Care Begins Here

Rockaway CDPAP Home Care Services

16-03 Central Avenue – Suite 200A
Far Rockaway, New York 11691
Phone: 718-471-5800 Fax: 718-327-0004

PERSONAL ASSISTANT ENROLLMENT CHECKLIST

Personal Assistant Name: _____

Consumer Name: _____

Required From Personal Assistant Prior To Start of Services

Enroller – Check Box and Initial upon Completion:	Document Description
☐ Initial: _____	Wages and Benefits Processing Information
☐ Initial: _____	Internal Revenue Service Form W-4
☐ Initial: _____	New York State Department of Taxation and Finance Form IT-2104
☐ Initial: _____	U.S Citizenship and Immigration Services Form I-9
☐ Initial: _____	Universal Precautions and Hepatitis B Vaccination Acknowledgment
☐ Initial: _____	Notice Acknowledgement of Pay Rate and Payday Under Section 195.1 of The New York State Labor Law
☐ Initial: _____	New York City's Earned Sick Time Act Notice of Employee Rights
☐ Initial: _____	Health Assessment Form

A copy of each document (except the Health Assessment Form) must be provided to the Consumer or, if applicable, the Consumer's Designated Representative.

For the I-9 Form. Copies of the document(s) presented by the Personal Assistant must be retained in the appropriate personal file.

For privacy reasons, no copy, of the Health Assessment Form will be provided to the Consumer Unless the Personal Assistant Specifically authorizes the disclosure.

Wage and Benefits Processing Information

Personal Assistant Information

Last Name: _____ First Name: _____ Middle Initial: __

Street Address: _____

_____

City: _____ State: _____ ZIP Code: _____

SSN: _____-_____-_____ Hire Date: _____/_____/_____

_____

Consumer Information

Last Name: _____ First Name: _____ Middle Initial: ___

Street Address: _____

_____

City: _____ State: _____ Zip code: _____

EIN (Assigned by the Internal Revenue Services): _____

Direct Deposit Authorization

Name (Please print as it appears on your account): _____

Account Type: [ ] Checking [ ] Savings Amount: [ ] Entire [ ] $ _____._____

Account #: _____ Bank Routing #: _____

Bank Name: _____ Bank Street Address: _____

City: _____ State: _____ Zip code: _____

ATTACH A VOIDED PERSONAL CHECK TO THIS FORMTO VERIFY YOUR ACCOUNT AND ROUTING NUMER

I authorize Rockaway CDPAP Home Care Services, as Fiscal Intermediary for the above names Consumer, and my bank to automatically deposit my payroll check into my account listed above(this includes my authorization to correct entries made in error). This authorization will remain in effect until I give written notice to cancel it.

Sign: _____ **Date:** _____

Form **W-4**

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

2023

Step 1: Enter Personal Information

(a) First name and middle initial | Last name | (b) Social security number

Address

City or town, state, and ZIP code

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*.

Must select your marital statues

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **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, other details, 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) Reserved for future use.

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **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 generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

TIP: If you have self-employment income, see page 2.

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 Dependent and Other Credits

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 for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

You must put the amount of people you are claiming. If you're not claiming anyone you must put zero.

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)

Department of Taxation and Finance

Employee's Withholding Allowance Certificate

New York State • New York City • Yonkers

IT-2104

2023

First name and middle initial	Last name	Your Social Security number
Permanent home address *(number and street or rural route)*	**Apartment number**	Single or Head of household ☐ Married ☐
		Married, but withhold at higher single rate ☐
City, village, or post office	**State** **ZIP code**	**Note:** If married but legally separated, mark an *X* in the *Single or Head of household* box.

Are you a resident of New York City? ..... Yes ☐ No ☐

Are you a resident of Yonkers? ..... Yes ☐ No ☐

Must select your marital statues

Before making any entries, see the *Note* below, and if applicable, complete the worksheet in the instructions.

1	Total number of allowances you are claiming for New York State and Yonkers, if applicable *(from line 19, if using worksheet)*	1	
2	Total number of allowances for New York City *(from line 31, if using worksheet)*	2	

Use lines 3, 4, and 5 below to have additional withholding per pay period under special agreement with your employer.

3	New York State amount	3	
4	New York City amount	4	
5	Yonkers amount	5	

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

Penalty – A penalty of $500 may be imposed for any false statement you make that decreases the amount of money you have withheld from your wages. You may also be subject to criminal penalties.

Employee's signature	Date

Employee: Give this form to your employer and keep a copy for your records. Remember to review this form once a year and update it if needed.

Note: Single taxpayers with one job and zero dependents, enter ***1*** on lines 1 and 2 (if applicable). Married taxpayers with or without dependents, heads of household or taxpayers that expect to itemize deductions or claim tax credits, or both, complete the worksheet in the instructions. Visit *www.tax.ny.gov* (search: *IT-2104-I)* or scan the QR code below.

Employer: Keep this certificate with your records.

If any of the following apply, mark an ***X*** in each corresponding box, complete the additional information requested, and send an additional copy of this form to New York State. See ***Employer*** in the instructions. Visit *www.tax.nys.gov* (search: *IT-2104-I)* or scan the QR code below.

A Employee claimed more than 14 exemption allowances for New York State ..... A ☐

B Employee is a new hire or a rehire ... B ☐ First date employee performed services for pay *(mm-dd-yyyy) (see Box B instructions)*: ☐

You may report new hire information online instead of mailing the form to New York State. Visit *www.nynewhire.com*.

Note: Employers **must** report individuals under an **independent contractor arrangement** with contracts in excess of $2,500 using the online reporting website above, **not** Form IT-2104.

Are dependent health insurance benefits available for this employee? ..... Yes ☐ No ☐

If *Yes*, enter the date the employee qualifies *(mm-dd-yyyy)*: ☐

Employer's name and address *(Employer: complete this section only if you are sending a copy of this form to the New York State Tax Department.)*	Employer identification number

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

Client/Client Representative must complete this part of the I-9 Form since you are the employer.

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.

Notice and Acknowledgement of Pay Rate and Payday/*Aviso y Acuse de Recibo de Tasa de Pago y Día de Cobro*
Under Section 195.1 of the New York State Labor Law/*Bajo la Sección 195.1 de La Ley de Trabajo del Estado de Nueva York*
Notice for Hourly Rate Employees/*Aviso para empleados con tasa de pago por hora*

1. Employer Information/*Información del Empleador*

Name/*Nombre*:

Doing Business As (DBA) name(s)/ *Nombre(s) comercial(es)*:

FEIN (optional)/ Número de Identificación Federal *(opcional)*:

Physical Address/*Dirección Física:*

Mailing Address/*Dirección postal u oficial:*

Phone/*Teléfono*:

2. Notice given/*Aviso emitido*:

- ☐ At hiring/ En la *contratación*
- ☐ On or before February 1/*En o antes del 1 de Febrero*
- ☐ Before a change in pay rate(s), allowances claimed or payday. *Antes de un cambio en tasa de pago, créditos tomados, o día de cobro*

3. Employee's Pay Rate/*Tasa de pago del empleado:*

$ _____ per hour/*por hora*

4. Allowances taken/*Créditos tomados:*

- ☐ None/*ninguno*
- ☐ Tips/*Propinas* _____per hour/ *por hora*
- ☐ Meals/*Comidas* _____ per meal/ *por comida*
- ☐ Lodging/ *Hospedaje* _____
- ☐ Other/*Otra* _____

5. Regular payday/*Día de Cobro Regular*:

_____

6. Pay is/*El pago es*:

- ☐ Weekly/ *Semanal*
- ☐ Bi-weekly/*Quincenal*
- ☐ Other/*Otro* _____

7. Overtime Pay Rate/*Tasa de Pago de Horas Extras (más de 40 horas trabajadas en una semana):*

$_____ per hour/*por hora* (This must be at least 1½ times the worker's regular rate, with few exceptions.)/*Con pocas excepciones, esta tasa debe ser por lo menos 1½ veces la tasa de pago regular para el trabajador.*

8. Employee Acknowledgement/*Acuse de Recibo del Empleado*: On this day, I received notice of my pay rate, overtime rate if eligible, allowances, and designated payday in English and my primary language. I told my employer that my primary language is **Spanish**. *En esta fecha, se me ha informado de mi tasa de pago, mi tasa de pago de horas extras (si elegible), créditos, y del día de cobro en inglés y en mi lengua materna. Le indiqué al empleador de que mi lengua materna es **español**.*

_____

Print Employee Name/*Escriba el nombre del empleado en letra de imprenta*

_____

Employee Signature/*Firma del Empleado*

_____

Date/*Fecha*

_____

Preparer Name and Title/*Nombre y Título del Preparador de este Documento.*

The employee must receive a signed copy of this form. The employer must keep the original for 6 years./*El empleado debe recibir una copia firmada, de este documento. El original debe permanecer con el empleador por 6 años.*

Care Begins Here

Rockaway CDPAP Home Care Services
16-03 Central Avenue Far Rockaway, New York 11691
(718) 471-5800 Fax (718) 327-0001

Hepatitis B Vaccine

Consent/ Declination Form

I understand that due to my occupational exposure to blood or other potentially infections material, I may be at risk of accruing **HEPATITIS B Virus (HBV)** infection.

I have been informed to the possible side effects and understand that the safety of receiving the vaccine during pregnancy has not been established. I have read or have had explained to me information about **HEPATITIS B** and the **Hepatitis B Vaccine**. I have had a chance to ask questions which were answered to my satisfaction. I believe understand the benefits and risks of the **HEPATITIS B Vaccine**.

The **HEPATITIS B Vaccine** is administrated in three doses, the second dose is given one month after the 1st and the 3rd dose is given five months after second dose. One month after the 3rd dose, the **HEPATITIS B Vaccine Titer** is given to establish immunity or none immunity to the vaccine.

_____ **No** - I DO NOT want to take the **HEPATITIS B Vaccine** at this time.
I understand that by declining the Vaccine, I continue to be at risk of acquiring **HEPATITIS B**, a serious disease.

_____ **Yes** - I DO want to take the **HEPATITIS B Vaccine**.

_____ _____

Name (Print Name) **Signature**

_____ _____/_____/_____

Social Security Number **Date**

OCCUPATIONAL EXPOSURE TO BLOODBORNE PATHOGENS

Universal Precautions

Blood has long been recognized as a potential source of pathogenic microorganisms that may present a risk to individuals who are exposed during the performance of their duties. Universal precautions is the method of control required by the Occupational Safety and Health.
Administration (OSHA) to protect workers from exposure to all human blood and body fluids. Universal precautions refers to a concept of blood borne disease control, which requires that all human blood and body fluids. Universal precautions refers to a concept of blood borne disease control. Which requires that all human blood and certain human body fluids be treated as if known to be infectious for HIV (the virus that causes AIDS), the Hepatitis B virus and other blood borne pathogens.

Protective barriers reduce the risk of exposure to blood, body fluids containing visible blood and other fluids to which universal precautions apply. Examples of protective barriers include gloves, gowns, mask and protective eyewear. Universal precautions are intended to supplement rather than replace recommendations for routine infection control, such as hand-washing and using gloves to prevent gross microbial contamination of hands. Universal pre cautions will be used during the provisions of services as applicable and appropriate.

Personal Assistant Initials _____

Hepatitis B

Hepatitis B is a serious infection involving the liver. Hepatitis B virus (HBV) can cause lifelong infection, cirrhosis (scarring) of the liver, liver cancer, liver failure and death. Hepatitis B is spread when blood or body fluids from an infected person enters the body of a person who is not infected. HBC is a major infectious occupational hazard for health care. Any health-care worker may be at risk for HBV exposure depending on the tasks that he or she performs. Workers should be vaccinated if their tasks involve contact with blood or blood-contaminated body fluids.

Personal Assistant Initials _____

Hepatitis B Vaccination

Hepatitis B Vaccination OSHA standards effective June 4, 1992, require that employers make available the Hepatitis B Vaccine and vaccination series to all employees who have occupational exposure. The hepatitis B vaccine is available at no cost to the employee.

The vaccine is administered in a prescribed series of three injections over a six month period:

- Dose 2 is administered 30 days after Dose 1.
- Dose 3 is administered five months following Dose 2.

The employee is responsible for the requesting from the healthcare provider administering the vaccination additional information specific to the efficiency, safety, benefits, and methods of administration and potential side effects of the Hepatitis B vaccination. The employee mat elect to receive or decline the Hepatitis B Vaccination.

Personal Assistant Initials _____

Care Begins Here

Rockaway CDPAP Home Care Services

16-03 Central Avenue Far Rockaway, New York 11691
(718) 471-5800 Fax (718) 327-0001

Employee Statement – Informed choice related to Hepatitis B Vaccination. Check one statement below:

☐ I decline the Hepatitis B vaccination. 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 Hepatitis B Vaccine at this time. 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 Hepatitis B vaccine, I can receive the vaccination series at no charge to me. (Federal Register: 61 FR 5507, February 13,1996 *OSHA 1910.1030 App A – Mandatory Declination Statement)

☐ I decline the Hepatitis B vaccination at this time because I have previously received the Hepatitis B vaccination.

☐ I agree to receive the Hepatitis B vaccination and the employer and I have agreed to the following arrangement(s) related to covering the cost of the vaccination.

I, The below-named Personal Assistant and employee of the below-named Consumer, acknowledge and certify that I received information on occupational exposure to blood borne pathogens, universal precautions, Hepatitis B and Hepatitis B vaccination. I have been provided the opportunity to ask questions and to seek additional information. I have made my choice (as documented in the Employee statement above) related to the Hepatitis B vaccination based on informed choice.

Consumer Name: _____

Personal Assistant Name: _____

Personal Assistant Signature: _____

Date: _____

RHAS
Rockaway Home Attendant Services, Inc.

Dear Home Health Aid:

Once again, New York State Department of Health has mandated that all home care aides are required to take the flu vaccine during the influenza season. Please read and sign the form below.

Patient Name (please print): _____

Received Flu Vaccine at: _____

_____ MD Office

_____ Clinic

_____ Other

_____ Dosage

Date Received: _____/_____/_____

Manufacturer's Name: _____

Lot #: _____

Site of injection: _____

_____
Patient's Signature

_____
Physician's Signature & Stamp

16-03 Central Ave. Far Rockaway, NY 11691 M: 718-471-5800 F: 718-327-0004

Declination of Influenza Vaccination
For Health Care Personnel

Employee's Name: _____

I have been advised that I should receive the influenza vaccine to protect myself and the patients I serve. I have read the Centers for Disease Control and Prevention's (CDC) Vaccine Information Statement explaining the vaccine and the disease it prevents. I have had the opportunity to discuss the statement and have my questions answered by a healthcare provider. I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands I the United States each year.
- Influenza vaccination is recommended for me and all other healthcare personnel to protect this facility's patients from influenza, it complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.
- If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.
- I understand that the strains of virus that cause influenza infection change almost every year and even if they don't, my immunity declines over time. This is why vaccination against influenza is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including all patients in this healthcare facility, coworkers, my family, and my community.
- Because I have refused vaccination against influenza, I will be required to wear surgical or procedure masks in areas where patients or residents may be present during influenza season.

I acknowledge that I have read in its entirety and fully understand it. Despite these facts, I have decided to decline the influenza vaccine by my signature below. I realize that I may re-address this issue at any time and accept vaccination in the future.

_____ _____/_____/_____

Signature **Date**

_____ _____/_____/_____

Witness Date

16-03 Central Ave. Far Rockaway, NY 11691 M: 718-471-5800 F: 718-327-0004

Care Begins Here

Rockaway CDPAP Home Care Services
1603 Central Avenue – Suite 200A
Far Rockaway, New York 11691
Phone: 718-471-5800 Fax: 718-327-0004

Drug Test Declination Form

Under the Consumer Directed Personal Assistance Program (CDPAP) all Personal Assistants (PA) are not obligated to take a drug test. A Personal Assistant (PA) is only required to take a drug test if the client/client representative is requesting for each Personal Assistant (PA) to take the drug test.

☐ **I DO NOT want my Personal Assistant (PA) taking a drug test**

☐ **I DO want my Personal Assistant (PA) to take the drug test**

_____

Consumer/Consumer Representative Name

_____ _____/_____/_____

Signature **Date**

Care Begins Here

Rockaway CDPAP Home Care Services

1603 Central Avenue - Suite 200A
Far Rockaway, New York 11691
Phone: 718-471-5800 Fax: 718-327-0004

Covid Vaccination Declination Form

COVID-19 is a disease caused by a type of coronavirus. It attacks a person's respiratory system—most commonly the sinuses, nose, throat, and lungs. But the symptoms can vary from person to person.

In 2020, over 3 million people died from COVID-19. It is arguably one of the most challenging public health problems the world has had to face. This global effort has helped create several vaccines to help prevent severe consequences of the disease. **We highly recommend each worker to get the Covid Vaccine to be on the safe side for you and the client.**

When working under the Consumer Directed Personal Assistance Program (CDPAP) you are not obligated to receive the Covid Vaccine unless the client/client representative is requesting for each Personal Assistant to receive it before employing them.

As a client you are able to wave/refuse your Personal Assistants (PA) from having to receive Covid Vaccinations.

☐ **I DO NOT need my Personal Assistant (PA) to receive the Covid Vaccination to be able to work for me**

☐ **I DO need my Personal Assistant (PA) to receive the Covid Vaccination to be able to work for me**

_____

Consumer/Consumer Representative Name

_____ _____ / _____ / _____

Signature **Date**

Copies that need to be brought in for CDPAP

- State ID or non-expired Passport.
- Permanent Resident Card (If you are a resident).
- Employment Authorization card if not a citizen.
- Your Social Security card.
- Recent Physical (no less than 6 months).
- Rubella and Rubeola (Measles) **blood work report showing immunity**. (If not immune must take MMR vaccine (Booster Shot) and send in report.
- PPD (TB skin test) or Quantiferon (TB blood rest) report. If TB positive, needs to bring in chest X-Ray report and complete TB Questionnaire.
- Hep B declination form/ or Heb B report showing Immunity if not declining.
- Flu vaccine report/ or Flu Vaccine declination form if You do not want to take it.
- A recent COVID-19 test.

RHAS

ROCKAWAY HOME ATTENDANT SERVICES, INC.

Annual Medical Examination

Agency I.D:_____ [ ] Pre-Employment [ ] Annual

Patient's Name: (Last, First, Middle) _____

D.O.B:____/____/_____ SS#:_____-_____-_____ Sex: [ ] F [ ] M

Home Phone# :( ) _____ I.D#:_____

Address: _____

_____

This is a limited physical examination for employment purposes only and is not a substitute for you comprehensive annual check-up by your own physician.

CONSENT FOR EXAMINATION AND RELEASE OF INFORMATION

Patient's Signature: _____ Date: _____

MEDICAL HISTORY:	YES	NO
Recurrent Bloody Nose:	[ ]	[ ]
Bleeding Gums	[ ]	[ ]
Blurred Vision/Nausea/Vomiting	[ ]	[ ]
Recurrent Headaches	[ ]	[ ]
Difficulty Walking Long Distance	[ ]	[ ]
Shortness of Breath: W/ or W/out Exertion	[ ]	[ ]
Difficulty Breathing While Sleeping	[ ]	[ ]
Swelling of Lower Extremities	[ ]	[ ]
Seizure Disorder (History of Epilepsy)	[ ]	[ ]
Dizziness/Fainting/Chest Discomfort	[ ]	[ ]
Weakness/Paralysis/Leg Pains	[ ]	[ ]
Urination with Bleeding or Blood	[ ]	[ ]
ILLNESSES:		
Tuberculosis/Hepatitis/Malaria	[ ]	[ ]
Measles/Mumps	[ ]	[ ]
Syphilis/Gonorrhea	[ ]	[ ]
Asthma/C.O.P/Allergies/Diabetes	[ ]	[ ]
Heart Disease/Hypertension	[ ]	[ ]
Surgery/Other Medical Illnesses	[ ]	[ ]
Depressants/Stimulants/Narcotics	[ ]	[ ]
Alcohol/Smoker	[ ]	[ ]
Present Medication	[ ]	[ ]

If yes, please list below:

_____

_____

RHAS

ROCKAWAY HOME ATTENDANT SERVICES, INC.

Patient's Name: _____ SS #: _____

Exam Result: [ ] RED [ ] YELLOW [ ] GREEN **Exam Date:** ____/____/____ Exam #: _____

HT:	WT:	BP:	PULSE:	RESP.:

SYMPTOMS:	ABNORMAL:	NORMAL:
Skin	[ ]	[ ]
Eyes	[ ]	[ ]
Ears	[ ]	[ ]
Nose	[ ]	[ ]
Throat/Neck	[ ]	[ ]
Hearts	[ ]	[ ]
Lungs	[ ]	[ ]
Back	[ ]	[ ]
Extremities	[ ]	[ ]

Physician's License # and Stamp:

Annual Tuberculosis Screening Questionnaire

1. Have you ever had a test for Tuberculosis? Yes: ___ No:___
   PPD/Mantoux Date: _____ Results: _____
   QuantiFERON Date: _____ Results: _____
   Chest X-Ray Date: _____ Results: _____
2. Do you currently have any of the following symptoms?

Symptoms	Yes	No	Comments
Weakness	___	___	_____
Fatigue	___	___	_____
Lack of Appetite	___	___	_____
Weight Loss	___	___	_____
Low Grade Fever	___	___	_____
Night Sweats	___	___	_____
Flu-Like Symptoms	___	___	_____
Chest Pain	___	___	_____
Shortness of Breath	___	___	_____
Persistent Cough	___	___	_____
Blood Streaked Sputum	___	___	_____

   If yes, Color of Sputum (circle) Clear/ Yellow
3. Have you ever been exposed to anyone exhibiting the signs or symptoms that has active Tuberculosis?
   Yes:__ No:__
   If yes, When and by whom were you exposed, and what type, if any, follow up treatment did you receive? _____

_____

If I should notice any of the above signs or symptoms, I understand that I am to immediately notify my Physician and my Employer.

Patient Signature: _____ **Date:** ____/____/_____

Physician Signature: _____ **Date:** ____/____/_____

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ROCKAWAY HOME ATTENDANT SERVICES, INC.

Patient's Name: _____ SS# _____

TESTS/LAB RESULTS:	DATE GIVEN:	DATE READ:	RESULTS:	LOT# & SITE:
T.B SKIN TEST-PPD (MANTOUX)				
PPD 2 STEP				
QuantiFERON-TB GOLD				
CHEST X-RAY (IF PPD POSITIVE)				

TESTS/ LAB RESULTS:	DATE:	RESULTS:	IMMUNE/NON-IMMUNE:
RUBELLA TITRE			
RUBEOLA TITRE			

*PLEASE PROVIDE LAB RESULTS FOR RUBELLA, RUBEOLA, AND QUANTIFERON.

Physical Demands: The physical demands described here are representative of those that must be met

IMMUNIZATIONS:	DATE:	DATE:	DATE:
MMR			
HEPATITIS VACCINE			
DIPTHERIA/TETNUS			

INFLUENZA (FLU SHOT):

DATE:	SITE:	LOT#:	MANUFACTURER:

by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform essential functions.

Check one physical requirement which applies to this position.

[ ] This is free from any health impairment or a habituation to drugs or alcohol that is a potential risk to the patient or other employee or which applies to this position.

[ ] This individual is able to work with the following limitations:

[ ] In my opinion, this individual can adequately perform his/her job functions.

[ ] This individual is recommended additional testing or treatment.

Physician Signature: _____ NYS LIC#: _____ Date: _____

Physician Stamp: Tel# :( ) _____

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