

# Premier Home Health Care LLC

## Job Application

Instructions: Print clearly in black or blue ink. Answer all questions. Sign and date the form.

### PERSONAL INFORMATION:

First Name \_\_\_\_\_

Middle Name \_\_\_\_\_

Last Name \_\_\_\_\_

Street Address  
\_\_\_\_\_

City, State, Zip Code  
\_\_\_\_\_

Phone Number

(\_\_\_\_) \_\_\_\_\_

Are you eligible to work in the United States?

Yes \_\_\_\_\_ No \_\_\_\_\_

If you are under age 18, do you have an employment/age certificates?

Yes \_\_\_ No \_\_\_

Have you been convicted of or pleaded no contest to a felony within the last five years?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

### POSITION/AVAILABILITY:

Position Applied For

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Days/Hours Available

Monday \_\_\_\_  
Tuesday \_\_\_\_  
Wednesday \_\_\_\_  
Thursday \_\_\_\_  
Friday \_\_\_\_  
Saturday \_\_\_\_  
Sunday \_\_\_\_

Hours Available: from \_\_\_\_ to \_\_\_\_

What date are you available to start work?

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**EDUCATION:**

Name and Address Of School - Degree/Diploma - Graduation Date

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Skills and Qualifications: Licenses, Skills, Training, Awards

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**EMPLOYMENT HISTORY:**

Present Or Last Position:

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Supervisor: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Position Title: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_

Responsibilities: \_\_\_\_\_

\_\_\_\_\_

Salary: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

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**Previous Position:**

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Supervisor: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Position Title: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_

Responsibilities: \_\_\_\_\_

\_\_\_\_\_

Salary: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

**May We Contact Your Present Employer?**

Yes \_\_\_\_\_ No \_\_\_\_\_

**References:**

Name/Title Address Phone

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I certify that information contained in this application is true and complete. I understand that false information may be grounds for not hiring me or for immediate termination of employment at any point in the future if I am hired. I authorize the verification of any or all information listed above.

Signature \_\_\_\_\_

Date \_\_\_\_\_



# Premier Home Health Carea LLC Employee's Agreement on Confidential Data

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I, the undersigned \_\_\_\_\_ acknowledge that I have received employment by the company, and I certify that I will not be a party to, or knowingly permit.

1. Disclosures of any confidential matters or trade secrets of the company.
2. Retention or copying of any confidential materials or documents issued to or used by me or others during my employment.

I acknowledge that I have again been carefully and fully advised by the company of my continuing obligations to preserve as confidential, and not to reveal to anyone or use, for myself or anyone else, any trade secrets or confidential matters learned by me during, or by reason of, my employment by the company, and I reaffirm such obligations. I agree that the company may inform my new employer, in writing, of my said obligations, provided only that I receive a copy of such letter or other related communication.

Employee: \_\_\_\_\_ Date: \_\_\_\_\_

**PREMIER HOME HEALTHCARE LLC.**

**CERTIFICATE VERIFICATION**

**Employee Name:** \_\_\_\_\_

**Type of Certificate:** \_\_\_\_\_

**Date Certificate Received:** \_\_\_\_\_

**Company Issuing Certificate:** \_\_\_\_\_

**Person verifying Authenticity of Certificate:** \_\_\_\_\_

**Title of Person verifying Certificate:** \_\_\_\_\_

**Date Certificate verified:** \_\_\_\_\_

**PREMIER HOME HEALTH CARE LLC  
EMPLOYMENT REFERENCE**

*The following person has applied for employment with Premier Home Health Care LLC We would greatly appreciate your assistance in verifying employment and evaluation on job performance.*

Applicant Release

Applicant Name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Company Facility: \_\_\_\_\_ Phone: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_

I authorize release of all information including opinion regarding employment with the above company facility. I hereby release and hold harmless any individual, or company providing this information, both factual and opinion from any legal liability for any damages that may result from the disclosure of this information.

Applicant signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Employment Dates from \_\_\_\_\_ to \_\_\_\_\_

Employer Response:

Please Check Appropriately:

Attendance: Poor \_\_\_ Average \_\_\_ Good \_\_\_ Excellent \_\_\_  
Punctuality: Poor \_\_\_ Average \_\_\_ Good \_\_\_ Excellent \_\_\_

Quality of work: Poor \_\_\_ Average \_\_\_ Good \_\_\_ Excellent \_\_\_  
Job Knowledge: ~~Poor~~ \_\_\_ Average \_\_\_ Good \_\_\_ Excellent \_\_\_  
Attitude: Poor \_\_\_ Average \_\_\_ Good \_\_\_ Excellent \_\_\_

Would you rehire? Yes \_\_\_ No \_\_\_ Does the employment dates correspond with your records? Yes \_\_\_ No \_\_\_

Reason for leaving? \_\_\_\_\_  
Evaluators Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_  
Facility/Company: \_\_\_\_\_ Phone: \_\_\_\_\_

# Form W-4 (2017)

**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 2017 expires February 15, 2018. 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 can't claim exemption from withholding if your total income exceeds \$1,050 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 don't apply to supplemental wages greater than \$1,000,000.

**Basic instructions.** If you aren't 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 income, 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 2017. 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](http://www.irs.gov/w4).

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

<b>A</b>	Enter "1" for yourself if no one else can claim you as a dependent . . . . .	<b>A</b>	<u>      </u>
<b>B</b>	Enter "1" if: <span style="font-size: 2em; vertical-align: middle;">}</span> <ul style="list-style-type: none"> <li>• You're single and have only one job; or</li> <li>• You're married, have only one job, and your spouse doesn't work; or</li> <li>• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.</li> </ul>	<b>B</b>	<u>      </u>
<b>C</b>	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.) . . . . .	<b>C</b>	<u>      </u>
<b>D</b>	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return . . . . .	<b>D</b>	<u>      </u>
<b>E</b>	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above) . . . . .	<b>E</b>	<u>      </u>
<b>F</b>	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.) . . . . .	<b>F</b>	<u>      </u>
<b>G</b>	<b>Child Tax Credit</b> (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> <li>• If your total income will be less than \$70,000 (\$100,000 if married), enter "2" for each eligible child; then less "1" if you have two to four eligible children or less "2" if you have five or more eligible children.</li> <li>• If your total income will be between \$70,000 and \$84,000 (\$100,000 and \$119,000 if married), enter "1" for each eligible child.</li> </ul>	<b>G</b>	<u>      </u>
<b>H</b>	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.) ▶	<b>H</b>	<u>      </u>
<p>For accuracy, complete all worksheets that apply. <span style="font-size: 2em; vertical-align: middle;">}</span></p> <ul style="list-style-type: none"> <li>• If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the <b>Deductions and Adjustments Worksheet</b> on page 2.</li> <li>• 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 <b>Two-Earners/Multiple Jobs Worksheet</b> on page 2 to avoid having too little tax withheld.</li> <li>• If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.</li> </ul>			

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

<b>Form W-4</b>	<b>Employee's Withholding Allowance Certificate</b>	OMB No. 1545-0074
▶ 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.		<b>2017</b>
1 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. 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. ▶ <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)	5 <u>      </u>	
6 Additional amount, if any, you want withheld from each paycheck	6 \$ <u>      </u>	
7 I claim exemption from withholding for 2017, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> <li>• Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and</li> <li>• This year I expect a refund of all federal income tax withheld because I expect to have no tax liability.</li> </ul> If you meet both conditions, write "Exempt" here. ▶ <span style="border: 1px solid black; padding: 2px;">7</span>		
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)

# FORM VA-4

## COMMONWEALTH OF VIRGINIA DEPARTMENT OF TAXATION

### PERSONAL EXEMPTION WORKSHEET

1. If no one else can claim you as a dependent, and you wish to claim yourself, write "1" .....
2. If you are married and your spouse is not claimed on his/her own certificate, write "1" .....
3. Exemptions for age .....
- (a) If you will be 65 or older on December 31, write "1" .....
- (b) If you claimed an exemption on line 2 and your spouse will be 65 or older on December 31, write "1" .....
4. Exemptions for blindness. ....
- (a) If you are legally blind, write "1" .....
- (b) If you claimed an exemption on line 2 and your spouse is legally blind, write "1" .....
5. Write the number of dependents you will be allowed to claim on your income tax return (do not include your spouse) .....
6. Total exemptions (add lines 1 through 5) .....

-----Detach here and give the certificate to your employer. Keep the top portion for your records.-----

### FORM VA-4 EMPLOYEE'S VIRGINIA INCOME TAX WITHHOLDING EXEMPTION CERTIFICATE

Your social security number	Name	
Street address		
City	State	ZIP code

#### COMPLETE THE APPLICABLE LINES BELOW

1. If subject to withholding, enter the number of exemptions claimed on line 6 of the Personal Exemption Worksheet. ....
2. Enter the amount of **additional** withholding requested (see instructions) .....
3. I certify that I am not subject to Virginia withholding. I meet the conditions set forth in the instructions (check here). ....

Signature	Date
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EMPLOYER: Keep exemption certificates with your records. If you believe the employee has claimed too many exemptions, notify the Department of Taxation, P.O. Box 1880, Richmond, Virginia 23282-1880, telephone (804) 367-8038.



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

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

▶ **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

**ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

**Section 1. Employee Information and Attestation** *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number [ ][ ] - [ ][ ] - [ ][ ][ ][ ]		Employee's E-mail Address		Employee's Telephone Number	

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. <i>(See instructions)</i>	
<p><i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i></p> <p>1. Alien Registration Number/USCIS Number: _____  <b>OR</b>          2. Form I-94 Admission Number: _____  <b>OR</b>          3. Foreign Passport Number: _____</p> <p>Country of Issuance: _____</p>	
<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: auto;">           QR Code - Section 1            Do Not Write in This Space         </div>	

Signature of Employee	Today's Date (mm/dd/yyyy)
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**Preparer and/or Translator Certification (check one):**

I did not use a preparer or translator.  A preparer(s) and/or translator(s) assisted the employee in completing Section 1.  
*(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)*

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code



*Employer Completes Next Page*







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

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

**Section 2. Employer or Authorized Representative Review and Verification**

*(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")*

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
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List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)
Document Title		<div style="border: 1px solid black; padding: 5px;">           Additional Information         </div>		<div style="border: 1px solid black; padding: 5px; text-align: center;">           QR Code - Sections 2 &amp; 3            Do Not Write In This Space         </div>
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				

**Certification:** I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment (mm/dd/yyyy): \_\_\_\_\_ (See instructions for exemptions)

Signature of Employer or Authorized Representative		Today's Date(mm/dd/yyyy)	Title of Employer or Authorized Representative		
Last Name of Employer or Authorized Representative		First Name of Employer or Authorized Representative		Employer's Business or Organization Name	
Employer's Business or Organization Address (Street Number and Name)			City or Town	State	ZIP Code

**Section 3. Reverification and Rehires (To be completed and signed by employer or authorized representative.)**

<b>A. New Name (if applicable)</b>			<b>B. Date of Rehire (if applicable)</b>	
Last Name (Family Name)	First Name (Given Name)	Middle Initial	Date (mm/dd/yyyy)	

**C.** If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date (if any) (mm/dd/yyyy)
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I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
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# PREMIER HOME HEALTH CARE LLC

## CRIMINAL BACKGROUND CHECK

I hereby authorize "Premier Home Health Care LLC" to make any investigations of my prior background history. This information will assist them in their assessment of my ability to gain employment.

I do acknowledge that "Premier Home Health Care LLC" will be deducting a fee of \$20.00 for a criminal background check. This fee will be deducted from my first (1<sup>st</sup>) paycheck.

I have carefully read and reviewed all the provisions above and have voluntarily agreed to sign this authorization.

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Print Name

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Signature

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Date



**To: PREMIER HOME HEALTH CARE LLC  
Employee's/New Hires**

**New Hires:**

A criminal history and sexual offender search will be performed within thirty (30) days of hire. There is a \$20 charge that will be deducted from your first pay!! Any criminal or sexual convictions where there are **felony** barrier crimes found will result in immediate termination from your work assignment!! **No Exceptions!!!**

**Employee's:**

A criminal history and sexual offender search will be done annually (from date last check was done) and there will be a charge of \$20 (payroll deducted). You will be notified before the charge is deducted. Any new criminal or sexual charges where there are **felony** barrier crimes found will result in your immediate termination!! **No Exceptions!!!**

I have read and understand the information presented above.

Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

## PREMIER HOME HEALTHCARE LLC

### PCA/CNA REQUIREMENTS

- Must be physically able to do this work.
- Must be 18 years of age or older.
- Must have the ability to read and write English to the degree necessary to perform the expected tasks and processes basic math skills.
- Must complete a DMAS-approved nurse aide training program.
- Must have a satisfactory work history as evidenced by two (2) satisfactory reference checks from prior employers.
- Must pass a criminal record check.
- Must have reliable transportation.

# PERSONAL REFERENCE

## Applicant Reference

*The following is suggested for a reference check. These references are used in a telephone check or in letters sent to the written employer for the applicant. This reference check will become the applicant, reviewable record file*

**Address: Premier Home Healthcare LLC, 3701A King St. direct: (757)966-1094 Fax: (757)966-1949**

Applicant: \_\_\_\_\_

Reference: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone: (     ) \_\_\_\_\_ - \_\_\_\_\_

Fax:     (     ) \_\_\_\_\_ - \_\_\_\_\_

Telephone verified: \_\_\_\_\_ Fax: \_\_\_\_\_

## Reference Questionnaire:

Team player: \_\_\_\_\_ very good \_\_\_\_\_ good \_\_\_\_\_ fair \_\_\_\_\_ poor

Personality: \_\_\_\_\_ very good \_\_\_\_\_ good \_\_\_\_\_ fair \_\_\_\_\_ poor

Friendly: \_\_\_\_\_ very good \_\_\_\_\_ good \_\_\_\_\_ fair \_\_\_\_\_ poor

Get along with others: \_\_\_\_\_ very good \_\_\_\_\_ good \_\_\_\_\_ fair \_\_\_\_\_ poor

Relationship: \_\_\_\_\_ friend \_\_\_\_\_ co-worker \_\_\_\_\_ relative \_\_\_\_\_ other

## Reference

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Authorization: The applicant signature below is giving Premier Home Health Care LLC., authorization to retrieve their information for employment.

Applicant: \_\_\_\_\_ Date: \_\_\_\_\_