Southern Healthcare Agency, Inc.

Required Documentation

We appreciate your interest in our agency and look forward to you working through us. You are responsible for insuring that the following information is collected and on file in our Jackson, MS office. Being certified by The Joint Commission, we must have your current credentials at all times. There will be no exceptions. The information below must be updated annually, if applicable, and remain on file for a period of three years in "active" or "inactive" files. Please get this information to us as soon as possible. You will not be considered an active employee if any of this documentation is missing. Thank you for your cooperation.

1) Fully complete application
2) Verification and copy of current Nursing License, Roster Number or Certification
3) Fingerprint Clearance Letter – (Mississippi only)
4) Copy of High School Diploma or GED – (Medicaid Only)
5) Copy of Driver's License and Social Security Card or Birth Certification (Please send copy of driver's license or photo ID for required ID badges)
6) Current CPR certification
7) Annual Skills Checklist (RNs, LPNs & CNAs)
8) W-4 and I-9 (located in the application packet)
9) Documentation of Health Screen
    A) Annual TB Skin Test or Chest X-Ray
    B) Hepatitis Record or Waiver
    C) Varicella Record or Waiver
    D) Rubella Titer (if required)
    E) Annual Physician Statement of Health (if required)
    F) Drug Screen (if required)
10) The Joint Commission requirements:
    A) Safety
    B) Body Mechanics
    C) Infection Control
    D) Risk Management
    E) Medication Exam
11) Proof of other current certifications (ACLS, CCRN, CEN, etc.)
12) Acknowledgement of Employee Handbook and Service Agreement

SOUTHERN HEALTHCARE AGENCY, INC.

APPLICATION

NAME: _____ SSN: _____ / _____ / _____
(Last) (First) (Middle)

PRESENT ADDRESS: _____ APT.# _____

CITY: _____ STATE: _____ ZIP: _____ COUNTY: _____

HOME PH.#: (_____)_____ ALTERNATE #: (_____)_____ MOBILE #: (_____)_____

**If you would like to receive text messages, please name your phone provider* _____

PAGER #: (_____)_____ EMAIL: _____

EMERGENCY CONTACT:

NAME: _____ RELATION: _____ NUMBER: (____) _____

POSITION APPLYING FOR: _____ REFERRED BY: _____

TYPE OF POSITION: ☐ Full-Time ☐ Part-Time ☐ Temporary ☐ Permanent

AVAILABLE TO WORK: ☐ Days ☐ Evenings ☐ Nights ☐ Weekends ☐ Shift Rotation

DATE AVAILABLE: _____ SALARY DESIRED: _____

EDUCATION

SCHOOL	NAME AND LOCATION OF SCHOOL	DATES ATTENDED	DID YOU GRADUATE?	DEGREE/DIPLOMA RECEIVED
High School				
College/ University				
Nursing School				
Other				

PROFESSIONAL REGISTRATION / CERTIFICATION / LICENSURE:

_____ _____ _____
(Type) (Number) (State)

_____ _____ _____
(Type) (Number) (State)

_____ _____ _____
(Type) (Number) (State)

EMPLOYMENT HISTORY

LIST ALL EMPLOYMENT. Start with present or most recent employer first. (Include applicable volunteer work and military service). If additional space is needed, attach a separate sheet.

If you are presently employed, may we contact your present employer? ☐ YES ☐ NO

Place of employment:_____ Phone: (____) _____

Address: _____
(Street Address) (City) (State) (Zip Code)

Your Job Title: _____ Hourly Rate: _____

Duties:_____

Supervisor's Name and Title: _____

Dates Employed: (From) _____(To) _____
(Month / Year) (Month / Year)

Reason for Leaving: _____

Place of employment:_____ Phone: (____) _____

Address: _____
(Street Address) (City) (State) (Zip Code)

Your Job Title: _____ Salary: _____

Duties:_____

Supervisor's Name and Title: _____

Dates Employed: (From) _____(To) _____
(Month / Year) (Month / Year)

Reason for Leaving: _____

Place of employment:_____ Phone: (____) _____

Address: _____
(Street Address) (City) (State) (Zip Code)

Your Job Title: _____ Salary: _____

Duties:_____

Supervisor's Name and Title: _____

Dates Employed: (From) _____(To) _____
(Month / Year) (Month / Year)

Reason for Leaving: _____

Place of employment:_____ Phone: (____) _____

Address: _____
(Street Address) (City) (State) (Zip Code)

Your Job Title: _____ Salary: _____

Duties:_____

Supervisor's Name and Title: _____

Dates Employed: (From) _____(To) _____
(Month / Year) (Month / Year)

Reason for Leaving: _____

List language(s) you are proficient in other than English:_____

Are you authorized to work in the United States of America? ☐ YES ☐ NO

Are you a Veteran? ☐ YES ☐ NO **Underline All That Apply:** Disable Veteran, Other Protected Veteran, Armed Forces Service Medal Veteran, Recently Separated Veteran

Have you ever been convicted of a felony or a misdemeanor? ☐ YES ☐ NO

If yes, please explain _____

Date: _____ Location: _____

Have you ever been terminated from employment? ☐ YES ☐ NO

If yes, please explain _____

Are you presently subject to any proceedings or investigations which could adversely affect your licensure? ☐ YES ☐ NO

Have you ever had disciplinary action taken against any of your professional licenses? ☐ YES ☐ NO ☐ N/A

If yes, please explain _____

Date: _____ Location: _____

REFERENCES: (Please do not list relatives)

NAME	ADDRESS	TELEPHONE	OCCUPATION

SOUTHERN HEALTHCARE AGENCY, INC.
INVESTIGATION AUTHORIZATION

Under the provisions of the Fair Credit Reporting Act U.S.C., Sec. 1681, et seq. notice is hereby given that a consumer report or an investigative consumer report may be made which may include information pertaining to your employment history, educational background, character, general reputation, driving record, criminal record, which will be used for employment purposes. An investigation into your worker's compensation or industrial accident claims background may also be conducted under the guidelines of the American with Disabilities Act.

You are further advised under said act that any person who procures or causes to be prepared an investigative consumer report on any consumer shall, upon written request by the consumer within a reasonable period of time after the receipt by him of the disclosure required by subsection 1681 (d), shall make a complete and accurate disclosure of the nature and scope of the investigation requested. This disclosure shall be made in writing, mailed or otherwise delivered, to the consumer five days after the date on which the request for such disclosure was received from the consumer or such report was first requested, whichever is the latter.

You are further advised that if you are denied employment, either wholly or partly, because of information contained in a consumer report as that team is defined in the Fair Credit Reporting Act, that a disclosure will be made to you of the name and address of the consumer reporting agency making such report.

I, the undersigned, have read the above and foregoing notice and understanding same. I hereby authorize Southern Healthcare Agency, Inc. to investigate and verify facts stated by me on the attached application.

Signed this _____ day of _____, 20____.

Applicant Name (signed): _____

Date of Birth: _____ Social Security #: ____ – ____ – _____

Address: _____

The statements made in this application are true to the best of my knowledge. I understand that any falsification will be basis for disqualification or termination of services.

_____ _____

SIGNATURE OF APPLICANT DATE

Form W-4 (2014)

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 2014 expires February 17, 2015. 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 $1,000 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

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 can 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. 505 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 iincome, see Pub. 505 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. 505 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. 505 to see how the amount you are having withheld compares to your projected total tax for 2014. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

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 $2,000 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 $65,000 ($95,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to six eligible children or **less** "2" if you have seven or more eligible children. • If your total income will be between $65,000 and $84,000 ($95,000 and $119,000 if married), enter "1" for each eligible child . . .	**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 are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 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.

---------- **Separate 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

2014

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, 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 2014, 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 2014 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1950) of your income, and miscellaneous deductions. For 2014, you may have to reduce your itemized deductions if your income is over $305,050 and you are married filing jointly or are a qualifying widow(er); $279,650 if you are head of household; $254,200 if you are single and not head of household or a qualifying widow(er); or $152,525 if you are married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,400 if married filing jointly or qualifying widow(er); $9,100 if head of household; $6,200 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 2014 adjustments to income and any additional standard deduction (see Pub. 505)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2014 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2014 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 $3,950 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 2014. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2014. 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 - $6,000	0	$0 - $6,000	0
6,001 - 13,000	1	6,001 - 16,000	1
13,001 - 24,000	2	16,001 - 25,000	2
24,001 - 26,000	3	25,001 - 34,000	3
26,001 - 33,000	4	34,001 - 43,000	4
33,001 - 43,000	5	43,001 - 70,000	5
43,001 - 49,000	6	70,001 - 85,000	6
49,001 - 60,000	7	85,001 - 110,000	7
60,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 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 - $74,000	$590	$0 - $37,000	$590
74,001 - 130,000	990	37,001 - 80,000	990
130,001 - 200,000	1,110	80,001 - 175,000	1,110
200,001 - 355,000	1,300	175,001 - 385,000	1,300
355,001 - 400,000	1,380	385,001 and over	1,560
400,001 and over	1,560		

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.

Form 89-350-13-8-1-000 (Rev. 12/13)

MISSISSIPPI EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Mississippi Department of Revenue
P.O. Box 960
Jackson, MS 39205

Employee's Name _____ **SSN** _____

Employee's Residence Address _____ (Number and Street) _____ (City or Town) _____ (State) _____ (Zip Code)

	CLAIM YOUR WITHHOLDING PERSONAL EXEMPTION			
	Marital Status		**Personal Exemption Allowed**	**Amount Claimed**
EMPLOYEE:	**1. Single**		☐ Enter $6,000 as exemption . . . . ▶	$
File this form with your employer. Otherwise, you must withhold Mississippi income tax from the full amount of your wages.	**2. Marital Status** (Check One)	(a)	☐ Spouse **NOT** employed: Enter $12,000 ▶	$
		(b)	☐ Spouse **IS** employed: Enter that part of $12,000 claimed by you in multiples of $500. See instructions 2(b) below . ▶	$
	3. Head of Family		☐ Enter $9,500 as exemption. To qualify as head of family, you must be single and have a dependent living in the home with you. See instructions 2(c) and 2(d)below . . . . . ▶	$
EMPLOYER: **Keep this certificate with your records.** If the employee is believed to have claimed excess exemption, the Department of Revenue should be advised.	**4. Dependents** Number Claimed		You may claim $1,500 for each dependent*, other than for taxpayer and spouse, who receives chief support from you and who qualifies as a dependent for Federal income tax purposes. * A head of family may claim $1,500 for each dependents excluding the one which qualifies you as head of family. Multiply number of dependents claimed by you by $1,500. Enter amount claimed... ▶	$
	5. Age and Blindness		• Age 65 or older ☐ Husband ☐ Wife ☐ Single • Blind ☐ Husband ☐ Wife ☐ Single Multiply the number of blocks checked by $1,500. Enter the amount claimed . . . . . ▶ *** Note:** No exemption allowed for age or blindness for dependents.	$
	6. TOTAL AMOUNT OF EXEMPTION CLAIMED - Lines 1 through 5...▶			$
	7. Additional dollar amount of withholding per pay period if agreed to by your employer . . . . . ▶			$
Military Spouses Residency Relief Act Exemption from Mississippi Withholding	**8.** If you meet the conditions set forth under the Service Member Civil Relief, as amended by the Military Spouses Residency Relief Act, and have no Mississippi tax liability, write **"Exempt"** on Line 8. You must attach a copy of the Federal Form DD-2058 and a copy of your Military Spouse ID Card to this form so your employer can validate the exemption claim.. ▶			_____

I declare under the penalties imposed for filing false reports that the amount of exemption claimed on this certificate does not exceed the amount to which I am entitled or I am entitled to claim exempt status.

Employee's Signature: _____ **Date:** _____

INSTRUCTIONS

1. The personal exemptions allowed:

(a) Single Individuals	$6,000	(d) Dependents	$1,500
(b) Married Individuals (Jointly)	$12,000	(e) Age 65 and Over	$1,500
(c) Head of family	$9,500	(f) Blindness	$1,500

2. Claiming personal exemptions:

(a) Single Individuals enter $6,000 on Line 1.

(b) Married individuals are allowed a joint exemption of $12,000.

If the spouse is not employed, enter $12,000 on Line 2(a). If the spouse is employed, the exemption of $12,000 may be divided between taxpayer and spouse in any manner they choose - in multiples of $500. For example, the taxpayer may claim $6,500 and the spouse claims $5,500; or the taxpayer may claim $8,000 and the spouse claims $4,000. The total claimed by the taxpayer and spouse may not exceed $12,000. Enter amount claimed by you on Line 2(b).

(c) Head of Family

A head of family is a single individual who maintains a home which is the principal place of abode for himself and at least one other dependent. Single individuals qualifying as a head of family enter $9,500 on Line 3. If the taxpayer has more than one dependent, additional exemptions are applicable. See item (d).

(d) An additional exemption of $1,500 may generally be claimed for each dependent of the taxpayer. A dependent is any relative who receives chief support from the taxpayer and who qualifies as a dependent for Federal income tax purposes. Head of family individuals may claim an additional exemption for each dependent excluding the one which is required for head of family status. For example, a head of family taxpayer has 2 dependent children and his dependent mother living with him. The taxpayer may claim 2 additional exemptions. Married or single individuals may claim an additional exemption for each dependent, but **should not** include themselves or their spouse. Married taxpayers may divide the number of their dependents between them in any manner they choose; for example, a married couple has 3 children who qualify as dependents. The taxpayer may claim 2 dependents and the spouse 1; or the taxpayer may claim 3 dependents and the spouse none. Enter the amount of dependent exemption on Line 4.

(e) An additional exemption of $1,500 may be claimed by either taxpayer or spouse or both if either or both have reached the **age of 65** before the close of the taxable year. No additional exemption is authorized for dependents by reason of age. Check applicable blocks on Line 5.

(f) An additional exemption of $1,500 may be claimed by either taxpayer or spouse or both if either or both are **blind**. No additional exemption is authorized for dependents by reason of blindness. Check applicable blocks on Line 5. Multiply number of blocks checked on Line 5 by $1,500 and enter amount of exemption claimed.

3. Total Exemption Claimed:
Add the amount of exemptions claimed in each category and enter the total on Line 6. This amount will be used as a basis for withholding income tax under the appropriate withholding tables.

4. A NEW EXEMPTION CERTIFICATE MUST BE FILED WITH YOUR EMPLOYER WITHIN 30 DAYS AFTER ANY CHANGE IN YOUR EXEMPTION STATUS.

5. PENALTIES ARE IMPOSED FOR WILLFULLY SUPPLYING FALSE INFORMATION

6. IF THE EMPLOYEE FAILS TO FILE AN EXEMPTION CERTIFICATE WITH HIS EMPLOYER, INCOME TAX MUST BE WITHHELD BY THE EMPLOYER ON TOTAL WAGES WITHOUT THE BENEFIT OF EXEMPTION..

7. To comply with the Military Spouse Residency Relief Act (PL111-97) signed on November 11, 2009.

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►START HERE. 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 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 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	E-mail Address	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):

☐ A citizen of the United States

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

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

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

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date *(mm/dd/yyyy):*

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.

Signature of Preparer or Translator:	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

DIRECT DEPOSIT TO BANK ACCOUNT FORM

AUTHORIZATION AGREEMENT FOR AUTOMATIC DEPOSITS (ACH CREDITS)

COMPANY NAME Southern Healthcare Agency Inc

COMPANY ID NUMBER 64-0829013

I (we) hereby authorize Southern Healthcare Agency, hereinafter called COMPANY, to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my (our) ☐ Checking ☐ Savings Account (select one) indicated below and the depository named below, hereinafter called DEPOSITORY, to credit and/or debit the same to such account.

DEPOSITORY NAME (your bank)

TRANSIT/ABA NO.

ACCOUNT NO.

This authority is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

NAME(S)

ID NUMBER (ssn)

DATE SIGNED

SIGNED (joint owner)

*** PLEASE ATTACH A VOIDED CHECK**

Hepatitis B Virus Vaccine or Declination

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV). At this time, I choose the following:

Check one, then sign at the bottom

☐ I have already received the vaccine

☐ I am obtaining the vaccine through_____

☐ I choose **not** to receive the vaccine

I hereby release and hold harmless Southern Healthcare Agency, Inc. and the institutions where I may be working from any liability, responsibility, damages, or loss, whether known or unknown, existing or potential, which I may ever claim as a result of any contact or consequences which may arise as a result of my association with said patients.

Electronic Signature Date

Varicella Vaccine or Declination

As per OSHA requirements, all nurses and healthcare workers must be encouraged to receive the Varicella Vaccine.

Check one, then sign at the bottom

☐ I received the vaccine on (date)_____

☐ I am obtaining the vaccine through_____

☐ I choose not to have the Varicella Vaccine at this time

I hereby understand that I may be asked to provide proof of vaccination.

Electronic Signature Date

Revised 02-03

Southern Healthcare Agency, Inc.

To: Mississippi Department of Human Services
Division of Family & Children Services
Child Abuse Central Registry
P.O. Box 352
Jackson, MS 39205

From: Hope Nope / Director of Human Resources
Southern Healthcare Agency, Inc
1088 Flynt Drive
Jackson, MS 39232
601-933-0037

(Printed) Applicant Full Name (list maiden name & list any aliases)

_____

Social Security Number: _____ Date of Birth: _____
(Requesting agency should verify by attaching a copy of the applicant's Driver's License and Social Security Card)

Physical Address: _____

By signing this form, I give the above named agency permission to request an MDHS Child Abuse/Neglect Central Registry background check. I understand that this information will be used only for employment purposes and will not be re-disseminated to other persons or used for other purposes.

_____ _____
Applicant Signature Date

I have witnessed the applicant's signature and the information is true and attested by my viewing of the applicant's Social Security Card and Driver's License. I understand that this information must be kept confidential with my agency.

Signature of Witness: _____ Date: _____
(Witness must be a representative of the requesting agency)

****

This section to be completed by MDHS Office

_____No Identifying information was found in the Central Registry

_____The following information was found in the Central Registry

_____

_____

_____ _____
Signature of MDHS Representative Date

1088 Flynt Drive + Jackson, MS 39232
P.O. Box 320999 + Jackson, MS 39232-0999
(601) 933-0037 + 1-800-880-2772 + FAX (601) 933-0067
www.southernhealthcare.com

ACKNOWLEDGEMENT OF POLICY & PROCEDURES MANUAL, HANDBOOK AND JOB DESCRIPTION

I acknowledge receipt of a copy of the Southern Healthcare Agency's (SHA) Employee Handbook and my job description, and have reviewed SHA's Policy and Procedure Manual, Employee Handbook, Training Manual, and my job description. I understand that SHA has the right, at any time, and for any reason, to make changes in all employment policies, instructions and procedures with or without notice and with retroactive effect. I further understand and agree that my employment is not for any specific term or period of time and that SHA may take any action concerning my employment, including termination of my employment, with or without cause, without notice and without further obligation to me, all at the sole and absolute discretion and will of SHA.

_____
Signature

_____ / _____ / _____
Date

****

SERVICE AGREEMENT

I understand that this is a fee-paid agency (the Client pays the fee). However, should the Client refuse to pay after requesting the services from SHA, I will have the option of quitting the job or paying the Client's fee (10% of the annual salary). Also,

* I will not accept a job offered by any Client of SHA where I have worked a prior assignment on behalf of SHA within a six (6) month period from the date of my last assignment unless arranged by Southern Healthcare Agency, Inc.

* I will not accept a job offer that I have received due to any type of introduction or interview arranged through SHA within a six (6) month period from the date of introduction or interview with the Client unless arranged by SHA.

The penalty for these circumstances is a fee of 10% of your annual salary to SHA.

_____
Signature

_____ / _____ / _____
Date

Southern Healthcare Agency, Inc.

In-service Acknowledgement

I acknowledge receipt of the following materials. I have carefully read and fully understand the following in-service information:

1. Infection Control
2. Needle Safety
3. Defensive Driving
4. Abuse & Neglect / Vulnerable Adult Act
5. Employee Handbook

_____ _____

Employee Name / Signature Date

Title of Program: Elder Abuse

Content:

- Definition
- Description
- Individuals At Risk
- Abusers and Their Afflictions
- Causes of Elder Abuse
- Continuation of Elder Abuse
- Stopping Elder Abuse

Post Test

True	False	
☐	☐	1. Denying a person the right to wear their eyeglasses is considered abuse.
☐	☐	2. Persons over the age of 75 are at greater risk for abuse.
☐	☐	3. Abuse continues to occur because people tend to not want to be involved.
☐	☐	4. Elder Abuse is most often committed by family members acting as caregivers.
☐	☐	5. As a healthcare provider it is your responsibility to report any signs of abuse or neglect to your supervisor.

I HAVE READ AND UNDERSTAND THE ENCLOSED MATERIAL.

_____ _____

EMPLOYEE SIGNATURE DATE

Infection Control

Washing - Best defense against the spread of germs

- DID YOU KNOW? The way you wash is as important as how often you wash. Germs are removed when you rub your soapy hands together. Rubbing is the most important key. Just soap does not remove germs. Rinsing well will remove many of harmful germs.
- REMEMBER: Wash before and after each client and in between as needed.

Universal Precautions

- Wear gloves on both hands whenever there is any possibility of contact with blood or body substances. Change gloves between procedures as appropriate. Again remember to wash hands after removal of gloves.
- This information can be passed on to clients to reduce the spread of germs.

Growth of Bacteria

- Bacteria love warm, moist places. They grow rapidly in that kind of environment. Any area where moisture tends to collect should be dried well after client's bath. Example: Ears, the armpits, under the breasts, the umbilicus, the perineal area, behind the knees, behind the toes, and under any folds of skin, especially on a heavy person.

****PLEASE DO YOUR PART IN HELPING TO PREVENT THE SPREAD OF INFECTION ALONG WITH SAVING MILLIONS IN HEALTH CARE DOLLARS TO TREAT INFECTION.****

Needle Safety

The following are just a few tips to prevent needle sticks and what to do in case of a needle stick.

- Practice universal precautions
- Do not recap used syringe needles
- Dispose of sharp objects in proper containers
- Do not attempt to put used syringe needles in containers that are over ¾ full
- Complete incident report and submit to supervisor within 24 hours
- Report to employee health at facility you are working and notify supervisor and Southern Healthcare of needle stick.

Tips on Safe Driving

Always use a safety belt – No matter how safely you drive, you can't control other drivers. Safety belts reduce the risk of serious injury and death from a crash.

- Look for and obey all traffic signs
- Use mirrors to expand your vision
- Signal before turning
- Do Not "Tailgate"
- Yield the right-of-way
- Keep both hands on the wheel at all times

Distractions – There can be many potential distractions while driving a vehicle. These can take many forms that include but are not limited to:

- Eating/Drinking
- Reading/Writing
- Personal grooming (i.e. applying makeup, etc.)
- Other passengers/Children
- Smoking
- Pets
- Electronic equipment (i.e. cell phones, stereos, laptops, etc.)

Reporting of Accidents/Moving Violations – Any employee who is involved in an accident or receives a moving violation must report the incident to Southern Healthcare Agency, Inc. ***immediately***. Employees must report incidents that include but are not limited to:

- DUI
- License suspension/ revoked
- Careless/Reckless driving
- Fleeing law enforcement
- Motor Vehicle Accidents (minor or major)
- Leaving the scene of an accident
- Drag racing
- Speeding tickets
- Other

Any combination of two or more of the following citations will result in immediate counseling and a probationary period of (90) days

- Two or more speeding tickets
- Disregarding traffic control
- Careless/ Reckless driving
- Following to closely
- Failure to yield the right-of-way
- Failure to have the vehicle under control
- Improper lane changing, backing, or other similar moving violations
- Passing through/around crossing barriers
- Failure to signal
- Failure to pay traffic tickets/ Fines
- Other

Please notify us with any questions or incidents at 601-933-0037 or 1-800-880-2772

Elder Abuse

Definition - The neglect or mistreatment of an older person, usually by a relative or other caregiver. Elder Abuse includes: physical violence, threats, verbal abuse, financial exploitation, emotional abuse, neglect and violation of an older person's other basic rights.

Description – Elder abuse may take the form of:

- Physical Abuse – Victims are kicked, punched, slapped, beaten and even raped. Pain, injury, or death may result.
- Neglect – Failure to provide medicine, food or personal care (such as help to the bathroom) is a common form of abuse.
- Financial Exploitation – Abusers may steal or mismanage money, property, savings or credit cards. Older people may be forced to sign a will or turn over assets.
- Rights Violations – Victims may be unfairly confined or forced out of the home. There behavior may be strictly controlled.
- Other Abuse – Older people may be forced to live in unsanitary conditions, or unventilated, poorly heated or cooled rooms.

Over medicating, or withholding aids (eyeglasses, dentures, etc.) is abuse too.

Individuals at risk

- Those over the age of 75
- Women
- Those dependent on there abuser for basic needs
- Those suffering from a mental or physical illness
- However many victims are financially independent and in good health

Abusers and their afflictions – Elder abuse is most often committed by family members acting as caregivers. They often suffer from stress, alcohol and other drug problems, dependency. But, there is no excuse for elder abuse.

Causes of Elder Abuse:

- Resentment
- Life crisis
- Lack of love and friendship
- Our attitudes toward violence
- Retaliation
- Longer life spans
- Lack of services
- Money problems
- Social Problems

Continuation of abuse:

- Denial- Individuals refuse to believe they are being abused by a loved one.
- Physical/Mental Illness - Individuals with a disability must overcome special obstacles to stop abuse.
- Lack of services - Shelters, respite care facilities may be lacking.
- Fear and shame- Individuals are afraid of what might happen or they are too ashamed to take action.

- Dependence- Many older people feel they have no one else to turn to, so they try to accept their situation.
- Lack of awareness- Older individuals may not be aware of who they should contact.
- Isolation- Those individuals who have little or no contact with the outside world may find it hard to escape abuse.

Stopping Elder Abuse- Everyone can help in stopping this problem.

- Prevention programs- to help identify and assist victims of elder abuse and their families. More research into the causes, treatment and prevention of elder abuse is also needed.
- Education- to fight negative attitudes toward older people and people who have disabilities.
- Resources- for older people and their caregivers. Greater public awareness of the problem. No policy or program will succeed unless concerned citizens get involved.
- Legislation- to help older people use the courts, find treatment and gain protection from further abuse.

Elder abuse is a serious problem. Learn the facts. Support efforts to end elder abuse. You have an obligation to report suspected cases of abuse or neglect by calling 1-877-210-8513. Should you **observe** an act of abuse on a client, you should notify your supervisor immediately.

Name:

Directions: On the answer sheet provided, please answer T for true or F for false.

SAFETY EXAM

1. The basic fire plan to use when a fire is detected is R.A.C.E., which stands for Run, Alarm, Confine, Extinguish.
2. In order to get everyone's attention when a fire is detected, scream "FIRE."
3. If you receive a bomb threat, obtain as much information as possible and report the threat immediately to your supervisor and security.
4. Hazardous materials come only in solid form.
5. Hazardous chemicals can enter the body through the nose, mouth, eyes, lungs, skin and by swallowing.
6. Use safety equipment when appropriate, such as goggles, gloves, apron, eye protection and ear plugs.
7. Improper handling of hazardous materials cannot cause serious problem
8. If you are exposed to a chemical, don't worry about washing it off unless it burns.
9. To ensure safety around x-ray machines when a picture is being taken, move at least 10 feet away from the x-ray machine or wear a leaded apron if you have to be close to the patient.
10. X-rays, such as a chest x-ray, makes a patient radioactive and therefore it becomes dangerous to give that patient care.

BODY MECHANICS EXAM

1. Good posture is the key to success in maintaining good body mechanics.
2. Most back injuries are not preventable.
3. The most common and costly on the job accidents reported among healthcare employees are back injuries.
4. Never let a patient put his arms around you or grab you in any way as you assist him.
5. When assisting patients, do not allow the patient to assist at all.
6. The greatest stress felt when assisting and lifting patients is in the lower back (lumbar) region, which is where most back injuries occur.
7. It is far easier an effective to treat back injuries rather than prevent them.
8. When lifting or assisting a patient, never pull the patient by the arms or legs and never lift under the neck or armpits for you could cause injury.
9. It is not necessary to explain to a patient that you plan to move him/her in order to eliminate his/her fear.
10. Strive to maintain your "normal" neck (cervical) and lower back (lumbar) curve during prolonged standing or sitting and when lifting.

INFECTION CONTROL EXAM

1. A nosocomial infection is an infection that the patient did not have when admitted in the hospital.

2. Another word for bacteria, viruses, and fungi are microbes. They are present everywhere and on everyone.

3. Most patients admitted to the hospital today are healthy with strong immune systems. Therefore they cannot easily acquire an infection.

4. The most important way to prevent infections is good handwashing.

5. Personal protective equipment such as gloves, mask eye shields, and gowns are not necessary if you are careful when caring for a patient.

6. Tuberculosis (TB) is an infectious disease that is completely under control with no reported cases since 1985.

7. Scalpel blades, glass slides, lancets, blood tubes, needles, syringes and other sharp items may be discarded in a regular trash can.

8. Needle sticks and sharp injuries must be reported immediately to your supervisor and Southern Healthcare. An employee injury report must be completed and you must be seen by a physician within the first 4 hours and not more than 24 hours following the incident.

9. TB can not be cured even if diagnosed early and treatment is started quickly.

10. You must wear a mask when you enter a room with "Respiratory Isolation" sign on the door.

RISK MANAGEMENT

1. The incident report is the most valuable piece of information Southern Healthcare has to address problems and decide on actions to prevent similar incidents in the future.

2. An incident report is not only used as a report of the facts but also your opinion and feelings about the incident.

3. In the event of a known injury, an Incident Report must be completed within a week of the incident.

4. We all are responsible for initiating an Incident Report when we discover an incident.

5. If medical equipment malfunctions it is not necessary to take up your time in reporting it. Biomedical Engineering will eventually discover the faulty equipment.

6. Healthcare Advance Directives allows a competent adult to designate a healthcare surrogate to make appropriate medical decisions for oneself should the patient become incapacitated.

7. As a healthcare professional, if you identify suspected abuse, you must report it. Failure to report may be probable cause for review by the Board of Nursing.

8. Breach of patient confidentiality through casual conversation is not considered unlawful or damaging.

9. Intensity of care is the level of care the medical team gives to prolong life. The patient or family must weigh the treatment of procedure against the possible benefits.

10. You can choose an adult relative (18 years of older) to be your Health Care Surrogate.