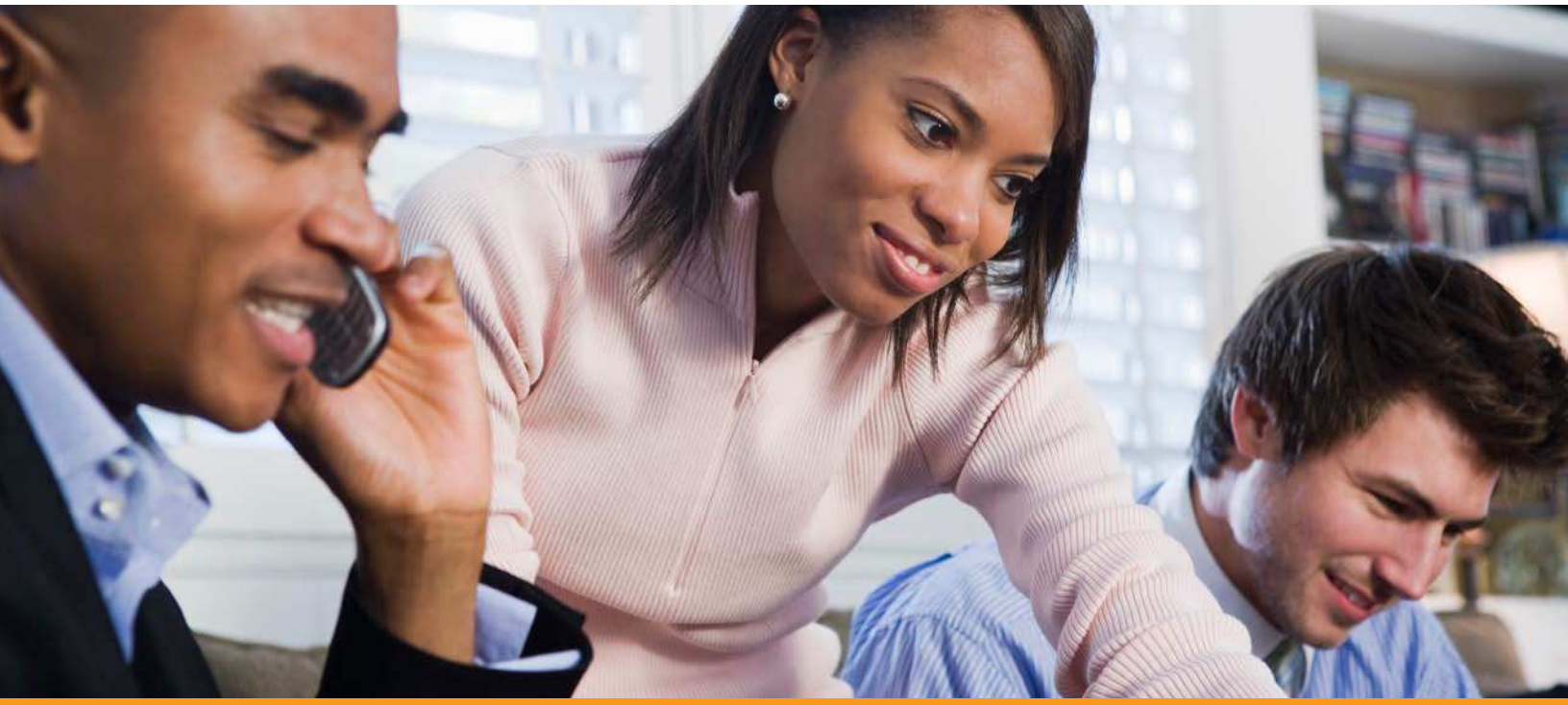
PROVIDENCE
Health & Services

# Welcome to Providence Health & Services.



**Providence is calling.**

**We're looking forward to you being part of our team!**

## New Hire Packet Forms

**Please print out all forms and fill each one out completely.**

- New Employee Information
- Employee Confidentiality and Nondisclosure Statement
- Equal Employment Opportunity Commission (EEOC) Information Form
- Direct Deposit Enrollment
- Medicaid and Children's Health Insurance Program
- Notice about Your Prescription Drug Coverage and Medicare
- Confidentiality and Acceptable Use Agreement
- Employment Eligibility Verification (FORM I-9)
- Employee Withholding Allowance Certificate (FORM W-4)

Answer the call. www.providence.org

PROVIDENCE
Health & Services

# NEW EMPLOYEE INFORMATION

System Support Services

## Employee Profile

Name: _____ Job Title: _____

Address: _____ Home Telephone: _____

City: _____ State: _____ Zip: _____

Social Security No: _____ Date of Birth: _____

## Emergency Contact

Please list names and phone numbers for two emergency contacts

**Primary**

Name: _____ Relationship: _____

Home Telephone: _____ Work Telephone: _____

**Secondary**

Name: _____ Relationship: _____

Home Telephone: _____ Work Telephone: _____

# EMPLOYEE CONFIDENTIALITY & NONDISCLOSURE STATEMENT

## System Support Services

- Name: _____ (Last, First, MI – Please Print)
- Position: _____

I understand that as an employee of Providence Health & Services-System Support Services (PH&S-SSS), I will have access to information not generally available or known to the public. I understand that such information is confidential information that belongs to PH&S-SSS. Confidential information includes but is not limited to patient, customer, member, provider, group, physician, employee, financial, and proprietary information, whether oral or recorded in any form or medium. I understand that information developed by me, alone or with others, within the scope of my employment with PH&S-SSS or which involved PH&S-SSS resources should also be considered confidential information belonging to PH&S-SSS in accordance with PH&S-SSS policies and procedures, unless otherwise specifically agreed in writing between me and an authorized representative of PH&S-SSS.

I will hold confidential information of PH&S-SSS in strict confidence and will not disclose or use it except as authorized by PH&S-SSS, for Providence Health & Services' benefit.

I will not knowingly access any of the PH&S-SSS confidential information for which I have no legitimate need to know.

I understand it is my responsibility to become familiar with and abide by applicable laws, regulations, and PH&SSSS policies and protocols regarding the confidentiality and security of confidential information.

I understand that PH&S-SSS views certain types of e-mail as not a secure, nor as a confidential method of communication. I will not include confidential patient information in e-mail communications outside of the Providence Health & Services (i.e. from or to non-providence.org email addresses), without first contacting the Privacy Officer or the System Integrity Officer for current protection method information and utilizing any such protection methodology in such e-mail communications.

I understand that PH&S-SSS electronic communication technologies (Internet and e-mail) are intended for jobrelated activities, however limited personal use is permitted. Personal use is defined as incidental and occasional use of electronic communications technologies for personal activities that should normally be conducted during personal time, such as break periods, or before and after scheduled working hours, and is not in conflict with business requirements of the department. Internet usage is monitored and audited on a regular basis by PH&S-SSS management. PH&S-SSS management also reserves the right to monitor e-mail and telephone usage.

I understand that this Confidentiality and Nondisclosure Statement does not limit my right to use my own general knowledge and experience, whether or not gained while employed by PH&S-SSS, or my right to use information that becomes generally known to the public through no fault of my own.

I understand that if I breach the terms of this Confidentiality and Nondisclosure Statement, PH&S-SSS may institute disciplinary action up to and including termination of my employment with PH&S-SSS.

- Employee Signature: _____ Date: _____

PROVIDENCE
Health & Services

# EMPLOYEE DEMOGRAPHIC INFORMATION

## System Support Services

Providence Health & Services is an equal opportunity employer and does not discriminate on the basis of race, gender, religion, sexual orientation, or national origin in recruiting, hiring, training, assignment, compensation, promotion, or use of facilities. This information is requested solely for the purpose of compiling statistics to comply with Federal and State reporting requirements. The completion of this form is entirely voluntary. If you do not provide the information, Providence is required to make a visual survey of race/ethnic identification for reporting purposes.

**Gender** ☐ Male ☐ Female

### Racial or Ethnic Identification

☐ **BLACK** (Not of Hispanic origin. All persons having origins in any of the Black Racial groups of Africa.)

☐ **HISPANIC** (All persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture of origin, regardless of race.)

☐ **ASIAN or PACIFIC ISLANDER** (All persons having origins in any of the original peoples of the Far East, South east Asia, the Indian Subcontinent, or the Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands, and Samoa.)

☐ **AMERICAN INDIAN or ALASKA NATIVE** (All persons having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.)

☐ **WHITE** (Not of Hispanic origin. All persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.)

### Are you:

A U.S. Military Veteran? ☐ Yes ☐ No
A disabled veteran with at least 30 percent disability? ☐ Yes ☐ No

If yes, provide dates of active duty: From _____ To _____

- Signature: _____

- Printed Name: _____ Date: _____

PROVIDENCE
Health & Services

# DIRECT DEPOSIT FORM

## System Support Services

**A.** ☐ **Checking** - Attach voided **Check** for accurate account numbers (No deposit slips please)

☐ Full Deposit (100% of Net) or

☐ Partial Deposit $_____ (Amount per payroll) or ☐ Percent of Pay _____ (% of net pay)

**B.** ☐ **Savings** - Attach Bank documents for accurate account numbers (not a deposit slip)

☐ Full Deposit (100% of Net) or

☐ Partial Deposit $_____ (Amount per payroll) or ☐ Percent of Pay _____ (% of net pay)

**C.** ☐ **529 Plan** - Attach Plan Administrator documents for accurate account numbers

☐ Amount of Deposit $_____ (Amount of deposit)

Frequency: ☐ Every pay period ☐ 1st pay period only ☐ 2nd pay period only

**ATTACH VOIDED CHECK IN THIS SPACE**
**(NO DEPOSIT SLIPS PLEASE AS BANK NUMBERS ARE NOT THE SAME)**

You may have your pay deposited in multiple accounts. **Please complete one form per account.** Return this form to Human Resources with the appropriate account documents. Remember that it may take up to two (2) payroll cycles for your check to be direct deposited.

I authorize Providence Health & Services and the bank(s) listed above to deposit my net pay or a portion thereof as indicated into the listed account(s) each payday. If funds to which I am not entitled are deposited into my account, I authorize Providence Health System to direct the bank to return said funds.

- Signature: _____

- Printed Name: _____ Date: _____

PROVIDENCE Health & Services

# Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage as an employee of Providence Health & Services, but are unable to afford the cost of coverage (premiums), some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

---

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of April 16, 2010. You should contact your State for further information on eligibility.

| **ALASKA** – Medicaid | **CALIFORNIA** – Medicaid |
|---|---|
| Website:<br>http://health.hss.state.ak.us/dpa/programs/medicaid/<br>Phone (Outside of Anchorage): 1-888-318-8890<br>Phone (Anchorage): 907-269-6529 | Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx<br>Phone: 1-866-298-8443 |
| **IDAHO** – Medicaid and CHIP | **MONTANA** – Medicaid |
| Medicaid Website: www.accesstohealthinsurance.idaho.gov<br>Medicaid Phone: 1-800-926-2588<br>CHIP Website: www.medicaid.idaho.gov<br>CHIP Phone: 1-800-926-2588 | Website:<br>http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml<br>Telephone: 1-800-694-3084 |
| **OREGON** – Medicaid and CHIP | **WASHINGTON** – Medicaid |
| Medicaid & CHIP Website:<br>http://www.oregonhealthykids.gov<br>Medicaid & CHIP Phone: 1-877-314-5678 | Website:<br>http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm<br>Phone: 1-877-543-7669 |

To see if any more States have added a premium assistance program since April 16, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

# Important Notice about Your Prescription Drug Coverage and Medicare

## For employees over age 65 or who will reach age 65 in 2011

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Providence Health & Services and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Providence Health & Services has determined that the prescription drug coverage offered is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

People with Medicare can enroll in a Medicare prescription drug plan between November 15 and December 31 each year. However, because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later.

If you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

If you do decide to enroll in a Medicare prescription drug plan and drop your Providence prescription drug coverage, be aware that you may not be able to get this coverage back. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

In addition, your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with Providence and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until the following November to enroll. For more information about this notice or your current prescription drug coverage, call your medical plan provider.

NOTE: You may receive this notice at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through Providence changes. You also may request a copy.

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook, which will be available online at *www.medicare.gov*. You can get more information about Medicare prescription drug plans from these places:

- Visit *www.medicare.gov* for personalized help.
- Call your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for their telephone number).
- Call (800) MEDICARE or (800) 633-4227. TTY users should call (877) 486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at *www.socialsecurity.gov*, or call them at (800) 772-1213; TTY: (800) 325-0778.

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date: September 1, 2010

Name of Entity/Sender: Providence Health & Services – WA (includes Alaska)

Contact – Position/Office: System Director, Compensation, H&W Benefits, HR Operations Service Delivery

Address: 1801 Lind Ave. SW#9016, Renton WA 98057

Phone Number: (425) 525-3137

# ACCEPTABLE USE AGREEMENT

*This Acceptable Use Agreement applies to Providence Health & Services ( PH&S) employees, volunteers, trainees, and all others doing business with Providence.*

Compliance with this agreement is a condition of continued employment or association with PH&S according to the Acceptable Use of Information Systems security policy found in the system policy manual.
The Acceptable Use of Information Systems policy describes the appropriate use of Providence information and technology resources including data, systems, networks and devices including but not limited to desktop computers, laptops, PDAs, fax machines and copiers and is intended to promote and protect the confidentiality, integrity, and availability of PH&S information and technology.

## I am aware and agree, unless further described herein:

- Internet usage, communications and transactions are not private. All computer activity is recorded and can be traced to a specific user ID.
- Information and technology associated with or belonging to PH&S must be protected by taking appropriate measures such as keeping passwords private, encrypting all computers and devices, and locking all portable devices. Additional information and online training on how to protect information and technology is provided by Providence.
- Information and technology is for business use and must not be used for purposes which may interfere or are in conflict with the PH&S mission and/or policies. Any use of PH&S information or technology for a purpose not specifically authorized by PH&S is prohibited.
- PH&S reserves the right to limit or restrict the use of information or technology to meet the business and service obligations of the organization.

**Although information and technology resources are for business use, limited personal use may be permitted with the following restrictions:**

- Usage must be reasonable, lawful and ethical and cannot be offensive or disrespectful to co-workers or others in the work or patient care environment.
- Usage must not interfere or be in conflict with PH&S responsibilities or productivity.

***IMPORTANT***: In addition to termination, non-compliance could result in further action, including civil or criminal prosecution. Violation of these requirements by a third party contracted with PH&S may result in termination of the representative's contractual arrangement with PH&S for default and may further result in such representative being subject to civil or criminal laws, as applicable.

By signing this document, I acknowledge that I have read, understand, and agree to abide by the Providence Health & Services Acceptable Use Agreement. This agreement does not limit my right to use my own general knowledge and experience, whether or not gained while employed by PH&S, or my right to use information which is known to the general public through no fault of my own.

Signature: _____ Date:__/__/____ Employee ID_____

Printed Name:_____ Position: _____

Department: _____ Work Location/Facility Site:_____

OMB No. 1615-0047; Expires 08/31/12

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

# Form I-9, Employment Eligibility Verification

## Instructions

**Read all instructions carefully before completing this form.**

**Anti-Discrimination Notice.** It is illegal to discriminate against any individual (other than an alien not authorized to work in the United States) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents presented have a future expiration date may also constitute illegal discrimination. For more information, call the Office of Special Counsel for Immigration Related Unfair Employment Practices at 1-800-255-8155.

## What Is the Purpose of This Form?

The purpose of this form is to document that each new employee (both citizen and noncitizen) hired after November 6, 1986, is authorized to work in the United States.

## When Should Form I-9 Be Used?

All employees (citizens and noncitizens) hired after November 6, 1986, and working in the United States must complete Form I-9.

## Filling Out Form I-9

**Section 1, Employee**

This part of the form must be completed no later than the time of hire, which is the actual beginning of employment. Providing the Social Security Number is voluntary, except for employees hired by employers participating in the USCIS Electronic Employment Eligibility Verification Program (E-Verify). **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

**Noncitizen nationals of the United States** are persons born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.

**Employers should note** the work authorization expiration date (if any) shown in **Section 1**. For employees who indicate an employment authorization expiration date in **Section 1**, employers are required to reverify employment authorization for employment on or before the date shown. Note that some employees may leave the expiration date blank if they are aliens whose work authorization does not expire (e.g., asylees, refugees, certain citizens of the Federated States of Micronesia or the Republic of the Marshall Islands). For such employees, reverification does not apply unless they choose to present in Section 2 evidence of employment authorization that contains an expiration date (e.g., Employment Authorization Document (Form I-766)).

**Preparer/Translator Certification**

The Preparer/Translator Certification must be completed if **Section 1** is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete **Section 1** on his or her own. However, the employee must still sign **Section 1** personally.

**Section 2, Employer**

For the purpose of completing this form, the term "employer" means all employers including those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors. Employers must complete **Section 2** by examining evidence of identity and employment authorization within three business days of the date employment begins. However, if an employer hires an individual for less than three business days, **Section 2** must be completed at the time employment begins. Employers cannot specify which document(s) listed on the last page of Form I-9 employees present to establish identity and employment authorization. Employees may present any List A document **OR** a combination of a List B and a List C document.

If an employee is unable to present a required document (or documents), the employee must present an acceptable receipt in lieu of a document listed on the last page of this form. Receipts showing that a person has applied for an initial grant of employment authorization, or for renewal of employment authorization, are not acceptable. Employees must present receipts within three business days of the date employment begins and must present valid replacement documents within 90 days or other specified time.

**Employers must record in Section 2:**

1. Document title;
2. Issuing authority;
3. Document number;
4. Expiration date, if any; and
5. The date employment begins.

Employers must sign and date the certification in **Section 2**. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. If photocopies are made, they must be made for all new hires. Photocopies may only be used for the verification process and must be retained with Form I-9. **Employers are still responsible for completing and retaining Form I-9.**

**For more detailed information, you may refer to the *USCIS Handbook for Employers* (Form M-274). You may obtain the handbook using the contact information found under the header "USCIS Forms and Information."**

**Section 3, Updating and Reverification**

Employers must complete **Section 3** when updating and/or reverifying Form I-9. Employers must reverify employment authorization of their employees on or before the work authorization expiration date recorded in **Section 1** (if any). Employers **CANNOT** specify which document(s) they will accept from an employee.

**A.** If an employee's name has changed at the time this form is being updated/reverified, complete Block A.

**B.** If an employee is rehired within three years of the date this form was originally completed and the employee is still authorized to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.

**C.** If an employee is rehired within three years of the date this form was originally completed and the employee's work authorization has expired **or** if a current employee's work authorization is about to expire (reverification), complete Block B; and:

1. Examine any document that reflects the employee is authorized to work in the United States (see List A **or** C);
2. Record the document title, document number, and expiration date (if any) in Block C; and
3. Complete the signature block.

Note that for reverification purposes, employers have the option of completing a new Form I-9 instead of completing **Section 3.**

## What Is the Filing Fee?

There is no associated filing fee for completing Form I-9. This form is not filed with USCIS or any government agency. Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the Privacy Act Notice below.

## USCIS Forms and Information

To order USCIS forms, you can download them from our website at www.uscis.gov/forms or call our toll-free number at 1-800-870-3676. You can obtain information about Form I-9 from our website at www.uscis.gov or by calling 1-888-464-4218.

Information about E-Verify, a free and voluntary program that allows participating employers to electronically verify the employment eligibility of their newly hired employees, can be obtained from our website at www.uscis.gov/e-verify or by calling 1-888-464-4218.

General information on immigration laws, regulations, and procedures can be obtained by telephoning our National Customer Service Center at 1-800-375-5283 or visiting our Internet website at www.uscis.gov.

## Photocopying and Retaining Form I-9

A blank Form I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed Form I-9s for three years after the date of hire or one year after the date employment ends, whichever is later.

Form I-9 may be signed and retained electronically, as authorized in Department of Homeland Security regulations at 8 CFR 274a.2.

## Privacy Act Notice

The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by authorized officials of the Department of Homeland Security, Department of Labor, and Office of Special Counsel for Immigration-Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

## Paperwork Reduction Act

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 12 minutes per response, including the time for reviewing instructions and completing and submitting the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachusetts Avenue, N.W., 3rd Floor, Suite 3008, Washington, DC 20529-2210. OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**

OMB No. 1615-0047; Expires 08/31/12

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

# Form I-9, Employment Eligibility Verification

**Read instructions carefully before completing this form. The instructions must be available during completion of this form.**

**ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.**

## Section 1. Employee Information and Verification *(To be completed and signed by employee at the time employment begins.)*

| Print Name: Last | First | Middle Initial | Maiden Name |
|---|---|---|---|
| | | | |
| Address *(Street Name and Number)* | | Apt. # | Date of Birth *(month/day/year)* |
| | | | |
| City | State | Zip Code | Social Security # |
| | | | |

**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):

- ☐ A citizen of the United States
- ☐ A noncitizen national of the United States (see instructions)
- ☐ A lawful permanent resident (Alien #) _____
- ☐ An alien authorized to work (Alien # or Admission #) _____
  until (expiration date, if applicable - *month/day/year*) _____

Employee's Signature | Date *(month/day/year)*

## Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

| Preparer's/Translator's Signature | Print Name |
|---|---|
| | |
| Address *(Street Name and Number, City, State, Zip Code)* | Date *(month/day/year)* |
| | |

## Section 2. Employer Review and Verification *(To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)*

| List A | OR | List B | AND | List C |
|---|---|---|---|---|
| Document title: | | | | |
| Issuing authority: | | | | |
| Document #: | | | | |
| Expiration Date *(if any)*: | | | | |
| Document #: | | | | |
| Expiration Date *(if any)*: | | | | |

**CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on** *(month/day/year)* _____ **and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)**

| Signature of Employer or Authorized Representative | Print Name | Title |
|---|---|---|
| | | |
| Business or Organization Name and Address *(Street Name and Number, City, State, Zip Code)* | | Date *(month/day/year)* |
| | | |

## Section 3. Updating and Reverification *(To be completed and signed by employer.)*

| A. New Name *(if applicable)* | B. Date of Rehire *(month/day/year) (if applicable)* |
|---|---|
| | |

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: _____ Document #: _____ Expiration Date *(if any)*: _____

**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 | Date *(month/day/year)* |
|---|---|
| | |

## LISTS OF ACCEPTABLE DOCUMENTS

**All documents must be unexpired**

| LIST A<br>**Documents that Establish Both Identity and Employment Authorization** | OR | LIST B<br>**Documents that Establish Identity** | AND | LIST C<br>**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.** Social Security Account Number card other than one that specifies on the face that the issuance of the card does not authorize employment in the United States |
| **2.** Permanent Resident Card or Alien Registration Receipt Card (Form I-551) | | | | **2.** Certification of Birth Abroad issued by the Department of State (Form FS-545) |
| **3.** Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa | | **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 | | **3.** Certification of Report of Birth issued by the Department of State (Form DS-1350) |
| **4.** Employment Authorization Document that contains a photograph (Form I-766) | | **3.** School ID card with a photograph | | |
| | | **4.** Voter's registration card | | **4.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal |
| **5.** In the case of a nonimmigrant alien authorized to work for a specific employer incident to status, a foreign passport with Form I-94 or Form I-94A bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, as long as the 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 | | |
| | | **6.** Military dependent's ID card | | |
| | | **7.** U.S. Coast Guard Merchant Mariner Card | | **5.** Native American tribal document |
| | | **8.** Native American tribal document | | **6.** U.S. Citizen ID Card (Form I-197) |
| | | **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:** | | **7.** Identification Card for Use of Resident Citizen in the United States (Form I-179) |
| | | **10.** School record or report card | | **8.** Employment authorization document issued by the Department of Homeland Security |
| | | **11.** Clinic, doctor, or hospital record | | |
| | | **12.** Day-care or nursery school record | | |

**Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)**

# Form W-4 (2011)

**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.** If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2011 expires February 16, 2012. See Pub. 505, Tax Withholding and Estimated Tax.

**Note.** If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $950 and includes more than $300 of unearned income (for example, interest and dividends).

**Basic instructions.** If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

**Head of household.** Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

**Tax credits.** You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

**Nonwage income.** If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

**Two earners or multiple jobs.** If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

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

**Check your withholding.** After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2011. See Pub. 919, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

## Personal Allowances Worksheet (Keep for your records.)

| | | | |
|---|---|---|---|
| **A** | Enter "1" for **yourself** if no one else can claim you as a dependent | **A** | |
| **B** | Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less. | **B** | |
| **C** | Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) | **C** | |
| **D** | Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return | **D** | |
| **E** | Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) | **E** | |
| **F** | Enter "1" if you have at least $1,900 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.) | **F** | |
| **G** | **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $61,000 ($90,000 if married), enter "2" for each eligible child; then **less** "1" if you have three or more eligible children. • If your total income will be between $61,000 and $84,000 ($90,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have six or more eligible children | **G** | |
| **H** | Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ► | **H** | |

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

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($10,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 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 below.

---------- **Cut here and give Form W-4 to your employer. Keep the top part for your records.** ----------

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

## Employee's Withholding Allowance Certificate

► **Whether you are 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

**2011**

| | | | |
|---|---|---|---|
| **1** | Type or print 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, but legally separated, or spouse is a nonresident alien, check the "Single" box. | |
| | 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 1-800-772-1213 for a replacement card.** ► ☐ | |
| **5** | Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2) | **5** | |
| **6** | Additional amount, if any, you want withheld from each paycheck | **6** $ | |
| **7** | I claim exemption from withholding for 2011, 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 lines 8 and 10 only if sending to the IRS.) | **9** Office code (optional) | **10** Employer identification number (EIN) |

## Deductions and Adjustments Worksheet

**Note.** Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

| | | | |
|---|---|---|---|
| 1 | Enter an estimate of your 2011 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions | 1 | $ |
| 2 | Enter: { $11,600 if married filing jointly or qualifying widow(er); $8,500 if head of household; $5,800 if 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 2011 adjustments to income and any additional standard deduction (see Pub. 919) | 4 | $ |
| 5 | **Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2011 Form W-4 Worksheet* in Pub. 919.) | 5 | $ |
| 6 | Enter an estimate of your 2011 nonwage income (such as dividends or interest) | 6 | $ |
| 7 | **Subtract** line 6 from line 5. If zero or less, enter "-0-" | 7 | $ |
| 8 | **Divide** the amount on line 7 by $3,700 and enter the result here. Drop any fraction | 8 | |
| 9 | Enter the number from the **Personal Allowances Worksheet,** line H, page 1 | 9 | |
| 10 | **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 | 10 | |

## Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

**Note.** Use this worksheet *only* if the instructions under line H on page 1 direct you here.

| | | | |
|---|---|---|---|
| 1 | Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) | 1 | |
| 2 | Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not 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 2011. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2010. 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 - $8,000 | 0 |
| 5,001 - 12,000 | 1 | 8,001 - 15,000 | 1 |
| 12,001 - 22,000 | 2 | 15,001 - 25,000 | 2 |
| 22,001 - 25,000 | 3 | 25,001 - 30,000 | 3 |
| 25,001 - 30,000 | 4 | 30,001 - 40,000 | 4 |
| 30,001 - 40,000 | 5 | 40,001 - 50,000 | 5 |
| 40,001 - 48,000 | 6 | 50,001 - 65,000 | 6 |
| 48,001 - 55,000 | 7 | 65,001 - 80,000 | 7 |
| 55,001 - 65,000 | 8 | 80,001 - 95,000 | 8 |
| 65,001 - 72,000 | 9 | 95,001 -120,000 | 9 |
| 72,001 - 85,000 | 10 | 120,001 and over | 10 |
| 85,001 - 97,000 | 11 | | |
| 97,001 -110,000 | 12 | | |
| 110,001 -120,000 | 13 | | |
| 120,001 -135,000 | 14 | | |
| 135,001 and over | 15 | | |

### 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 - $65,000 | $560 | $0 - $35,000 | $560 |
| 65,001 - 125,000 | 930 | 35,001 - 90,000 | 930 |
| 125,001 - 185,000 | 1,040 | 90,001 - 165,000 | 1,040 |
| 185,001 - 335,000 | 1,220 | 165,001 - 370,000 | 1,220 |
| 335,001 and over | 1,300 | 370,001 and over | 1,300 |

**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 are not required to provide the information requested on a form that is 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.