Dear Applicant,

Welcome and thank you for your interest in working for MORNING STAR SUPPORTIVE SERVICES CORPORATION. We are a DDD Provider that dedicate our lives in supporting individuals with Developmental Disabilities.

We need Caregivers like yourself who are dedicated and compassionate in providing the care to our beloved individuals.

Below are the required documents to complete the onboarding process.

Please provide the copy of the following Credentials:

o Driver's License

o Social Security Card

o Permanent Resident Card or Workers Permit for non-US Citizen.

o Auto Insurance

o Auto Registration

o CPR/First Aid Certification

o Highschool Diploma, Equivalent or higher

o Fingerprint Receipt

o Headshot photo for Company ID

You will also need to be set up for the following appointment:

o Drug Screen – Pre-employment

o Fingerprint appointment – https://uenroll.identogo.com

Once completed. Please provide the copy of the Fingerprint Receipt

o CDS online classes – Link, log in and Password below: (upon completing the application)

https://login.elsevierperformancemanager.com/EMBCenter

Log in: first letter of your first name, full last name, last 4 digit of your social security number.

Example: JDoe1234

Password: hello

While completing the onboarding process, you may be contacted by our staff member regarding your availability and willingness to travel for our cases. As part of our process, we conduct a meet and greet with the individuals and their family members prior to starting the case. We request of you to wear casual/appropriate clothing during the said meeting.

Welcome and thank you for being part our team MORNINGSTAR!

Sincerely,

INFO@MORNINGSTARSUPPORTIVESERVICES.COM

Tel. 862-772-5153

APPLICANT ACKNOWLEGEMENT

(NOTE: Application will not be considered complete without the applicant's signature)

I certify that the information in this application is accurate, current and complete. I understand that misstatements or omissions may result in disqualification from further consideration or termination of employment. I agree that, if hired, I may be discharged if Morning Star Supportive Services learns of any falsification or material omission in the information I have provided and if discovered prior to hire, I would be ineligible for consideration not only for this position, but future positions, as well. (NOTE: You will not automatically be excluded from consideration if you have been convicted of a crime. Your suitability for the position sought will be evaluated based upon the totality of circumstances such as the nature of the crime, the recency of the conviction, the type of work involved, etc.)

I understand and agree that all information concerning patients and their families is strictly confidential. I am not permitted to disclose any financial, medical or personal information related to any patient or family member to fellow employees, company administrative staff or individuals, except my supervisor at Morning Star Supportive Services.

I authorize Morning Star Supportive Services. to investigate my employment history, credentials, license verification and to obtain any relevant information, including a criminal background check needed to make an employment decision. I authorize Morning Star Supportive Services. to disclose this application along with any information about me obtained through reference checks or during the interview process for state, federal, contractual or accreditation audit purposes. I also authorize Morning Star Supportive Services. to disclose any of my performance appraisals, disciplinary records or skills tests for the same purposes as above. I release Morning Star Supportive Services. and any individual or entity providing information to Morning Star Supportive Services. from all liability for any damage from the disclosure of this information.

I also understand and agree that passing a medical examination (which is my responsibility) and/or medical screening may be required. If medical restrictions cannot be reasonably accommodated, I may not be hire of if hired, I may be terminated.

I understand and agree that I may be subject to pre-employment drug testing and/or alcohol testing, random testing, as well as testing where reasonable suspicion or improper usage has occurred, or were warranted by an on-the-job injury, circumstance, workplace conditions or contractual requirements.

I understand and agree nothing contained in this employment application or in granting of an interview creates an employment con- tract between Morning Star Supportive Services. and I for either employment or for the providing of any benefit. No promises regarding employment have been made to me. If an employment relationship is established, I understand that my employment will be terminable "at will;" that is, I will have the right to terminate my employment at any time and that Morning Star Supportive Services. retains the same right to terminate my employment at any time.

I understand that should I become employed by Morning Star Supportive Services, my work assignments, schedules and/or work locations are subject to change according to the needs of the business and the clients of Morning Star Supportive Services.

I understand that Morning Star Supportive Services. is committed to promoting safety and high standards of employee performance, productivity and reliability. To achieve this, I may be subjected to a drug test prior being hired to assure Morning Star Supportive Services. I do not currently have narcotics, sedatives, stimulants or other controlled substances and/or mood-altering substances in my body. I understand if I have any such substance in my body at the time of the drug test, Morning Star Supportive Services will not hire me.

I understand that Morning Star Supportive Services reserves the right to add to, change and/or delete their policies, procedures, work rules and benefits at any time andthat no one in Morning Star Supportive Services has the authority to enter into any agreement forany particular period of time, or contrary to the above terms, unless that agreement is set forth in writing and signed by an authorized representative of Morning Star Supportive Services.

Applicant's Signature_____ Date _____

Pursuant to Title VII of the Civil Rights Act of 1965 (42 U.S.C., §20000d et seq.) and 45 C.F.F. Part 80, §504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §6101 et seq.), Morning Star Supportive Services adheres to an equal opportunity policy for all persons seeking admission as clients or seeking employment and for all persons employed by Morning Star Supportive Services. Morning Star Supportive Services offers equal employment and advancement opportunities to qualified individuals without regard to race, color, religion, sex, age, national origin, marital status, disability, or any other category protected by any applicable local, state, federal law, ordinance, or regulation.

Application Reviewed by_____ Date _____

Application for Employment

Today's Date _____

PERSONAL DATA - If you have lived at current address less than one year, list previous address.

Name; Last:	First:		Middle	
Soc. Sec. #	Telephone #		SMS #	
Address	City	County	State	Zip
Previous Address:	City	County	State	Zip

EDUCATION

Date	School, Location	Degree/Diploma	Course of Study
Date	school, Location	Degree/Diploma	Course of Study
Date	school, Location	Degree/Diploma	Course of Study

SPECIAL LICENSES, CERTIFICATIONS OR REGISTRATION

License/Certification Type	License/Certification No.	State	Expiration Date
License/Certification Type	License/Certification No.	State	Expiration Date
CPR Expiration Date	Last Physical Exam Date	Lab TB/Chest X-Ray Date	

GENERAL INFORMATION

Are you legally authorized to work in the USA ❒ Yes ❒ No

(If you became an employee of MSSS, you will be required to provide documentation proving your eligibility to work in the USA)

Has your professional license ever had any action taken against it or been suspended? ❒ Yes ❒ No

Have you ever been convicted of a felony or misdemeanor crime? ❒ Yes ❒ No

(This does not apply if the conviction has been expunged, is contained in a sealed record, or was a juvenile conviction.) A criminal conviction will not necessarily bar you from employment.

We will consider the nature of the crime, the time that has expired since its occurrence and any rehabilitation you have undergone. If yes, state the basis for each conviction and the date of the conviction:

Are you able to perform the tasks according to the job description without accommodation?
Yes ☐No ☐
If accommodation is needed, how would perform the task and with what accommodation?

_____

How did you hear about MSSS? ❒ Newspaper ❒ Trade Publication ❒ Job Fair/Open House

❒ Employment Agency ❒ MSSS employee (name) _____

❒ Work location _____

In case of emergency, notify: _____

Telephone#_____ Relationship_____

Address _____

Morning Star Supportive Services

REFERENCE REQUEST FORM

Name:_____DOB: _____

Name of Agency Contact: _____

Employer: _____

Address: _____

Phone Number/Email: _____

Dates of Employment: _____

Name of Agency Contact: _____

Employer: _____

Address: _____

Phone Number/Email: _____

Dates of Employment:_____-

I,_____do hereby authorize Morning Star Supportive Services to verify my references and background.

NAME (Print)_____ **Signature** _____

DSP Job Description

Staff Qualifications

- Minimum 18 years of age – AND –
- Complete State/Federal Criminal Background checks and Central Registry checks
- Valid driver's license and abstract (not to exceed 5 points) if driving is required
- Pass a drug Test
- Pass a Child and Adult Abuse Clearance
- Employer will train
- Support from staff to enable an individual to attend an event, take a class, etc.
- Support from staff to assist an individual participating in activities such as: assistance in completing activities of daily living, ordering off a menu, purchasing items, learning basic cooking, laundry skills, etiquette, travel training, accessing activities in the community, etc.
- One-on-one tutoring
- Support on a job site to assist in basic self-care, social skills, and activities of daily living.

Pay: $14.50

Employee Name:_____ Date: _____

APPENDIX A
COMMUNITY AGENCY HEAD AND EMPLOYEE CERTIFICATION, PERMISSION FOR BACKGROUND CHECK AND RELEASE OF INFORMATION

I hereby authorize the Department of Human Services to conduct a criminal history background check and I agree to be fingerprinted in order to complete the state and federal background check process. I further authorize the release of all information regarding the results of my background check to the Department of Human Services. Check one of the options listed below.

Option 1_____I hereby certify under penalties of perjury, that I have not been convicted of any of the offenses listed below and no such record exits in the State Bureau of Identification in the Division of State Police or in the Federal Bureau of Investigation, Identification Division.

Option 2_____I hereby affirm that I have been convicted of the following offense listed below_____ on_____.
(date)

If I have checked Option 2 or the criminal history background check reveals any conviction(s) for the offenses listed below, I understand that I may be subject to termination from employment.

FOR PROVISIONAL EMPLOYEES ONLY: As a provisional employee, I further understand that I may be employed by the agency for a period not to exceed six (6) months during which time a background check will be completed. I understand that I will work under the supervision of a superior where possible.

Offenses covered under P.L. 1999, C. 358:

In New Jersey, any crime or disorderly person offense:
-involving danger to the person as set forth in N.J.S.A. 2C:11-1 et seq. through 2C:15-1 et seq. including the following:

i. Murder
ii. Manslaughter
iii. Death by auto
iv. Simple assault
v. Aggravated assault
vi. Recklessly endangering another person
vii. Terroristic threats
viii. Kidnapping
ix. Interference with custody of children
x. Sexual assault
xi. Criminal sexual contact
xii. Lewdness
xiii. Robbery

-against the children or incompetents as set forth in N.J.S.A. 2C:24-1 et seq. including the following:

i. Endangering the welfare of a child

ii. Endangering the welfare of an incompetent person

-a crime or offense involving the manufacture, transportation, sale, possession or habitual use of a controlled dangerous substance as defined in N.J.S.A. 2C:24-1 et seq.

-in any other state or jurisdiction, conduct which, if committed in New Jersey, would constitute any of the crimes or disorderly persons offenses described above.

FOR COMMUNITY AGENCY HEAD: I understand the results of this background check will be reported to the President of the Board of my agency.

PLEASE LIST THE NAME AND HOME OR BUSINESS ADDRESS OF THE BOARD PRESIDENT.

_____

_____

_____

_____ _____ _____

Employee Name (please print) Employee Signature Date

_____ _____ _____

Witnessed by (please print) Witness Signature Date

CHILD ABUSE RECORD INFORMATION FORM
STATE OF NEW JERSEY
DEPARTMENT OF CHILDREN & FAMILIES

Indicate Reason for CARI by Checking Appropriate Box

DHS/DDD Employee:
- ☐ Community Provider/Agency — ☐ *check here if Agency head*
- ☐ Community Care Residence Provider — ☐ *check here if CCR Licensee*
- ☐ DHS Developmental Center Staff — ☐ *check here if New Employee*
- ☐ *check here if Existing Employee*

Agency/Facility: _____

COST CODE: _____

PLEASE PRINT CLEARLY IN INK. DO NOT USE PENCIL. PLEASE GIVE YOUR FULL NAME; DO NOT USE INITIALS. COMPLETE BOTH PAGES OF THIS FORM. SIGN, DATE, AND RETURN THE FORM TO YOUR EMPLOYER FOR SUBMISSION TO DCF. ATTACH ADDITIONAL SHEETS IF MORE SPACE IS NEEDED.

Print your full name (first, middle, last): _____

Previous name, maiden name or nicknames: _____

Date of name change, if applicable: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Date of birth: _____ Race: _____

Social Security number:[1] _____ Sex: _____

Applicant Phone number: ( ) _____

Full Names and Dates of Birth of your children, if any, whether living with you or not:

NOTE: If none, check this box ☐

Child's First Name	Middle Name	Last Name	Date of Birth

[1] Pursuant to the Federal Privacy Act of 1974 (P.L. 93-579), the disclosure of your Social Security Number is voluntary. Your Social Security Number, race, date of birth, and sex will only be used for the purpose of conducting a Child Abuse Record Information background check as authorized by N.J.S.A. 30:6D-76.

Your previous addresses since 1980 and the dates you lived at each address: **NOTE: If none, check this box** ☐
(ATTACH ADDITIONAL SHEETS IF MORE SPACE IS NEEDED)

1) _____

From:_____ To: _____
(month) (year) (month) (year)

2) _____

From:_____ To: _____
(month) (year) (month) (year)

3) _____

From:_____ To: _____
(month) (year) (month) (year)

4) _____

From:_____ To: _____
(month) (year) (month) (year)

5) _____

From:_____ To: _____
(month) (year) (month) (year)

All persons completing this form **must** read the following and sign below:

I consent to have the Department of Children and Families conduct a Child Abuse Record Information check to determine whether an allegation of child abuse or neglect has been substantiated against me. I certify that I am not currently being investigated for any allegation of child abuse or neglect. I understand that if a record of substantiated child abuse or neglect is found, or if I refuse to sign this consent form, I may not be permitted to work, or continue to work as a DHS employee, contractor, or volunteer. I certify that all information I have given on this form is accurate and complete to the best of my knowledge.

Signature:_____ Date: _____

FOR DEPARTMENT OF CHILDREN & FAMILIES USE ONLY

CARI staff initials _____

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

► **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

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		
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		**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		

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Form W-4 (2019)

Future developments. For the latest information about any future developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. You may claim exemption from withholding for 2019 if **both** of the following apply.

- For 2018 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2019 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2019 expires February 17, 2020. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2019 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income not subject to withholding outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2019. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married filing jointly and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

Nonwage income. If you have a large amount of nonwage income not subject to withholding, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Additional Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. ***Head of household please note:*** Generally, you may claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you may be eligible to claim a child tax credit for each of your eligible children. To qualify, the child must be under age 17 as of December 31, must be your dependent who lives with you for more than half the year, and must have a valid social security number. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line F. Credit for other dependents. When you file your tax return, you may be eligible to claim a credit for other dependents for whom a child tax credit can't be claimed, such as a qualifying child who doesn't meet the age or social security number requirement for the child tax credit, or a qualifying relative. To learn more about this credit, see Pub. 972. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total

Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▸ **Whether you're entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2019

1 Your first name and middle initial	Last name	**2 Your social security number**
Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married filing separately, check "Married, but withhold at higher Single rate."	
City or town, state, and ZIP code	**4 If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card.** ▸ ☐	

5	Total number of allowances you're claiming (from the applicable worksheet on the following pages)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2019, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▸	**7**	

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

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

8 Employer's name and address (**Employer:** Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)	**9** First date of employment	**10** Employer identification number (EIN)

income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line G. Other credits. You may be able to reduce the tax withheld from your paycheck if you expect to claim other tax credits, such as tax credits for education (see Pub. 970). If you do so, your paycheck will be larger, but the amount of any refund that you receive when you file your tax return will be smaller. Follow the instructions for Worksheet 1-6 in Pub. 505 if you want to reduce your withholding to take these credits into account. Enter "-0-" on lines E and F if you use Worksheet 1-6.

Deductions, Adjustments, and Additional Income Worksheet

Complete this worksheet to determine if you're able to reduce the tax withheld from your paycheck to account for your itemized deductions and other adjustments to income, such as IRA contributions. If you do so, your refund at the end of the year will be smaller, but your paycheck will be larger. You're not required to complete this worksheet or reduce your withholding if you don't wish to do so.

You can also use this worksheet to figure out how much to increase the tax withheld from your paycheck if you have a large amount of nonwage income not subject to withholding, such as interest or dividends.

Another option is to take these items into account and make your withholding more accurate by using the calculator at *www.irs.gov/W4App*. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Two-Earners/Multiple Jobs Worksheet

Complete this worksheet if you have more than one job at a time or are married filing jointly and have a working spouse. If you don't complete this worksheet, you might have too little tax withheld. If so, you will owe tax when you file your tax return and might be subject to a penalty.

Figure the total number of allowances you're entitled to claim and any additional amount of tax to withhold on all jobs using worksheets from only one Form W-4. Claim all allowances on the W-4 that you or your spouse file for the highest paying job in your family and claim zero allowances on Forms W-4 filed for all other jobs. For example, if you earn $60,000 per year and your spouse earns $20,000, you should complete the worksheets to determine what to enter on lines 5 and 6 of your Form W-4, and your spouse should enter zero ("-0-") on lines 5 and 6 of his or her Form W-4. See Pub. 505 for details.

Another option is to use the calculator at *www.irs.gov/W4App* to make your withholding more accurate.

Tip: If you have a working spouse and your incomes are similar, you can check the "Married, but withhold at higher Single rate" box instead of using this worksheet. If you choose this option, then each spouse should fill out the Personal Allowances Worksheet and check the "Married, but withhold at higher Single rate" box on Form W-4, but only one spouse should claim any allowances for credits or fill out the Deductions, Adjustments, and Additional Income Worksheet.

Instructions for Employer

Employees, do not complete box 8, 9, or 10. Your employer will complete these boxes if necessary.

New hire reporting. Employers are required by law to report new employees to a designated State Directory of New Hires. Employers may use Form W-4, boxes 8, 9, and 10 to comply with the new hire reporting requirement for a newly hired employee. A newly hired employee is an employee who hasn't previously been employed by the employer, or who was previously employed by the employer but has been separated from such prior employment for at least 60 consecutive days. Employers should contact the appropriate State Directory of New Hires to find out how to submit a copy of the completed Form W-4. For information and links to each designated State Directory of New Hires (including for U.S. territories), go to ***www.acf.hhs.gov/css/employers.***

If an employer is sending a copy of Form W-4 to a designated State Directory of New Hires to comply with the new hire reporting requirement for a newly hired employee, complete boxes 8, 9, and 10 as follows.

Box 8. Enter the employer's name and address. If the employer is sending a copy of this form to a State Directory of New Hires, enter the address where child support agencies should send income withholding orders.

Box 9. If the employer is sending a copy of this form to a State Directory of New Hires, enter the employee's first date of employment, which is the date services for payment were first performed by the employee. If the employer rehired the employee after the employee had been separated from the employer's service for at least 60 days, enter the rehire date.

Box 10. Enter the employer's employer identification number (EIN).

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for yourself . . . . . **A** _____

B Enter "1" if you will file as married filing jointly . . . . . **B** _____

C Enter "1" if you will file as head of household . . . . . **C** _____

D Enter "1" if:
- You're single, or married filing separately, and have only one job; or
- You're married filing jointly, have only one job, and your spouse doesn't work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.

D _____

E **Child tax credit.** See Pub. 972, Child Tax Credit, for more information.

- If your total income will be less than $71,201 ($103,351 if married filing jointly), enter "4" for each eligible child.
- If your total income will be from $71,201 to $179,050 ($103,351 to $345,850 if married filing jointly), enter "2" for each eligible child.
- If your total income will be from $179,051 to $200,000 ($345,851 to $400,000 if married filing jointly), enter "1" for each eligible child.
- If your total income will be higher than $200,000 ($400,000 if married filing jointly), enter "-0-" . . . . . **E** _____

F **Credit for other dependents.** See Pub. 972, Child Tax Credit, for more information.

- If your total income will be less than $71,201 ($103,351 if married filing jointly), enter "1" for each eligible dependent.
- If your total income will be from $71,201 to $179,050 ($103,351 to $345,850 if married filing jointly), enter "1" for every two dependents (for example, "-0-" for one dependent, "1" if you have two or three dependents, and "2" if you have four dependents).
- If your total income will be higher than $179,050 ($345,850 if married filing jointly), enter "-0-" . . . . . **F** _____

G **Other credits.** If you have other credits, see Worksheet 1-6 of Pub. 505 and enter the amount from that worksheet here. If you use Worksheet 1-6, enter "-0-" on lines E and F . . . . . **G** _____

H Add lines A through G and enter the total here . . . . . ▸ **H** _____

For accuracy, **complete all worksheets that apply.**

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, or if you have a large amount of nonwage income not subject to withholding and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.
- If you **have more than one job at a time** or are **married filing jointly and you and your spouse both work,** and the combined earnings from all jobs exceed $53,000 ($24,450 if married filing jointly), see the **Two-Earners/Multiple Jobs Worksheet** on page 4 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 above.

Deductions, Adjustments, and Additional Income Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income not subject to withholding.

1 Enter an estimate of your 2019 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 10% of your income. See Pub. 505 for details . . . . . **1** $ _____

2 Enter:
- $24,400 if you're married filing jointly or qualifying widow(er)
- $18,350 if you're head of household
- $12,200 if you're single or married filing separately

. . . . . **2** $ _____

3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" . . . . . **3** $ _____

4 Enter an estimate of your 2019 adjustments to income, qualified business income deduction, and any additional standard deduction for age or blindness (see Pub. 505 for information about these items) . . **4** $ _____

5 **Add** lines 3 and 4 and enter the total . . . . . **5** $ _____

6 Enter an estimate of your 2019 nonwage income not subject to withholding (such as dividends or interest) . **6** $ _____

7 **Subtract** line 6 from line 5. If zero, enter "-0-". If less than zero, enter the amount in parentheses . . . **7** $ _____

8 **Divide** the amount on line 7 by $4,200 and enter the result here. If a negative amount, enter in parentheses. Drop any fraction . . . . . **8** _____

9 Enter the number from the **Personal Allowances Worksheet,** line H, above . . . . . **9** _____

10 **Add** lines 8 and 9 and enter the total here. If zero or less, enter "-0-". If you plan to use the **Two-Earners/ Multiple Jobs Worksheet,** also enter this total on line 1 of that worksheet on page 4. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 . . . . . **10** _____

Two-Earners/Multiple Jobs Worksheet

Note: Use this worksheet *only* if the instructions under line H from the **Personal Allowances Worksheet** direct you here.

1 Enter the number from the **Personal Allowances Worksheet,** line H, page 3 (or, if you used the **Deductions, Adjustments, and Additional Income Worksheet** on page 3, the number from line 10 of that worksheet) . . . . . **1** _____

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you're married filing jointly and wages from the highest paying job are $75,000 or less and the combined wages for you and your spouse are $107,000 or less, don't enter more than "3" . . . . . **2** _____

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet . . . . . **3** _____

Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet . . . . . **4** _____

5 Enter the number from line 1 of this worksheet . . . . . **5** _____

6 **Subtract** line 5 from line 4 . . . . . **6** _____

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . . **7** $ _____

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . . **8** $ _____

9 **Divide** line 8 by the number of pay periods remaining in 2019. For example, divide by 18 if you're paid every 2 weeks and you complete this form on a date in late April when there are 18 pay periods remaining in 2019. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . . . **9** $ _____

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $5,000	0	$0 - $7,000	0
5,001 - 9,500	1	7,001 - 13,000	1
9,501 - 19,500	2	13,001 - 27,500	2
19,501 - 35,000	3	27,501 - 32,000	3
35,001 - 40,000	4	32,001 - 40,000	4
40,001 - 46,000	5	40,001 - 60,000	5
46,001 - 55,000	6	60,001 - 75,000	6
55,001 - 60,000	7	75,001 - 85,000	7
60,001 - 70,000	8	85,001 - 95,000	8
70,001 - 75,000	9	95,001 - 100,000	9
75,001 - 85,000	10	100,001 - 110,000	10
85,001 - 95,000	11	110,001 - 115,000	11
95,001 - 125,000	12	115,001 - 125,000	12
125,001 - 155,000	13	125,001 - 135,000	13
155,001 - 165,000	14	135,001 - 145,000	14
165,001 - 175,000	15	145,001 - 160,000	15
175,001 - 180,000	16	160,001 - 180,000	16
180,001 - 195,000	17	180,001 and over	17
195,001 - 205,000	18		
205,001 and over	19		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $24,900	$420	$0 - $7,200	$420
24,901 - 84,450	500	7,201 - 36,975	500
84,451 - 173,900	910	36,976 - 81,700	910
173,901 - 326,950	1,000	81,701 - 158,225	1,000
326,951 - 413,700	1,330	158,226 - 201,600	1,330
413,701 - 617,850	1,450	201,601 - 507,800	1,450
617,851 and over	1,540	507,801 and over	1,540

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You aren't required to provide the information requested on a form that's subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

New Jersey Department of Human Services
Division of Developmental Disabilities
www.nj.gov/humanservices/ddd

Community Based / Individual Supports

(Not applicable when delivering daily rate version of Individual Supports. Only used for 15 minute unit version)

Name: _____ **Service Plan Year:** _____

ISP Outcome: _____

Service Strategies (check all that apply):

☐ Assistance with Activities of Daily Living (such as getting dressed, eating, personal hygiene, etc.)
☐ Assistance with Increasing Community Participation (such as daily errands, attending events, restaurant, purchasing items, travel training, etc.)
☐ Assistance with Increasing Independence (such as helping the individual learn to do laundry, cook, clean, dress, grocery shop, pay for items, etc.)
☐ Assistance with On-The-Job Support (such as safety awareness, using the restroom, attending to task, lunch/breaks, etc.)
☐ Assistance with Learning Activities (such as basic tutoring – math, reading, writing; support in attending a class; etc.)

Date	Start Time	End Time	Individualized Activity	Tell us about the day, and how the activities will help the individual reach the above outcome

Completed By: _____

June 2018

New Jersey Universal Fingerprint Form

www.bioapplicant.com/nj

(1) Originating Agency Number (ORI #)	(2) Category	(3) Statute Number	
NJ920540Z	**HSK**	**30:6D-64**	
(4) Reason for Fingerprinting		(5) Document Type	(6) Payment Information
HUMAN SERVICES PRIVATE CONTRACTOR		**RB2**	**BILL STATE AGENCY**
(7) Contributor's Case # (Unique Identifier)		(8) Miscellaneous	
PC 3364 **(enter 4 digit cost code after PC)**			

(9) First Name	(10) MI	(11) Last Name		
(12) Daytime Phone Number ( ) -	(13) Social Security Number (Optional)	(14) Date of Birth	(15) Height	(16) Weight
(17) Maiden or Alias Last Name	(18) Place of Birth (US State if US Citizen; Country for all others)		(19) Country of Citizenship	
(20) Home Address Address City State Zip				
(21) Gender (Select one) [ ] Female [ ] Male [ ] Both	(22) Hair Color	(23) Eye Color	(24) Race (Select One) [A] Asian/ Pacific Islander (includes Asian Indian) [B] Black [I] American Indian / Alaska Native [W] White (Includes Hispanic/ Spanish Origin) [U] Unknown	
(25) Occupation / Position (with respect to Requirement)	(26) Employer / Organization Name (with respect to Requirement) **Morning Star Supportive Services.** Employer Address 8803 Timberline Ct. City **Monmouth junction** State **NJ** Zip **08852**			

Identification Requirement - *Identification must be presented at the time of printing.* Identification presented MUST be one (1) document that is current (not expired). A combination of documents will not be accepted. The single document must include the following criteria; Photo, Name, Address (home/employer), Date of Birth and is issued by a Federal, State, County or Municipal entity for Identification purposes. Examples of acceptable ID are: 1) Valid U.S. State Photo Driver's License/ Non Driver's License, 2) U.S. Passport, 3) USCIS Permanent Resident ID Card (issued after 5/10/2010), and 4) USCIS Employment Authorization Card (issued after 10/31/2010).

Please READ this form carefully

and follow all of the instructions provided by your agency/employer to complete the fingerprint process. You must have this form (Blocks 1 through 26) completed prior to scheduling your fingerprint appointment via the website or call center. ***PLEASE PRINT LEGIBLY****. It is* ***required*** *you* ***present*** *this completed Universal Fingerprint Form, IDG_NJAPP_020115_V2, at your scheduled appointment.*

Appointment Scheduling:

Scheduling is available anytime at **www.bioapplicant.com/nj.** Appointments may also be scheduled through our Call Center. English and Spanish speaking agents are available at **1-877-503-5981**, Monday through Friday, 8:00AM to 5:00PM EST and Saturday, 8:00AM to 12 Noon EST.

Payment:

When an Applicant is responsible for payment, Payment Is Required at the time of scheduling. The following forms of payment are accepted: Visa, MasterCard, or electronic debit (ACH) from a checking account; accounts will be debited immediately.

Cancel/ Reschedule:

Appointments may be canceled or rescheduled via the website or the call center before the deadline of 5PM EST the business day prior to the scheduled appointment (Saturday Noon for Monday appointments). An appointment fee of $10.00 will be incurred by applicants who do not cancel/reschedule their appointment prior to the deadline. MorphoTrust will refund the remainder of the fee paid (state/federal search fees) to the original payment method.

Unable to be Fingerprinted:

An applicant is considered "Unable to be Fingerprinted" for any of the following reasons: Failure to appear for scheduled appointment; Inability to present proper Identification; Inability to present this completed Universal Fingerprint Form IDG_NJAPP_020115_V2; Information on this form does not exactly match the information provided during the scheduling process. Applicants unable to be fingerprinted will incur a $10.00 appointment fee; MorphoTrust will refund the remainder of the fee paid (state/federal search fees) to the original payment method.

PCN and Receipts:

Upon the completion of fingerprinting you will be assigned a PCN number. The PCN will be recorded on this form and on your receipt. MorphoTrust will not provide *duplicate receipts, PCN Numbers or any appointment/printing information after the time of printing.*

Applicant ID Number:	Payment Authorization:	PCN:
Scheduled Day & Date:	Scheduled Time:	Scheduled Site:
Agency Information: **STATE AND FBI BACKGROUND CHECK**		

You **MUST** retain a copy of this form and the receipt of printing for your personal records.

APPLICANTS MUST NOT ALTER, SHARE, OR REUSE THIS FORM

Hepatitis B Vaccine Declination

I understand that due to my occupational exposure to blood or other potentially infectious materials may be at risk of acquiring hepatitis B (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination currently. 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.

Name (Print) _____ Social Security _____

Signature _____ Date _____

Hepatitis B Vaccination Consent Form

Hepatitis B vaccine is usually well tolerated. The most common side effect is soreness at the local injection site and fatigue. The vaccine is administered in three doses.

CONTRAINDICATIONS: Employees who are pregnant, breast-feeding mothers, have allergies to the vaccine or its components, mercury, or yeast, have a fever or active infection, heart disease, Guillain-Barre Syndrome, or immune deficiency disorders will be referred to their private physician for evaluation, prior to receiving the vaccine.

POSSIBLE ADVERSE REACTIONS: Flushed face, redness, swelling, or warmth at injection site, muscle aches, fatigue, and dizziness. Low-grade fever (less than 101 degrees F) occurs occasionally.

I have read the above information and have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of hepatitis B vaccine and consent to vaccination.

Name (Print) _____ Social Security _____

Signature _____ Date _____

FIRST INJECTION	SECOND INJECTION	THIRD INJECTION
Employee Signature	Employee Signature	Employee Signature
Date Vaccinated	Date Vaccinated	Date Vaccinated
Vaccine/Lot#/Exp. Date	Vaccine/Lot#/Exp. Date	Vaccine/Lot#/Exp. Date
Site of Injection	Site of Injection	Site of Injection
Administered by	Administered by	Administered by
Time Administered	Time Administered	Time Administered

NJ MVR RELEASE CONSENT FORM

In conjunction with my potential employment at **Morning Star Supportive Services** ("the company"), I_____(applicant) consent to the release of my Motor Vehicle Records (MVR) to the company.

I understand the company will use these records to evaluate my suitability to fulfill driving duties that. may be related to the position for which I am applying. I also consent to the review, evaluation, and other use of any MVR I may have provided to the company.

This consent is given in satisfaction of Public Law 18 USC 2721 et. Seq., "Federal Drivers Privacy Protection Act" and is intended to constitute "written consent" as required by this Act.

Signed (applicant)_____

Date: _____

Drivers' License Number: _____

State: _____

DRIVER RECORDS

Regardless of what business you are in, the deadliest hazard faced by American workers is that of the road. More workers are killed in vehicular accidents than by any other cause. Since most accidents are the result of human error, not vehicular condition, one of the best controls available for vehicular accidents, is to properly screen drivers. One of the best tools available for screening drivers is the MVR, or Motor Vehicle Record, of the driver. This is a report, available from the state, listing all tickets, accidents, and other similar infractions for a given driver, over a set period of years (usually 3 years, or 7 years). It is recommended that an MVR be obtained and reviewed **prior** to hiring an employee who will drive, and **certainly before allowing that employee to drive on company business**. MVR's should also be reviewed at least annually for all driving employees. This is the only way to be certain problems have not come up undetected. Drivers do not usually come in and announce a rash of speeding tickets, or a DUI. Many employers assume they know their employees well, and they would know if they got a ticket. This is not the case. A criterion should be set up for the evaluation of MVR's and should be fairly and uniformly applied to all drivers.

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES
PO BOX 726
TRENTON, NJ 08625-0726
609.631.2200
www.nj.gov/humanservices/ddd

CHRIS CHRISTIE
GOVERNOR

KIM GUADAGNO
LT. GOVERNOR

Elizabeth Connolly
Acting Commissioner

Dawn Apgar
Deputy Commissioner

Elizabeth M. Shea
Assistant Commissioner

Acknowledgement of Receipt of Information Regarding *"Danielle's Law"*

I have received the following information pertaining to Danielle's Law:

In accordance with Danielle's Law, 911 is to be called in life threatening emergencies. As defined in the law, "Life threatening emergency means a situation in which a prudent person *could* reasonably believe that immediate intervention is necessary to protect the life of a person receiving services, or to protect the lives of other persons at the facility or agency from an immediate threat or actual occurrence of a potentially fatal injury, impairment to bodily functions or dysfunction of a bodily organ or part."

Failure to call 911 in a life threatening emergency includes monetary fines: $5,000 for the first offense, $10,000 for the second offense, and $25,000 for the third and each subsequent offense. Additionally, a health care professional, licensed or alternately authorized to provide services, may be subject to revocation of that professional license or other authorization to practice as a health care professional.

I have received training on Danielle's Law including a Power Point Presentation on Danielle's Law, Frequently Asked Questions about Danielle's Law, a Fact Sheet on Life Threatening Emergencies, and a copy of Chapter 191, the actual Law.

I understand that it is my responsibility to call 911 if a person served by the Division of Developmental Disabilities is experiencing a life threatening emergency, as defined in Danielle's Law." I understand it is the responsibility of the emergency medical professionals to assess the severity of the emergency. My responsibility is to make the call to 911, provide information regarding the condition of the person, and direct emergency workers to the scene of the emergency. It is also my responsibility to provide immediate care until the emergency medical professionals arrive and take over.

Signature _____ **Date** _____

Print Name _____ **Title** _____

EMPLOYEE DIRECT DEPOSIT REQUEST

NAME:_____BRANCH: _____

Complete the required information. Allow at least 2-3 weeks for processing. For checking accounts, a copy of a voided check must be provided. For savings accounts, a copy of a deposit slip must be provided.

DIRECT DEPOSIT 1

NAME OF BANK_____
ABA#:_____ACCOUNT #: _____

- CHECKING
- SAVINGS I would like to deposit:

- Entire Net Pay $_____ %_____

ATTACH A COPY OF A VOIDED CHECK / SAVINGS DEPOSIT SLIP

In order for this direct deposit authorization to be valid, the name of the employee must be on the voided check or deposit slip. A notice from the bank authorizing the employee to deposit funds into the account will be accepted.

DIRECT DEPOSIT 2

NAME OF BANK_____
ABA#:_____ACCOUNT #: _____

- CHECKING
- SAVINGS I would like to deposit:

- Entire Net Pay $_____ %_____

ATTACH A COPY OF A VOIDED CHECK / SAVINGS DEPOSIT SLIP

For this direct deposit authorization to be valid, the name of the employee must be on the voided check or deposit slip. A notice from the bank authorizing the employee to deposit funds into the account will be accepted. I hereby authorize my employer to deposit any amounts owed me by initiating credit entries to my account at the financial institution(s) listed above. Further, I authorize the financial institution(s) listed above to accept and to credit any entries indicated by Morning Star Supportive Services to my account. If Morning Star Supportive Service deposits funds erroneously into my account, I authorize Morning Star Supportive Service to debit my account not to exceed the original amount of the erroneous credit. This authorization is to remain in full force and effect until Morning Star Supportive Service. has received written notice from me of its termination in such time and in such manner as to afford Morning Star Supportive Service a reasonable amount of time to act on it.

Employee Signature _____ Date _____