



Mi Casa Care Employment Application

Position:
Application Date:

Name:	
First	Middle Initial
Last	
Address:	
City:	
State:	Zip:
Home Phone #:	Cell Phone #:
(Optional) Email Address:	

EDUCATION:	
High School:	Graduated (Y/N)
College:	
Major/Degree:	
Trade School:	
Field/Certificate:	
Other Relevant Training:	



Mi Casa Care Employment Application

EMPLOYMENT HISTORY:

Please provide your previous employment history information for a minimum of five years.

Employer:	
Position:	Final Salary:
Starting Date:	Ending Date:
Reason for Leaving:	
Employer:	
Position:	Final Salary:
Starting Date:	Ending Date:
Reason for Leaving:	
Employer:	
Position:	Final Salary:
Starting Date:	Ending Date:
Reason for Leaving:	
Employer:	
Position:	Final Salary:
Starting Date:	Ending Date:
Reason for Leaving:	



Mi Casa Care Employment Application

Social Security Number:
Date of Birth:

Emergency Contact
Name:
Relationship:
Phone Number:

Have you ever had a complaint filed (to any law enforcement, school or work authority) regarding any form of abuse, neglect, sexual misconduct, or exploitation?	(Y/N)
Have your intentional actions or neglect subjected another person to serious injury?	(Y/N)
If you have answered "Yes" to either of the previous questions, a detailed explanation must be submitted on a separate piece of paper.	

Mi Casa does drug testing, tuberculosis (TB) testing, and background investigations. If given a conditional offer of employment, by my signature below I agree and grant my permission for these tests and investigation.

Signed:
Date:

MI CASA CARE CAREGIVER PERSONNEL MANUAL

EMPLOYEE ACKNOWLEDGMENT

I have received access to a copy, either electronic or printed version, of the Mi Casa Care Caregivers Personnel Manual, which outlines the Policies, Benefits, and Employee Responsibilities for the Organization. I will familiarize myself with the information contained in this Manual.

The information in this Manual is subject to change as situations warrant. I understand that changes in the policies may supersede, modify or eliminate the policies in this book, with the exception of the policy of employment at will. Either the Mi Casa or I may choose to terminate this employment relationship at any time and for any or no reason.

I further understand that the language and material contained in the employee application or this Manual do not constitute a contract, guarantee of employment, or in any way alter the employ-at-will standards. This only establishes conditions of employment and a code of conduct that may be deleted or modified at any time.

I understand that I have an obligation to inform my supervisor or the management of any relevant personal changes such as phone number, address, marital status, etc.

I further understand that this Manual supersedes any and all handbooks or manuals previously produced or provided to me by the management of Mi Casa, Inc. I hereby acknowledge receipt of a copy of the Mi Casa Care Caregivers Personnel Manual. I recognize I have a responsibility to read the policies and procedures contained in here, and I have the right to ask for clarification from my supervisor or the management of anything printed in this manual.

Employee Signature

Date



MI CASA CARE ORIENTATION ACKNOWLEDGEMENT

I, _____, have accepted a position with Mi Casa Care.
(Please Print Name)

I have truthfully completed my employment forms, taken the required tests and received my Personnel Manual.

I attest I have never have been shown by credible evidence to have abused, neglected, sexually assaulted, exploited or deprived any person or to have subjected any person to serious injury as the result of intentional or grossly negligent misconduct. Initial _____

I attest that I will immediately report tuberculosis (TB), hepatitis or other communicable disease(s) exposure to Mi Casa Care. Initial _____

Part of my employment requires attendance at a staff orientation which included training and information on the following:

- ◆ Mi Casa Care Policies on Scope of Services; Type of Clients, Client's Rights & Responsibilities.
- ◆ A review of the relevant duties and responsibilities of a Mi Casa Care employee.
- ◆ My job description with my assigned duties
- ◆ Reporting and documentation procedures for client progress, submitting problems to supervisors, medical emergency and incidents procedures related to delivery of services in accordance with the client's service plan. Move to job description
- ◆ My minimum of eight (8) hours of annual training or instruction.

Signature:

Date:



JOB DESCRIPTION:

CERTIFIED NURSING ASSISTANT / PERSONAL CARE ASSISTANT

Please read and sign below.

Job Duties:

The following tasks fall under the duties of CNA (Certified Nursing Assistant) and/or PCA (Personal Care Assistant) personnel. The actual duties will vary from client to client. This list is not all inclusive, but cites reasonable examples of duties under each heading.

Supporting the functional needs of elderly, persons with disabilities or convalescing individuals.
Reporting any change in condition, accident, illness or hospitalization of the client.

Transportation and escort: Planning/transporting/accompanying clients on excursions outside their residence for purposes such as appointments, entertainment, exercise, recreation, shopping or social activities

Meal preparation and serving: Shopping, meal planning and preparation

Light housekeeping: Laundry, changing linens, trash disposal, sweeping, dusting, cleaning, washing dishes and other activities related to the cleanliness and upkeep of the home.

Handling medical emergencies in the home and infection control.

Requirements:

- 1- To have never have been shown by credible evidence to have abused, neglected, sexually assaulted, exploited or deprived any person or to have subjected any person to serious injury as the result of intentional or grossly negligent misconduct.
- 2- To be free of tuberculosis, hepatitis or other communicable disease(s).
- 3- The employee must be physically and mentally capable of performing any and/or all of the listed duties.
- 4- To be able to read and write in English; follow verbal and written instructions; and complete written reports and documents.
- 5- To be able to understand the characteristics, needs and care requirements of elderly, persons with disabilities or convalescing individuals.
- 6- To be licensed to provide nursing services in Georgia in accordance with professional licensing laws and associated rules. CNA's performing professional practices consistent with the activities as regulated by the Georgia license statutes and associated rules.
PCA's performing practices consistent with the activities as governed by professional standards certified in the Georgia Association of Community Care Providers certification.

Signature: _____



JOB DESCRIPTION:

COMPANION / SITTER

Please read and sign below.

Job Duties:

The following tasks fall under the duties of a companion/sitter. The actual duties will vary from client to client. This list is not all inclusive, but cites reasonable examples of duties under each heading.

Reporting any change in condition, accident, illness or hospitalization of the client.

Transportation and escort: Planning/transporting/accompanying clients on excursions outside their residence for purposes such as appointments, entertainment, exercise, recreation, shopping or social activities

Meal preparation and serving: Shopping, meal planning and preparation

Light housekeeping: Laundry, changing linens, trash disposal, sweeping, dusting, cleaning, washing dishes and other activities related to the cleanliness and upkeep of the home.

Handling medical emergencies in the home and infection control.

Requirements:

- 1- To have never have been shown by credible evidence to have abused, neglected, sexually assaulted, exploited or deprived any person or to have subjected any person to serious injury as the result of intentional or grossly negligent misconduct.
- 2- To be free of tuberculosis, hepatitis or other communicable disease(s).
- 3- The employee must be physically and mentally capable of performing any or all of the listed duties.
- 4- To be able to read and write in English; follow verbal and written instructions; and complete written reports and documents.
- 5- To be able to understand the characteristics, needs and care requirements of elderly, persons with disabilities or convalescing individuals.
- 6- To know or be willing to learn and perform basic first aid, CPR and emergency management.

Signature: _____

Form W-4 (2007)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

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 2007 expires February 16, 2008. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds \$850 and includes more than \$300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 adjust your withholding allowances based on

itemized deductions, certain credits, adjustments to income, or two-earner/multiple job situations. Complete all worksheets that apply. However, you may claim fewer (or zero) allowances.

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.

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/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.

Nonresident alien. If you are a nonresident alien, see the Instructions for Form 8233 before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2007. 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 \$1,000 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 \$1,500 of **child or dependent care expenses** for which you plan to claim a credit **F** _____

(**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

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 \$57,000 (\$85,000 if married), enter "2" for each eligible child.
 • If your total income will be between \$57,000 and \$84,000 (\$85,000 and \$119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have 4 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 (\$25,000 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 <small>Department of the Treasury Internal Revenue Service</small>	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.	<small>OMB No. 1545-0074</small> 2007
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 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. <small>Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.</small>
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. ► <input type="checkbox"/>
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 2007, 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 <small>(Form is not valid unless you sign it.)</small> ►		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)



Direct Deposit Authorization Form

We are pleased to be able to offer you a new payday convenience—Direct Deposit. Now you can have your paycheck automatically deposited in your checking or savings account on payday. And you don't have to change your present banking relationship to take advantage of this service.

Direct Deposit will help you in many ways.

- It saves you trips to your financial institution.
- It saves you time in depositing checks—no long payday lines to wait in.
- It eliminates the possibility of lost, stolen or forged checks.
- Your money is deposited faster—reduces the possibility of overdrafts.
- You get your money deposited into your account even if you're on vacation or away from the office on business or illness.

Here's how Direct Deposit works:

On payday you will receive an earnings statement showing gross salary, taxes, other deductions, and net pay. Your money will already have been deposited in your account.

The amount of the deposit will appear on your bank statement. We believe you will like the added convenience of having your net pay automatically deposited for you.

NOTE: Be sure to sign the form!

Please complete the information below and return to payroll.

I authorize Mi Casa, Inc. to initiate electronic credit entries each pay period, and if necessary, debit entries and adjustments for any credit entries in error to my:

_____ checking account (or) _____ savings account

I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. This authority will remain in effect until I have cancelled it in writing.

Date _____

FINANCIAL INSTITUTION NAME (PLEASE PRINT) _____

FINANCIAL INSTITUTION ROUTING NUMBER _____

ACCOUNT NUMBER AT FINANCIAL INSTITUTION _____

FINANCIAL INSTITUTION CITY AND STATE _____

PRINT NAME _____

SIGNATURE _____

Direct Deposit is safe, convenient and easy. To take advantage of this service, complete the attached authorization form and return it to the Mi Casa Care office.

The authorization form below gives Mi Casa Care the authority to deposit your pay to your account. Simply complete the form in order to take advantage of Direct Deposit.

All you need to do is:

1. Mark the box before type of account to indicate whether your pay will be deposited in your checking or savings account.
2. Fill in your name, the name and location of your financial institution, and today's date.
3. For verification of all financial institution information attach a copy of a check or a voided check and fill in your account number.



MI CASA CARE

Pre-Employment Drug Test

Policy:

It is the policy of Mi Casa Care to have a pre-employment drug test for all applicants.

Procedure:

This commercial urine test checks for five common illegal drugs.

TEST ADMINISTERED TO: Name _____

Address: _____

Phone Number: _____

	PASS	FAIL
❖ COCAINE	_____	_____
❖ METHAMPHEMINE	_____	_____
❖ THC	_____	_____
❖ OPIATES	_____	_____
❖ PCP	_____	_____

Test Monitored by: _____

Date Taken: _____

POST-OFFER-OF-EMPLOYMENT MEDICAL INQUIRY

Completion of this report is requested to assist your employer in meeting the knowledge requirement of the Georgia Subsequent Injury Trust Fund.

Name _____ Department _____ Position _____

To the best of your knowledge do you have or have had any of the following medical problems?

Answer YES or NO

- | | |
|---|--|
| <input type="checkbox"/> 1. Epilepsy | <input type="checkbox"/> 19. Muscular dystrophy |
| <input type="checkbox"/> 2. Diabetes | <input type="checkbox"/> 20. Total occupational loss of hearing as defined in Code 34-9-264 |
| <input type="checkbox"/> 3. Arthritis | <input type="checkbox"/> 21. Compressed air sequelae |
| <input type="checkbox"/> 4. Amputated foot, leg, arm or hand | <input type="checkbox"/> 22. Ruptured intervertebral disc |
| <input type="checkbox"/> 5. Loss of sight of one or both eyes or a partial loss of uncorrected vision of more than 75% bilaterally | <input type="checkbox"/> 23. Back conditions (Identify below) |
| <input type="checkbox"/> 6. Residual disability from Poliomyelitis | <input type="checkbox"/> a. back surgery |
| <input type="checkbox"/> 7. Cerebral palsy | <input type="checkbox"/> b. degenerative disc disease |
| <input type="checkbox"/> 8. Multiple sclerosis | <input type="checkbox"/> c. multiple back strains |
| <input type="checkbox"/> 9. Parkinson's disease | <input type="checkbox"/> d. chronic back pain |
| <input type="checkbox"/> 10. Cardiovascular disorders | <input type="checkbox"/> e. other (explain) |
| <input type="checkbox"/> 11. Tuberculosis | <input type="checkbox"/> 24. Neck conditions (Identify below) |
| <input type="checkbox"/> 12. Mental retardation, provided the employee's intelligence quotient is such that he falls within the lowest 2% of the general population; provided, however, that it shall not be necessary for the employer to know the employee's actual intelligence quotient of the general population | <input type="checkbox"/> a. neck surgery |
| <input type="checkbox"/> 13. Psychoneurotic disability following confinement for treatment in a recognized medical or mental institution for a period in excess of six months | <input type="checkbox"/> b. degenerative disc disease |
| <input type="checkbox"/> 14. Hemophilia | <input type="checkbox"/> c. multiple neck strains |
| <input type="checkbox"/> 15. Sickle cell anemia | <input type="checkbox"/> d. chronic neck pain |
| <input type="checkbox"/> 16. Chronic osteomyelitis | <input type="checkbox"/> e. other (explain) |
| <input type="checkbox"/> 17. Ankylosis of major weight bearing joints | <input type="checkbox"/> 25. Knee conditions (Identify below) |
| <input type="checkbox"/> 18. Hyperinsulism | <input type="checkbox"/> a. left knee surgery |
| | <input type="checkbox"/> b. right knee surgery |
| | <input type="checkbox"/> c. other (explain) |
| | <input type="checkbox"/> 26. Hip replacement surgery |
| | <input type="checkbox"/> 27. Any permanent condition that has been rated by a doctor as 20% or more, impairment to the foot, leg, hand, arm, or to the body as a whole |
| | <input type="checkbox"/> 28. Any other chronic medical condition or pre-existing disease (explain below) |

For "yes" responses indicate the nature of injury or illness and name of physician in Remarks.

Remarks _____

Employee Signature _____ Date _____

Employer Signature _____ Date _____

Georgia New Hire Reporting Form

Send completed forms to:
 Georgia New Hire Reporting Program
 PO Box 38480
 Atlanta, GA 30334-0480
 Fax: (404) 525-2983 or toll-free fax 1 (888) 541-0521

To ensure the highest level of accuracy, please print neatly in capital letters and avoid contact with the edges of the boxes. The following will serve as an example:

A	B	C	1	2	3
---	---	---	---	---	---

EMPLOYER INFORMATION

Federal Employer ID Number (FEIN) (Please use the same FEIN that appears on your quarterly wage reports you submit to the State):

56 2414483

Multiple medical insurance: Y/N

Primary Insurance Company Name (if available to the employee):

If available/offered: Y/N

Starbridge

Employer Name:

Mi Casa Inc.

Employer Address: (Please indicate the address where the Wage Withholding Orders should be sent).

2271 Brengare Dr

Employer City:

Employer State: Zip Code (5 digit):

Decatur

GA

30033

Employer Phone:

Extension:

Employer Fax:

6782613665

8663834655

E-mail:

EMPLOYEE INFORMATION

Employee Social Security Number (SSN):

Employee Starting Salary (Monthly):*

.00

Employee First Name:

Middle Initial:*

Employee Last Name:

Employee Address:

Employee City:

Employee State: Zip Code:

Date of Hire:

Date of Birth:

Actual First Day of Work:*

Medical Insurance Company Name:*

*optional

Reports must be submitted within 10 days of date of hire or rehire

Questions? Call us at (404) 525-2985 or toll-free 1 (888) 541-0469

Employment Eligibility Verification

Please 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 eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because of 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):
	<input type="checkbox"/> A citizen or national of the United States
	<input type="checkbox"/> A Lawful Permanent Resident (Alien #) A _____
	<input type="checkbox"/> An alien authorized to work until _____ (Alien # or Admission #) _____

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 eligible 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	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 eligibility. Document Title: _____ Document #: _____ Expiration Date (if any): _____	

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible 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)
--	-----------------------