth herein by the Employee will result in irreparable injury to this Healthcare Facility for which money damages are inadequate; therefore, in the event of a breach or an anticipatory breach, Practice will be entitled (in addition to any other rights and remedies which it may have at law or in equity, including monetary damages) to have an injunction without bond issued enjoining and restraining the Employee and/or any other person involved from breaching this Agreement.

7. Binding Arrangement. This Agreement shall be binding upon and endure to the benefit of all Parties hereto and to each of their successors, assigns, officers, agents, employees, shareholders and directors. This Agreement commences on the date set forth above and the terms of this Agreement shall survive any termination, cancellation, expiration or other conclusion of this Agreement unless the Parties otherwise expressly agree in writing.

8. Governing Law. The Parties agree that the interpretation, legal effect and enforcement of this Agreement shall be governed by the laws in the State of Virginia and by execution hereof,

each party agrees to the jurisdiction of the courts of the State. The Parties agree that any suit arising out of or in relation to this Agreement shall be brought in the county where this Healthcare Facility's principal place of business is located.

9. Severability. If any provision under this Agreement shall be held invalid or unenforceable for any reason, the remaining provisions and statements shall continue to be valid and enforceable.

IN WITNESS WHEREOF, and intending to be legally bound, the Parties hereto have executed this Agreement on the date first above written, when signing below and after training on HIPAA Law with full understanding this agreement shall stand.

Jio Home Health Care, Inc.

42835 Delphinium Cir., Leesburg, VA 20176
Ph. 571-416-7004, Fax 833-223-4439
Email ID: jiohomehealthcare@gmail.com

EMPLOYEE DOCUMENTATION OF HIPAA PRIVACY TRAINING

The Health Insurance Portability Act of 1996 (HIPAA) requires our privacy officer to train employees on our health information privacy policies and procedures to the HIPAA Omnibus Standards of 2013 which also includes HI-TECH and Protected Health Information (PHI), Electronic Protected Health Information (ePHI), and Electronic Health Records (EHR). All employees with treatment, payment or healthcare operations responsibilities, which allow access to protected health information, are trained with updates periodically as State and Federal mandates require. HIPAA also requires that we keep this documentation (that the training was completed) for six years after the training.

I, the undersigned, do hereby certify that I have received, read, understood and agree to abide by this Healthcare Facilities HIPAA Policies and Operating Procedures.

Employee's Signature _____ Date _____

Print Name _____

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42835 Delphinium Cir., Leesburg, VA 20176
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REFERENCE CHECKS

Name of Candidate:_____ Date: _____

Position Applied for: _____

Name of Reference Giver: _____ Phone No._____

1. Did the candidate work for you?_____
2. What were the dates of employment? _____
3. What position(s) did the candidate hold? _____
4. What were his/her job duties?

   _____

   _____
5. Did the candidate perform these duties competently? _____

   _____
6. How was the candidate's attendance record?_____
7. If the candidate missed much work, what were the major reasons (i.e. illness, family issues; etc.)? _____
8. Please comment on the candidate's working habits and traits:
   a. Is the candidate punctual? _____
   b. Is the candidate dependable?_____
   c. Is the candidate honest? _____
   d. Is the candidate trustworthy?_____
   e. Is the candidate tactful? _____
   f. Does the candidate use good judgment?_____
   g. Is the candidate compassionate? _____
   h. Does the candidate show initiative? _____
   i. Has the candidate got a good attitude? _____
   i. Is the candidate a Team Player? _____
   j. Does the candidate respect authority? _____

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k. Does the candidate need constant supervision? _____

l. Can the candidate handle stress? _____

m. Have you ever had any disciplinary issues with the candidate? _____

If yes, explain _____

_____

9. What do you feel the candidate's main strengths are? _____

_____

_____

10. What do you feel the candidate's weaknesses are? _____

_____

_____

11. The candidate has applied for a _____position.

Do you feel the candidate is suitable for it? _____

12. What was the reason the candidate left your employment? _____

13. Would you hire the candidate again? _____

14. Do you have any other comments you would like to make? _____

_____

_____

_____

_____

Reference check conducted by: _____

Position: _____

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REQUEST or DECLINE A HEPATITIS B VACCINE

I hereby request the series of Hepatitis B vaccine injections. _____
I hereby decline the series of Hepatitis B vaccine injections because: 1. I have previously received the series of Hepatitis vaccine injections. _____ 2. I have been determined to have antibodies against Hepatitis B. _____ 3. I should not have the Hepatitis B vaccine because of medical reasons. _____
I hereby decline the Hepatitis B vaccine injections. _____ I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine, at no charge to me; however, I decline the Hepatitis B vaccination at this time. I understand that by declining this vaccine I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Employee Signature:_____ Date:_____

_____
Print Name

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CONSENT FOR TUBERCULIN SKIN TEST

LAST NAME _____ FIRST NAME _____ MI ___
ADDRESS _____DATE OF BIRTH _____
CITY _____STATE ____ ZIP CODE_____
PHONE _____

1. Have you ever had a TB Skin Test? Yes / No
2. Have you ever had a positive reaction to a TB Skin Test? Yes / No
3. Have you had any immunizations within the past six weeks? Yes / No

I Need to received TB Test to work as a PCA Personal care attendant For the Agency Jio Home Health Care, Inc.

Date _____

Signature of Patient or Guardian of Minor

_____

Admin:

Kuldeep K Gurna

RECORD OF MANTOUX TEST

Date _____ Date Read _____ Result _____

Time _____ Time Read _____

TUBERSOL Lot# _____ Read By _____

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FLU SHOTS

All Employees / Contractors and clients should have their flu shots up to date to reduce the risk of flu infections.

Wall Green has flu shots available 8 to 5 Monday through Friday.

Signature :_____

Name (Employee):_____

Date :_____

Administrator :_____

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DECLINATION OF INFLUENZA VACCINATION

My employer or home care agency, _____, has recommended that I received influenza vaccination in order to protect myself and the clients I serve.

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills an average of 36,000 persons and hospitalizes more than 200,000 persons in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare workers to prevent influenza disease and its complications, including death.
- If I contract influenza, I will shed the virus for 24-48 hours before influenza symptoms appear. My shedding the virus can spread influenza infections to clients.
- If I become infected with influenza, even when my symptoms are mild, I can spread severe illness to others.
- I understand that that the strains of virus that cause influenza infection change almost every year, which is why a different influenza vaccine is recommended each year.
- I cannot get the influenza disease from the influenza vaccine.
- The consequences of my refusing to be vaccinated could endanger my health and the health of those with whom I have contact, including:
  - clients
  - my co-workers
  - my family
  - my community

Despite these facts, I am choosing to decline influenza vaccination right now.

I understand that I may change my mind at any time and accept influenza vaccination, if vaccine is available.

I have read and fully understand the information on this declination form.

Signature: _____ Date: _____

Name (print) _____

I

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EMPLOYEE ORIENTATION CHECKLIST

Topics to Review	Points to Address	Completed	
		Yes	No
Overview of Agency	Incude history, location, contaction information, organizational structure, management team, communication with management		
Scope of Services	Review services provided by Agency such as: Personal Care, Homemaker Companion/Sitter; Respite, Friendly Reassurance Services, Chore Services		
Job Description	Ensure all employees receive a copy of their job description and they sign it to acknowledge they understand job expectations and limitations.		
Employee Handbook	Distribute Agency's *Employee Handbook* & provide an overview of its contents		
Employer/Employee Agreement	Review Agency's *Employer-Employee Agreement*. Have employee sign the agreement and place a copy in the employees' Personnel File		
General Rights and Responsibilities	Review anti-discrimination, equal employment opportunity, harassment, cultural diversity & disabilities regulations.		
Pay & Compensation	Discuss hours of work, shifts; salary/wages; overtime; pay schedules; timesheets, vacation time; sick leave; other benefits; compensation for private vehicle usage;, completion of appropriate employment-related forms including income tax, benefits, etc.		
Grievances/Complaints	Review Agency policy on *Grievances & Complaints*, and the Agency's. *Complaints/Grievances* form.		
Agency Expectations	Review what Agency expects from its employees including requirements for background checks; performance standards; competency evaluations; probationary period; training and development; workloads; staff meetings; conferences, assignments; supervision of services;		
Compliance	Advise of responsibility to comply with: Agency Policies; federal & state laws and regulations including False Claims Acts & Federal Deficit Reduction Act of 2005; regulatory agencies including CMS's Conditions of Participation; & federal, state and local agencies governing home care. Have employees sign *Policies & Procedures Compliancy Agreement.*		
Standards of Conduct	Issue & review Agency *Standards of Conduct* .Have all employees sign and date it. Put a copy in the Employee's Personnel file		
Ethics	Review Agency policy on *Standards of Conduct & Work Ethics*. Emphasize respecting patient choices; protecting patient confidentiality, privacy, and security; delivering health care services according to professionally-accepted standards; and issues prone to conflicts.		
Conflict of Interest	Review Agency's Conflict of Interest Policy, emphasizing what constitutes a conflict of interest. Have each employee sign the Agency's and *Conflict of Interest Statement.* Place a copy into each employee's Personnel Files.		
Performance Reviews	Discuss how and when performance appraisals are conducted; performance improvement activities including identification of problems & issues; opportunities for improvement and consequences if performance standards continue to be unmet.		
Training/Staff Development	Review Agency's *Training & Development* & *Annual Training* Policies and *Staff Record of Training* If the state has continuing education requirements and the Agency is accredited and/or certified, include continuing education and/or in-services that are required monthly and/or annually		
Health and Safety Committee	Supply a copy the Health and Safety Committee members and the location of the safety bulletin board. Explain how the employee can participate in the health and safety process (e.g., report hazards)		

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Topics to Review	Points to Address	Completed	
		Yes	No
Safety in the Workplace or Home	Review, personal and home safety; medical and non-medical emergency responses; environmental emergencies and disasters; reporting accidents; adverse/threatening clients; & the requirement obligation to notify Supervisor of any known exposure to Tuberculosis, Hepatitis or other infectious/communicable diseases. Review the Agency's *Home Safety Checklist* and *Home Environment Safety* Policy. Focus on Safety precautions for bathroom, electrical, and fire safety in the home; evaluating neighborhoods for safety hazard & the client's/resident's potential for violence.		
Emergency Procedures	Review procedures for emergency situations that occur in client's homes and in the office environment. Stress importance of ensuring client have emergency telephone numbers & contacts lists.		
Emergency Preparedness	Review Emergency Preparedness Plan, with focus on: policies and procedures on how the Agency handles client care during natural (and non-natural) disasters (e.g. flood, fire, hurricane, tornado, or other disaster) that affect the delivery of scheduled home care services; maintaining uninterrupted communication between Agency management and caregivers; and providing uninterrupted home care services to priority patients.		
Emergency Contact	Obtain a list of names, addresses, phone numbers and fax numbers of the persons who must be contacted in case of an employee emergency.		
Infection Control & Hazard Waste Standards	Provide orientation and training for the OSHA standards; review Agency policies on Infection Control, Blood-borne diseases Household Wastes, Handling & Transporting specimens.		
Personal Protective Equipment (PPE)	Review the Personal Protective Equipment program. If employees will be required to wear PPE, issue appropriate PPE that must be worn as required by the work being performed.		
Incident Reporting	Review Agency's Incident Reporting Policy, focusing on what constitutes an incident; reporting incidents such as injury and/or accident and exposure to blood borne diseases. Provide procedures for completing incident reports using the Agency's appropriate Incident Report form.		
Security & Confidentiality Of Client Information	Ensure employees know about *Health Insurance Portability and Accountability Act* (HIPAA) & procedures for protecting patients' PHI ('protected identifiable health information. Include how the agency physically protects client's records & procedures for reporting HIPAA violations. Review the Agency's *Confidentiality & Privacy of Client Information* policy. Have employee sign Agency's *Confidentiality & Non-Disclosure Agreement*		
Case Management & Clinical Record Management	Review Case management policies and procedures, particularly assessments & care plan development; documentation requirements & maintenance of client records; roles in reimbursement;		
Equipment & Supplies	Ensure employees know where equipment & supplies are located and any requirements for procuring items from the stock.		

Date: _____

_____
Employee's Signature

_____
Supervisor's Signature

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PRE-EMPLOYMENT BACKGROUND CHECK AUTHORIZATION

I, _____, understand that as part of the employment process, Jio Home Health Care, Inc. needs to complete a background check on me regarding:

1. Criminal record;
2. Sex and Violent Offenders Record;
3. Employment Verification;
4. Education Verification;
5. License Verification;
6. Motor Vehicle Records;
7. Personal/Professional Reference Verification;
8. Medical Suitability
9. Drugs/Alcohol

- I authorize all federal and state agencies, persons and organizations that may have information relevant to this research to disclose such information to Jio Home Health Care, Inc. or its authorized agent(s).
- I understand that this authorization is to be part of the written and signed employment application.
- I also understand that I do not have to give authorization for a background check but if I don't give permission, my employment application will not be processed further.
- I understand that I have specific rights under the federal Fair Credit Reporting Act (FCRA) and may have additional rights under relevant State law.
- I further authorize that a photocopy of this authorization may be considered as valid as the original.
- I hereby certify that all statements on this form are true and correct to the best of my knowledge and belief. I understand that employment with Jio Home Health Care, Inc. is contingent upon successful completion of a background check.

_____ _____
Signature Date

Full Name _____ Telephone No. _____

Former Name(s) and Date(s) used: _____

Current Address _____

Date of Birth _____ Social Security Number: _____

Current Driver's License: _____ State: _____

List any other cities, states and dates of residency during last 10 years (Use back of sheet, if necessary.)

City	State	From: Month/Year	To: Month/Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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JOB DESCRIPTION: HOME CARE PERSONAL CARE ATTENDANT

Description

- Personal Care Attendants provide service to individuals in their own homes and communities, who need assistance caring for themselves as a result of old age, sickness, disability and/or other inflictions. Personal Care may include assistance with the activities of daily living, housecleaning, laundry, meal preparation, transportation, companionship and respite,
- Personal Care Attendants are responsible for ensuring that service is delivered in a caring and respectful manner, in accordance with relevant Agency policies and industry standards.

Reporting Relationship

- Reports to Supervisor.

Responsibilities/Activities:

- Assist with the activities of daily living and personal care including:
  - bathing
  - mouth care
  - hair care
  - nail care
  - skin care
  - shaving
  - dressing
  - feeding
  - positioning
  - transferring
  - ambulation
  - exercise
  - toileting
  - medication reminding
  - vital signs and Blood Pressure
- Ensure client's safety and security by supervising the home environment.
- Teach/perform meal planning and preparation, routine housekeeping activities such as making/changing beds, dusting, vacuuming, washing floors, cleaning kitchen and bathroom, and laundry.
- Provide companionship including social interactions, conversations, emotional reassurance and encouragement of activities that stimulate the mind.
- Provides respite care for families in accordance with care plans.
- Perform/assist with essential shopping/errands, which may include handling the client's money in accordance with the care plan and under the observation of the Supervisor.
- Assist clients with following a written, special diet plan and reinforcement of diet maintenance, which is provided under the direction of a Physician and as identified on the care plan.
- Escort clients to medical facilities, errands, shopping and outings as specified in the care plan.
- Assist clients with communication by writing or typing correspondence for them or researching information for them.
- Participate on the Care Team by providing input and making suggestions.
- Ensure service is delivered in accordance with all relevant policies, procedures and practices.
- Monitor supplies and resources.
- Evaluate the program and make recommendations to it, as indicated.
- Follow the written care plan.
- Carry out duties as assigned by the Supervisor.
- Observe clients and their environments and reports unsafe conditions to Supervisor.
- Observe clients and their environments and reports behavior, physical and/or cognitive changes and/or changes in living arrangements to Supervisor.
- Complete and maintain records of daily activities, observations, and direct hours of service.

- Attend orientation, in-service training sessions and staff meetings.
- Develop and maintain constructive and cooperative working relationships with others.
- Make decisions and solve problems.
- Communicate with Supervisor and co-workers.
- Observe, receive and obtain information from relevant sources.
- Performs other duties as required.

Required Knowledge

- Knowledge of personal care and home management skills.
- Knowledge of principles and processes for providing client and personal care services, including needs determinants, meeting quality standards and evaluation of client satisfaction.
- Knowledge of the English language.
- Knowledge of the information and techniques needed to diagnose and treat injuries including emergency first aid and CPR.
- Knowledge of clerical procedures such as maintaining records and completing forms.

Required Skills/Abilities

- The ability to competently assist clients with their activities of daily living.
- The ability to be aware of other people's reactions and understanding why they react as they do.
- The ability to establish and maintain relationships.
- The ability to teach others.
- The ability to listen actively.
- The ability to identify problems and determine effective solutions.
- The ability to apply reason and logic to identify strengths and weaknesses of possible solutions.
- The ability to monitor and assess themselves, clients and effectiveness of service.
- The ability to understand written and oral instructions.
- The ability to communicate information orally so others understand.
- The ability to communicate in writing so others understand.
- The ability to work independently and in cooperation with others.
- The ability to determine or recognize when something is likely to go wrong.
- The ability to suggest a number of ideas on a subject.
- The ability to perform activities that use the whole body.
- The ability to handle and move objects and people.
- The ability to provide advice and consultation to others.
- The ability to observe and recognize changes in clients.
- The ability to establish and maintain harmonious relations with clients/families/co-workers.

Physical and Mental Demands:

- Good physical and mental health.
- Physical ability to stand, walk, use hands and fingers, reach, stoop, kneel, crouch, talk, hear and see.
- Mental fortitude and stability to handle stress.
- Physical and mental ability to drive a vehicle.

Qualifications/Education

- Certification in Personal Care

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- Current driver's license.
- Proper Vehicle Insurance Coverage.

Training/Experience:

- May require related experience.
- On the job training for new activities.

I have read and understand the job description and agree to fulfill the position's responsibilities.

_____ _____

Employee Signature Date

_____ _____

Supervisor Signature Date

Jio Home Health Care, Inc.

42835 Delphinium Cir

Leesburg VA 20176

Sworn Statement

I, the undersigned being duly sworn and state that I have not been convicted of any crime or suffered any judgment, involving dishonesty or the violation of any state or federal laws.

I have not been convicted of any felony in COMMON WEALTH OF VIRGINIA OR ANY OTHER STATE EITHE, I do not have a criminal background whatsoever

I declare under the penalties of perjury that all information provided by myself is true and correct.

SIGNATURE : _____

Full Name : _____

DATE : _____

Authorization for Direct Deposit

I hereby authorize The Jio Home Health Care, Inc. to directly deposit my pay in the bank account(s) listed below in the percentages specified. (If two accounts are designated, deposits are to be made in whole percentages of pay to total 100%.) I have attached a voided personalized check (checking accounts) or deposit slip (savings accounts) for each account specified below. No more than two accounts may be designated. This authorization is to remain in force until the Company has received written authorization from me of its termination or change. Also, I hereby grant The Jio Home Health Care, Inc. the right to correct any such electronic funds transfer resulting from an erroneous overpayment by debiting my account to the extent of such overpayment.

Name (PRINT): _____

Signature: _____ Date: _____

Account #1 (Check only one)

[] Checking (attached voided check)
[] Savings (attach deposit slip and obtain ABA routing number from your bank)

Financial Institution: _____

Street Address: _____

City, State and Zip Code: _____

Telephone: (_____) _____

ABA (Routing) Number: _____

Personal Account Number: _____

Amount of pay to be deposited into this account:

$_____ or _____%

Account #2 (Check only one)

[] Checking (attached voided check)
[] Savings (attach deposit slip and obtain ABA routing number from your bank)

Financial Institution: _____

Street Address: _____

City, State and Zip Code: _____

Telephone: (_____) _____

ABA (Routing) Number: _____

Personal Account Number: _____

Amount of pay to be deposited into this account:

$_____ or _____%

Form **W-4** (Rev. December 2020)
Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

▶ **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
▶ **Give Form W-4 to your employer.**
▶ **Your withholding is subject to review by the IRS.**

OMB No. 1545-0074

2021

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		▶ **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying widow(er)**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at *www.irs.gov/W4App*, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ▶ ☐

TIP: To be accurate, submit a 2021 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ▶ $ _____

Multiply the number of other dependents by $500 . . . . ▶ $ _____

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

▶ _____ **Employee's signature** (This form is not valid unless you sign it.)

▶ _____ **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.