Home Care of Baltimore

Application for Employment – Personal Care Provider

Date Received: _____

Personal Information			
Last Name	**First Name**	**Middle Name**	Today's Date

Street Address	City	State	Zip Code

Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____ Other: (_____)_____-_____ Email address _____	Are you a United States Citizen or legally eligible to work in the U. S.? _____Yes _____No (*if hired, you will be required to provide documentation that you are eligible to work in the U.S.)*

Are you 18 or over? ____Yes ____No

Title of Position Applying For	Date Available to Work

Have you been previously interviewed or employed by Home Care of Baltimore? ____Yes ____No
If Yes, list date(s) and job title(s):

What is the lowest pay you will accept?

Are you employed now? If so, may we contact your present employer?

List all other professional licenses, registrations, and certificates:_____

List any special skills you possess that would be appropriate for the job for which you are applying:

_____

_____

List times you will be willing/able to work:
(Mornings:)_____
(Afternoons)_____(Evenings)_____

(Weekend) _____ (Live-In) _____

Do you have transportation available? Yes_____ No_____

Please list the zip codes or areas within Baltimore County where you are willing/able to accept patients for personal care services:

_____

Are you fluent in any languages other than English?

_____

Education

Name and Location		# Years Completed	Major Area of Study	Degree/Diploma
High School				
College				
Graduate School				
Technical or Certificate Programs				

Employment History

Please provide the following information for your previous three employers, beginning with the most recent: (Please attach an additional page if necessary, do not use "see attached resume".)

Employer:	Dates Employed: From_____ To_____	Job Title:
Address:		
Telephone:		Job Duties:
Weekly Pay Start: Finish:		
Reason for Leaving:		

Employer:	Dates Employed: From_____ To_____	Job Title:
Address:		
Telephone:		Job Duties:
Weekly Pay Start: Finish:		
Reason for Leaving:		

Employer:	Dates Employed: From_____ To_____	Job Title:
Address:		
Telephone:		Job Duties:
Weekly Pay Start: Finish:		
Reason for Leaving:		

Describe your qualifications for the type of employment you are seeking: (Please include skills, special training, etc.)

_____
_____
_____
_____

References Please list names of supervisors, managers, or others who can comment directly on your abilities:

Name	Address	Phone #	Relationship/Occupation	Years Known

Have you ever been disciplined or asked to resign from any position? ( ) Yes ( ) No
If yes,
explain:_____

Can you perform the functions of the job for which you are applying with or without reasonable accommodations?
( ) Yes ( ) No

TO BE COMPLETED BY ALL APPLICANTS

Home Care of Baltimore is an Equal Opportunity Employer. It is the policy of Home Care of Baltimore ot to discriminate in employment matters on the basis of race, creed, color, age, marital status, physical or mental disability, national origin, sex, or sexual orientation.

******

I certify that the facts set forth in this application for employment are true and complete to the best of my knowledge. I understand that if employed, false statements on this application shall be considered sufficient cause of dismissal. You are hereby authorized to make investigation of my personal references.

_____ _____
Signature of Applicant Date

UNDER MARYLAND LAW, AN EMPLOYER MAY NOT REQUIRE OR DEMAND, AS A CONDITION OF EMPLOYMENT, PROSPECTIVE EMPLOYMENT, OR CONTINUED EMPLOYMENT, THAT AN INDIVIDUAL SUBMIT TO OR TAKE A LIE DETECTOR OR SIMILAR TEST. AN EMPLOYER WHO VIOLATES THIS LAW IS GUILTY OF A MISDEMEANOR AND SUBJECT TO A FINE NOT EXCEEDING $100.

DICLOSURE STATEMENT BACKGROUND CHECK RELEASE FORM

HOME CARE OF BALTIMORE

I hereby authorize Home Care of Baltimore and its designated agents and representatives to conduct a comprehensive review of my background through a consumer report and/or an investigative consumer report to be generated for employment, promotion, reassignment or retention as an employee. I understand that the scope of the consumer report/investigative consumer report may include, but is not limited to, the following areas: Verification of Social Security Number, current and previous residences, employment history including all personnel files, education, character references, credit history and reports, criminal history records from any criminal justice agency in any or all federal, state county jurisdictions, birth records, motor vehicle records to include traffic citations and registration and any other public records.

I_____, authorize the complete release of these records or data pertaining to me which an individual, company, firm, corporation, or public agency may have. I understand that I must provide my date of birth to adequately complete said screening, and acknowledge that my date of birth will not affect any hiring decisions. I hereby authorize and request any present or former employer, school, police department, financial institution or other persons having personal knowledge of me, to furnish bearer with any and all information in their possession regarding me in connection with an application for employment. This authorization and consent shall be valid in original, fax, or copy form. I hereby release Home Care of Baltimore, and its agents, officials, representatives, or assigned agencies, including officers, employees, or related personnel both individually and collectively, from any and all liability for damages of whatever kind, which may at any time, result to me, my heirs, family or associates because of compliance with this authorization and request to relapse. You may contact me as indicated below; I understand that a copy of this authorization may be given to me at any time, provided I request it in writing. Information on this application and results of the background investigation will be maintained in confidence in accordance with company hiring practices.

Name:_____

Social Security Number:_____ **SEX:**_____ **Race:**_____

D/O/B:_____

Current Address:_____

City_____**State:**_____ **Zip:** _____

Drivers License Number:_____ **State of Issuance:**_____

May we contact Your Current Employers:_____

Signature_____ **Date**_____

Hepatitis B Immunization Consent/Refusal Form

Please check one:

- o **Yes, I want to receive the Hepatitis B vaccine.**

I read the information given to me about Hepatitis B virus and Hepatitis B vaccine and I had the opportunity to ask questions. My questions were answered.
I want to participate in the vaccination program. I understand this includes three injections at prescribed intervals over a six month period. I understand that there is no guarantee that I will become immune to Hepatitis B. I understand that I might experience an adverse side effect as the result of the vaccination.

Employee Name

City, State, Zip

Social Security Number

- o **No, I don't want to receive the Hepatitis B Vaccine.**

I understand that due to my occupational exposure to blood or other potentially infectious material, I may be at risk of acquiring Hepatitis B Virus (HBV). I was given the opportunity to be vaccinated with Hepatitis B vaccine at no charge to me. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at an increased risk of acquiring Hepatitis B, a serious disease.

If in the future, I want to be vaccinated with the Hepatitis B vaccine, I understand that I can receive the vaccine series at no charge to me.

Employee Name

City, State, Zip

Social Security Number

Signature

PRIVACY ACT INFORMATION
Agency: Home Care of Baltimore

Address: 2 Jill ct., Reisterstown MD, 21136

Telephone Number: 410-978-8236

Date:

Home Care of Baltimore

Job Description — Personal Care Aide	Policy No. HC 450	Page **1** of 2
Personnel and Contractors	Date of Origin: 09-24-2010	Reviewed:
Effective Date: 09-24-2010	Date: 09-24-2010	Approved:

Position: Personal Care Aide

Reports to: Home Care Supervisor

Summary of Responsibilities:
The Personal Care Assistant provides personal care and household assistance to clients in their own homes. The Personal Care Assistant works under the supervision of the Home Care Supervisor and is assigned specific tasks through the Home Care Plan of Care.

Specific duties include:

Assists clients with personal care, which may include bathing, shampooing, shaving, toileting, dressing, transfers, ambulation and positioning.

Performs household services essential to the client's safety and care at home including; laundry, meal preparation, housekeeping, transportation and shopping.

Performs only the tasks defined in the Home Care Plan of Care for the client and observes, documents and reports any changes in the client's condition. May assist with medications as indicated in the plan of care.

Reports to the Home Care Supervisor any changes in the client's mental or physical condition as well as changes in the client's need for care.

Follows agency policies and procedures.

Meets the requirements for submission of time cards and documentation of assignments.

Respects the rights of clients and families to have different beliefs, opinions, cultures and customs.

Attends orientation and in-service training as required by the agency.

As a member of the home care team keeps and maintains a professional attitude in the client's home.

Skills Requirements:

1. Possesses and maintains good physical stamina and mental health. Prior to patient contact, presents a pre-employment health clearance.
2. Is self-directing with the ability to work with little direct supervision.
3. Demonstrates empathy for the needs of the ill, injured, frail and the impaired.
4. Demonstrates flexible and cooperation in fulfilling role obligation.
5. Demonstrates tact, patience, and good personal hygiene.
6. They usually are trained on the job by registered nurses or other experienced aides.
7. Aides are should be able to cook for a client, including on special diets.
8. Aides arc should be able to pass the test for basic housekeeping, such as making a bed and keeping the home sanitary and safe for the client.
9. Aides are should be able to learn how to respond to an emergency.
10. Aides are should be able to learning basic safety techniques.

Other qualifications. Aides should have a desire to help people. They should be responsible, compassionate, patient, emotionally stable, and cheerful. In addition, aides should be tactful, honest, and discreet, because they work in private homes. Aides also must be in good health. A physical examination, including State-mandated tests for tuberculosis and other diseases, may be required. A criminal background check and a good driving record also may be required for employment

Signature:___

Home Care of Baltimore

Orientation Process of 1	Policy No. HC 435	Page 1
Personnel, Contractors and Volunteer Policies	Date of Origin: 09-24-2010	Reviewed:
Effective Date: 09-24-2010	Date: 09-24-2010	Approved:

PERSONNEL ORIENTATION TRAINING

The following areas of orientation have been reviewed and understood by:

Employee Name:_____

Philosophy of care
Job description
Time cards and pay periods
Personnel requirements
Documentation of care
Policy and Procedure review
Client's Bill of Rights
Client Care Policies and
Procedures General Policies
Communication with clients
Detection of Abuse and
Neglect Infection Control
Control of Communicable
Disease Medication Assistance
Emergency Procedures I
tome Care Plan of Care
Supervision of Personal Care Aides

Employee Signature:_____ Date:_____

INTERVIEW CHECK LIST

Name of Candidate_____

Time of interview _____ _____

Salary_____

Appearance/Demeanor_____

Date_____

When evaluating the candidate post interview make sure to consider how the person interacted with others, energy level, genuine interest in your agency and position and also evaluate personal qualities, organizational fit, common- sense and good judgment

Technical Questions:

Qt. What made you decide to apply for this job?

A1._____

Q2. Do you have any work experience in care giving or similar areas?

A2._____

Q3 Tell us about specific training or courses pertaining to in-home health work

A3._____

Accomplishments:

Ql. How did you fill downtime at your last job?

A1._____

Q2.When you have a lot of work to do and not enough time or assistance to get it all done, how do you handle it?

A2._____

Q3. It Is your lunch break and you see a client fall. What do you do?

A3._____

Patient/Customer Service Questions:

Qt How have you responded when your supervisor asked you to work a different shift to fill vacancies

Al._____

Q2. What is your relationship with your grandparents?

A2._____

Q3. How do you feel about the philosophy of the customer always being right?

A3._____

Other: (List other questions which are important for this position)

Q1. How do you respond if you know the customer is wrong?

Al._____

Q2. What does being responsible mean to you?

A2._____

Home Care of Baltimore

Policy and Procedures Addendum 05/18/2017

Attn: Personal Care Providers

Memo: Compliance with Deficit Reduction Act - Employee Education

Fraud

Caregiver must follow the next rules, while providing services through the Agency:

1. Providers can only bill for direct care, meaning the staff provider **MUST** be providing care to the client at all times. If the staff provider needs to run errands for the client, the client **MUST** be present. The staff provider may never bill through ISAS while the client is not present. No service will be reimbursed while the participant is admitted to the Emergency room, hospital, admitted to a nursing facility, admitted to an institution for mental disease, attending a day care program. (COMAR 10.09.20.01).
2. Personal Assistance services can only be reimbursed if they are provided in the participant's presence. Errands, including for groceries or medications, cannot be reimbursed unless the participant is escorted by the aide. (COMAR 10.09.84.02).
3. Services provided during vacation must be: within POS hours, not out of state of Maryland for more than 14 days per year, within the US, logged in ISAS using phone listed on client POS or OTP device. For clock in and out staff providers MUST use the client's home phone. If personal OTP device is assigned to the participant, provider can use any other phones. OTP device **MUST** be kept with the Participant or in an easily accessible location at the Participants home at all times (COMAR 10.09.36.04)

Waste

Caregiver can help to prevent pollution, illness by following a few rules when disposing the sharp objects and any contaminated materials:

1. Lancets, sharps, needles, syringes and other sharp objects should be stored in metal containers with a tightly screwed on lid.
2. Before discarding a container, be sure to reinforce the lid with heavy-duty tape. Do not put sharp objects in any container you plan to recycle and do not use glass or clear plastic containers
3. Keep all containers with sharp objects out of the reach of visitors such as children and pets.
4. When disposing medical gloves, bandages, sheets they should be secured in regular plastic trash bag if not visibly soiled; and should be secured to the bag with Biohazard label if visibly soiled with blood or potentially infectious material.

Abuse & Neglect

1. Caregiver must not be involved in unauthorized use of participant's funds, steal cash or household goods, misuse participants credit cards or accounts
2. Caregiver must not be involved in emotional/psychological/sexual abuse: caretaker cannot yell, threat, ignore the participant, and cannot isolate the client from his / her friends.
3. Caregiver cannot neglect the participant: should respond to clients needs in a timely manner, provide the meals, medication or hygienic activities on time and respond to clients fall with or without injury immediately and call 911 when required.

I have read, understand and agree to abide by the terms of Home Care of Baltimore policy regarding the prevention of waste/fraud/ abuse of the participant.

Caregiver name:_____

Caregiver Signature_____ Date_____

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

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

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

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

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

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

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

☐ 1. A citizen of the United States

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

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

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

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

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

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	**OR**	**List B** Identity	**AND**	**List C** Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

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

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

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code

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

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

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

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	**(b) Social security number**
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

MARYLAND
FORM
MW507

Purpose. Complete Form MW507 so that your employer can withhold the correct Maryland income tax from your pay. Consider completing a new Form MW507 each year and when your personal or financial situation changes.

Basic Instructions. Enter on line 1 below, the number of personal exemptions you will claim on your tax return. However, if you wish to claim more exemptions, or if your adjusted gross income will be more than $100,000 if you are filing single or married filing separately ($150,000, if you are filing jointly or as head of household), you must complete the Personal Exemption Worksheet on page 2. Complete the Personal Exemption Worksheet on page 2 to further adjust your Maryland withholding based on itemized deductions, and certain other expenses that exceed your standard deduction and are not being claimed at another job or by your spouse. However, you may claim fewer (or zero) exemptions.

Additional withholding per pay period under agreement with employer. If you are not having enough tax withheld, you may ask your employer to withhold more by entering an additional amount on line 2.

Exemption from withholding. You may be entitled to claim an exemption from the withholding of Maryland income tax if:

a. Last year you did not owe any Maryland Income tax and had a right to a full refund of any tax withheld; AND,

b. This year you do not expect to owe any Maryland income tax and expect to have a right to a full refund of all income tax withheld.

If you are eligible to claim this exemption, complete Line 3 and your employer will not withhold Maryland income tax from your wages.

Students and Seasonal Employees whose annual income will be below the minimum filing requirements should claim exemption from withholding. This provides more income throughout the year and avoids the necessity of filing a Maryland income tax return.

Certification of nonresidence in the State of Maryland. Complete Line 4. This line is to be completed by residents of the District of Columbia, Virginia or West Virginia who are employed in Maryland and who do not maintain a place of abode in Maryland for 183 days or more.

Residents of Pennsylvania who are employed in Maryland and who do not maintain a place of abode in Maryland for 183 days or more, should complete line 5 to exempt themselves from the state portion of the withholding tax. These employees are still liable for withholding tax at the rate in effect for the Maryland county in which they are employed, unless they qualify for an exemption on either line 6 or line 7. Pennsylvania residents of York and Adams counties may claim an exemption from the local withholding tax by completing line 6. Pennsylvania residents living in other local jurisdictions which do not impose an earnings or income tax on Maryland residents may claim an exemption by completing line 7. Employees qualifying for exemption under 6 or 7, should also write "EXEMPT" on line 4.

Line 4 is **NOT** to be used by residents of other states who are working in Maryland, because such persons are liable for Maryland income tax and withholding from their wages is required.

If you are domiciled in the District of Columbia, Pennsylvania or Virginia and maintain a place of abode in Maryland for 183 days or more, you become a statutory resident of Maryland and you are required to file a resident return with Maryland reporting your total income. You must apply to your domicile state for any tax credit to which you may be entitled under the reciprocal provisions of the law. If you are domiciled in West Virginia, you are not required to pay Maryland income tax on wage or salary income, regardless of the length of time you may have spent in Maryland.

Under the Servicemembers Civil Relief Act, as amended by the Military Spouses Residency Relief Act, you may be exempt from Maryland income tax on your wages if (i) your spouse is a member of the armed forces present in Maryland in compliance with military orders; (ii) you are present in Maryland solely to be with your spouse; and (iii) you maintain your domicile in another state. If you claim exemption under the SCRA enter your state of domicile (legal residence) on Line 8; enter "EXEMPT" in the box to the right on Line 8; and attach a copy of your spousal military identification card to Form MW507. **In addition, you must also complete and attach Form MW507M.**

Duties and responsibilities of employer. Retain this certificate with your records. You are required to submit a copy of this certificate and accompanying attachments to the Compliance Division, Compliance Programs Section, 301 West Preston Street, Baltimore, MD 21201, when received if:

1. You have any reason to believe this certificate is incorrect;
2. The employee claims more than 10 exemptions;
3. The employee claims an exemption from withholding because he/she had no tax liability for the preceding tax year, expects to incur no tax liability this year and the wages are expected to exceed $200 a week;
4. The employee claims an exemption from withholding on the basis of nonresidence; or
5. The employee claims an exemption from withholding under the Military Spouses Residency Relief Act.

Upon receipt of any exemption certificate (Form MW507), the Compliance Division will make a determination and notify you if a change is required.

Once a certificate is revoked by the Comptroller, the employer must send any new certificate from the employee to the Comptroller for approval before implementing the new certificate.

If an employee claims exemption under 3 above, a new exemption certificate must be filed by February 15th of the following year.

Duties and responsibilities of employee. If, on any day during the calendar year, the number of withholding exemptions that the employee is entitled to claim is less than the number of exemptions claimed on the withholding exemption certificate in effect, the employee must file a new withholding exemption certificate with the employer within 10 days after the change occurs.

FORM
MW507 Employee's Maryland Withholding Exemption Certificate

Print full name	Social Security Number
Street Address, City, State, ZIP	County of residence (Nonresidents enter Maryland county (or Baltimore City) where you are employed.)

☐ Single ☐ Married (surviving spouse or unmarried Head of Household) Rate ☐ Married, but withhold at Single rate

1. Total number of exemptions you are claiming not to exceed line f in Personal Exemption Worksheet on page 2. . . . . 1. _____
2. Additional withholding per pay period under agreement with employer. . . . . 2. _____
3. I claim exemption from withholding because I do not expect to owe Maryland tax. See instructions above and check boxes that apply.
   ☐ a. Last year I did not owe any Maryland income tax and had a right to a full refund of all income tax withheld and
   ☐ b. This year I do not expect to owe any Maryland income tax and expect to have the right to a full refund of all income tax withheld. (This includes seasonal and student employees whose annual income will be below the minimum filing requirements). If both a and b apply, enter year applicable _____ (year effective) Enter "EXEMPT" here . . . . . 3. _____
4. I claim exemption from withholding because I am domiciled in one of the following states. Check state that applies.
   ☐ District of Columbia ☐ Virginia ☐ West Virginia
   I further certify that I do not maintain a place of abode in Maryland as described in the instructions above. Enter "EXEMPT" here. . . . . 4. _____
5. I claim exemption from Maryland **state** withholding because I am domiciled in the Commonwealth of Pennsylvania and I do not maintain a place of abode in Maryland as described in the instructions on Form MW507. Enter "EXEMPT" here. . . . . 5. _____
6. I claim exemption from Maryland **local** tax because I live in a local Pennsylvania jurisdiction within York or Adams counties. Enter "EXEMPT" here and on line 4 of Form MW507. . . . . 6. _____
7. I claim exemption from Maryland **local** tax because I live in a local Pennsylvania jurisdiction that does not impose an earnings or income tax on Maryland residents. Enter "EXEMPT" here and on line 4 of Form MW507. . . . . 7. _____
8. I certify that I am a legal resident of the state of _____ and am not subject to Maryland withholding because I meet the requirements set forth under the Servicemembers Civil Relief Act, as amended by the Military Spouses Residency Relief Act. Enter "EXEMPT" here. . . . 8. _____

Under the penalty of perjury, I further certify that I am entitled to the number of withholding allowances claimed on line 1 above, or if claiming exemption from withholding, that I am entitled to claim the exempt status on whichever line(s) I completed.

Employee's signature	Date
Employer's name and address including ZIP code (For employer use only)	Federal Employer Identification Number

Authorization for Direct Deposit - Employee Form

This authorizes Home Care of Baltimore (the "Company") to send credit entries (and appropriate debit and adjustment entries), electronically or by any other commercially accepted method, to my (our) account(s) indicated below and to other accounts I (we) identify in the future (the "Account"). This authorizes the financial institution holding the Account to post all such entries.

Note: Enter your company name in the blank space above.

Account #1

Account #1 Type (check one): ☐ Checking ☐ Savings

Employee Bank Name

Bank Routing # (ABA#) | Account #

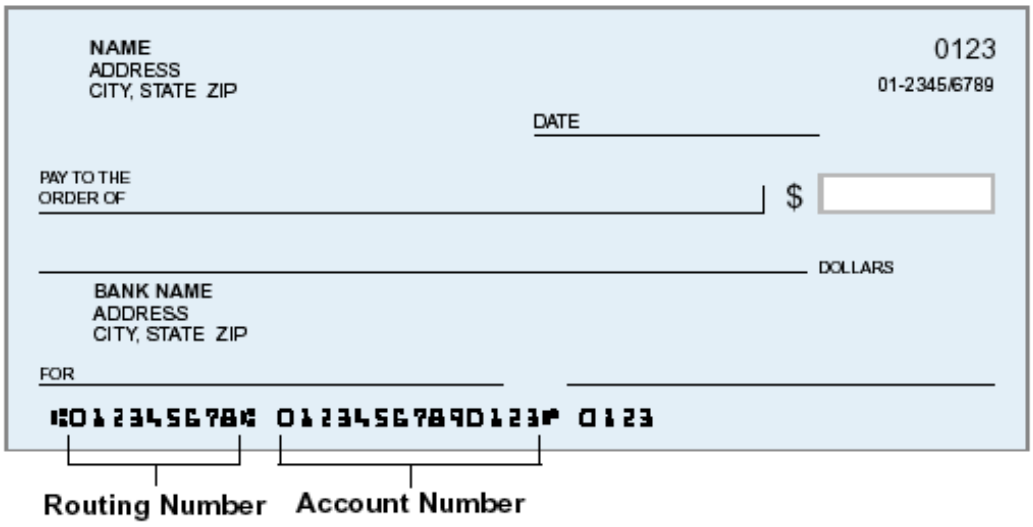
Percentage or Dollar Amount to be Deposited to This Account

Account #2 (remainder to be deposited to this account)

Account #2 Type (check one): ☐ Checking ☐ Savings

Employee Bank Name

Bank Routing # (ABA#) | Account #



This authorization will be in effect until the Company receives a written termination notice from myself and has a reasonable opportunity to act on it.

Signature

Printed Name

Employee ID # | Date

IMPORTANT: This document must be signed by employees requesting automatic deposit of paychecks and retained on file by the employer.

Employee: Please fill out and return to your employer. **Employer: Please save for your files only.**

Employee Waiver Form

This waiver form must be completed by any eligible employee who has voluntarily elected to waive his/her opportunity to participate in the dealership's employer-sponsored group health plan.

Name (Last, First, MI)			Sex	Social Security #
Street Address			City, State & Zip	
Birth Date	Marital Status	Date of Hire	Phone #	

I hereby certify that the medical benefits provided by my employer have been explained to me, and that I elect to decline to participate in the plan. I understand by declining this offer I may not be offered another opportunity to participate unless I marry, divorce, have a child (natural or adoption), have an involuntary loss of other health benefits, or any other involuntary cause as defined under section 125 of the IRS code. I must request to enroll within 30 days after a qualifying event. I may also enroll during the next open enrollment period. I also understand that my employer has offered me a compliant health plan as defined by the Affordable Care Act (ACA). I understand that by electing not to enroll in this ACA compliant plan, I will not be eligible for a premium subsidy at either a state based or federally operated insurance exchange.

Reason for decline (please choose one):

- ☐ I have other insurance through other job or spouse's employer.
- ☐ I have other insurance through my parent(s).
- ☐ I have other insurance through the military.
- ☐ I have other insurance through my former employer (COBRA or Retirement).
- ☐ I have my own insurance directly with an insurance carrier.
- ☐ I have state or federal coverage through Medicare or Medicaid.
- ☐ I have no health insurance and do not want any.
- ☐ Other (please explain):

_____ _____

Signature Date

STANDARDS FOR THE HOME CARE OF BALTIMORE ***PROVIDERS***

Providers should:

- Be available, accessible and responsive.
- Be compassionate, dependable and non-judgmental.
- Encourage independence in the people they support.
- Provide full disclosure of services that may be expected or not expected.
- Be open to communication with families and provide a lot of feedback about how the family member is doing.
- Not assume they understand everything about the person they support.
- Have respect for families.
- Be well trained.
- Show up on time – do things in a timely manner.
- Be knowledgeable about resources.
- Appropriately attend to the physical care and other special needs of individuals for whom they provide support.
- Pay a lot of attention to the desires and opinions of people they work with
- Have the "personal touch."
- Provide a warm, pleasant environment for people who live in their homes.
- Offer recognition of the accomplishments of those they support.
- Be honest, understanding, patient and flexible.
- Know how to ask the right questions.
- Adapt to the individuals they work with - not expect those individuals to adapt to them.
- Be well organized.
- Meet federal and state requirements.

_____

Print Name

_____

Signature

_____

Date

HOME CARE OF BALTIMORE
PROCEDURES/SKILL CHECKLIST

I _____ verify that all the below procedures/skills were taught to me by a Registered Nurse and I successfully demonstrated them back to the nurse. I understand all of the skills and feel comfortable in completing any of them as needed.

Gloves	Supine Position	Lateral position	Fowlers position
Semi-Fowler's Position	Sit On Edge of Bed	Assist Resident to Move to Head of Bed	Protective Devices
Walking	Assist with Walker	Assist to Chair	Transfer to Wheelchair and Transport
Drape and Undrape	Rub Back	Heel or Elbow Protectors	Check Skin
Range of Motion	Change Gown	Dressing a Dependent Resident	Unoccupied Bed
Occupied Bed	Fingernail Care	Safety Razor	Electric Razor
Denture Care	Oral Care	Comb Hair	Assist to Eat
Feeding	Showering	Bed bath	Perineal Care
Assist to Bathroom	Bedside Commode	Weight	Pulse and Respirations
Oral Temperature	Axillary temperature	Choking	Fire
Falling and Fainting	Hand Washing	Blood Pressure	

Staffs signature:

Date:

Nursing Supervisors signature:

Date:

HOME CARE OF BALTIMORE

Initial Caregiver's Self Evaluation Form

Self-Rating Skills Assessment Checklist

Caregiver Name: _____

Skills	I can perform this independently	I need to review this again	I have no experience
Bathing			
Care of Teeth			
Care of Skin			
Care of Hair			
Dressing			
Meal Preparation			
Eating			
Toileting			
Transferring			
Ambulation			
Straightening Area			
Changing Bed			
Food shopping			
Escort to Med.Service			
Monitoring for Safety			
Infection Control			
Light Housekeeping			
Medication*			
Others (Please specify)			

Caregiver signature: _____ Date: _____

MUTUAL ARBITRATION AGREEMENT

This Mutual Arbitration Agreement is a contract and covers important issues relating to your rights. It is your sole responsibility to read it and understand it. You are free to seek assistance from independent advisors of your choice outside the Company or to refrain from doing so if that is your choice.

Это обоюдное арбитражное соглашение является контратком и охватывает важные вопросы касательно Ваших прав. Ответсвтенность за его прочтение и понимание целиком и полностью ложится на Вас. Вы можете беспрепятственно обращаться за помощью независимых советников за пределами компании по Вашему усмотрению или же воздержаться от этого по Вашему выбору.

1. This Mutual Arbitration Agreement ("Agreement") is between Employee and Home Care of Baltimore LLC("COMPANY"). The Federal Arbitration Act (9 U.S.C. §§ 1 *et seq.*) governs this Agreement, which evidences a transaction involving commerce. **EXCEPT AS THIS AGREEMENT OTHERWISE PROVIDES, ALL DISPUTES COVERED BY THIS AGREEMENT WILL BE DECIDED BY AN ARBITRATOR THROUGH FINAL AND BINDING ARBITRATION AND NOT BY WAY OF COURT OR JURY TRIAL.**

2. **MANDATORY CONDITION OF EMPLOYMENT**. This Agreement is a mandatory condition of your employment.

3. **COVERED CLAIMS/DISPUTES**. Except as otherwise provided in this Agreement, this Agreement applies to any and all disputes, past, present or future, that may arise between Employee (sometimes "you" or "your") and COMPANY, including without limitation any dispute arising out of or related to Employee's application, employment and/or separation of employment with COMPANY. This Agreement applies to a covered dispute that COMPANY may have against Employee or that Employee may have against COMPANY, its parent companies, subsidiaries, related companies and affiliates, franchisors, or their officers, directors, principals, shareholders, members, owners, employees, and managers or agents, any of which may enforce this Agreement as direct or third-party beneficiaries.

   The claims subject to arbitration are those that absent this Agreement could be brought under applicable law. Except as it otherwise provides, this Agreement applies, without limitation, to claims based upon or related to the application for employment, background checks, privacy, the employment relationship, discrimination, harassment, retaliation, defamation (including post-employment defamation or retaliation), breach of a contract or covenant, fraud, negligence, emotional distress, breach of fiduciary duty, trade secrets, unfair competition, wages, minimum wage and overtime or other compensation claimed to be owed, breaks and rest periods, termination, tort claims, equitable claims, and all statutory and common law claims unless specifically excluded below. Except as it otherwise provides, the Agreement covers, without limitation, claims arising under the Fair Credit Reporting Act, Defend Trade Secrets Act, Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 1981, the Americans With Disabilities Act, the Age Discrimination in Employment Act, the Family Medical Leave Act, the Fair Labor Standards Act, Rehabilitation Act, Civil Rights Acts of 1866 and 1871, the Civil Rights Act of 1991, the Pregnancy Discrimination Act, the Equal Pay Act, the Genetic Information Non-Discrimination Act, Employee Retirement Income Security Act of 1974 (except for claims for employee benefits under any benefit plan sponsored by the COMPANY and (a) covered by the Employee Retirement Income Security Act of 1974 or (b) funded by insurance), Affordable Care Act, Uniform Services Employment and Reemployment Rights Act, Worker Adjustment and Retraining Notification Act, state statutes or regulations addressing the same or similar subject matters, and all other federal or state legal claims arising out of or relating to Employee's employment or the termination of employment.

   Additionally, except as otherwise provided in this Section 3 of this Agreement, Employee and the COMPANY agree that any legal dispute or controversy arising out of, relating to, or concerning the arbitrability of any dispute or controversy or the validity, enforceability or breach of this Agreement shall be subject to final and binding arbitration.

   EXCLUDED CLAIMS/DISPUTES. This Agreement does not apply to litigation pending in a state or federal court as of the date of your receipt of this Agreement and in which you are a party or a member or putative member of an alleged class ("Pending Lawsuit"). However, this Pending Lawsuit exclusion will not apply once that lawsuit is dismissed or the class alleged in that lawsuit is decertified. The Agreement also does not apply to claims for worker's compensation benefits, state disability insurance benefits and unemployment insurance benefits; however, this Agreement applies to retaliation claims based upon seeking such benefits, such as claims for worker's compensation retaliation.

intended to be a substitute for the utilization of such procedures. In addition, either party may apply to a court of competent jurisdiction for temporary or preliminary injunctive relief in connection with an arbitrable controversy, but only upon the ground that the award to which that party may be entitled may be rendered ineffectual without such relief or to prevent irreparable harm. Such relief may include for example, an order to prevent the unauthorized use of patient or referral source information or confidential proprietary business information, subject to final relief in arbitration.

Nothing in this Agreement prevents you from making a report to or filing a claim or charge with a government agency, including without limitation the Equal Employment Opportunity Commission, U.S. Department of Labor, U.S. Securities and Exchange Commission, National Labor Relations Board, or Office of Federal Contract Compliance Programs. Nothing in this Agreement prevents the investigation by a government agency of any report, claim or charge otherwise covered by this Agreement. This Agreement also does not prevent federal or state administrative agencies from adjudicating claims and awarding remedies based on those claims, even if the claims would otherwise be covered by this Agreement. Nothing in this Agreement prevents or excuses a party from satisfying any conditions precedent and/or exhausting administrative remedies under applicable law before bringing a claim in arbitration. The COMPANY will not retaliate against you for filing a claim with an administrative agency or for exercising rights (individually or in concert with others) under Section 7 of the National Labor Relations Act.

4. **CLASS AND COLLECTIVE ACTION WAIVER.** Both you and COMPANY agree to bring any dispute in arbitration on an individual basis only, and not on a class or collective action basis on behalf of others. There will be no right or authority for any dispute to be brought, heard or arbitrated as a class or collective action and the arbitrator will have no authority to hear or preside over any such claim ("Class Action Waiver"). Regardless of anything else in this Agreement and/or the American Arbitration Association ("AAA") rules or procedures, a dispute or controversy over the validity, enforceability or breach of the Class Action Waiver may only be determined by a court and not an arbitrator. In any case in which (1) the dispute is filed as a class or collective action and (2) there is a final judicial determination that all or part of the Class Action Waiver is unenforceable, the class or collective action to that extent must be litigated in a civil court of competent jurisdiction, but the portion of the Class Action Waiver that is enforceable shall be enforced in arbitration. You will not be retaliated against, disciplined or threatened with discipline by the filing of or participation in a class or collective action in any forum. However, COMPANY may lawfully seek enforcement of this Agreement and the Class Action Waiver under the Federal Arbitration Act and seek dismissal of such class or collective actions or claims.

5. **ARBITRATOR SELECTION**. The parties will proceed to arbitration before a single arbitrator and in accordance with the then current American Arbitration Association ("AAA") Employment Arbitration Rules ("AAA Rules") (the AAA Rules may be found at www.adr.org or by searching for "AAA Employment Arbitration Rules" using a service such as www.Google.com), provided, however, that if there is a conflict between the AAA Rules and this Agreement, this Agreement will govern. Unless the parties mutually agree otherwise, the Arbitrator will be either an attorney experienced in employment law and licensed to practice law in the state in which the arbitration is convened or a former judge from any jurisdiction. The AAA will give each party a list of eleven (11) arbitrators drawn from its panel of arbitrators. Ten days after AAA's transmission of the list of neutrals, AAA will convene a telephone conference and the parties will strike names alternately from the list of common names until only one remains. The party who strikes first will be determined by a coin toss. The person that remains will be designated as the Arbitrator. If for any reason, the individual selected cannot serve, AAA will issue another list of eleven (11) arbitrators and repeat the alternate striking selection process. If for any reason the AAA will not administer the arbitration, either party may apply to a court of competent jurisdiction with authority over the location where the arbitration will be conducted to appoint a neutral Arbitrator.

6. **INITIATING ARBITRATION**. A party who wishes to arbitrate a claim covered by this Agreement must make a written Request for Arbitration and deliver it to the other party by hand or mail no later than the expiration of the statute of limitations (deadline for filing) that applicable law prescribes for the claim. The Request for Arbitration shall identify the claims asserted, the factual basis for the claim(s), and the relief and/or remedy sought. The Arbitrator will resolve all disputes regarding the timeliness or propriety of the Request for Arbitration and apply the statute of limitations that would have applied if the claim(s) had been brought in court.

7. **RULES/STANDARDS GOVERNING PROCEEDING**. The Arbitrator may award any remedy to which a party is entitled under applicable law, but remedies are limited to those that would be available to a party in his or her individual capacity in a court of law for the claims presented to the Arbitrator, and no remedies that otherwise would be available to an individual under applicable law will be forfeited by this Agreement. Each party can take the deposition of one individual witness and any expert witness designated by another party. Each party also has the right to make requests for production of documents to any party. The parties can jointly agree to more discovery, and either party can ask the Arbitrator to order more discovery. Each party will

also have the right to subpoena witnesses and documents for the arbitration, including documents relevant to the case from third parties. At least thirty (30) days before the final hearing, the parties must exchange a list of witnesses, excerpts of depositions to be introduced, and copies of all exhibits to be used.

Unless the parties jointly agree otherwise, the arbitration will take place in or near the city and in the same state in which Employee is or was last employed by the COMPANY. The Arbitrator has the authority to hear and rule on pre-hearing disputes. The Arbitrator will have the authority to hear and decide a motion to dismiss and/or a motion for summary judgment by any party, consistent with Rule 12 or Rule 56 of the Federal Rules of Civil Procedure. The Arbitrator will issue a written decision or award, stating the essential findings of fact and conclusions of law. A court of competent jurisdiction will have the authority to enter judgment upon the Arbitrator's decision/award.

8. **PAYMENT OF FEES**. The COMPANY will pay the Arbitrator's and arbitration fees and costs, except for the filing fee as required by the AAA. If you are financially unable to pay a filing fee, the COMPANY will pay the filing fee, and you will be relieved of the obligation to pay the filing fee. Disputes regarding the apportionment of fees will be decided by the Arbitrator. Each party will pay for its own costs and attorneys' fees, if any, but if any party prevails on a claim which affords the prevailing party costs or attorneys' fees, the Arbitrator may award costs and fees to the prevailing party as provided by law.

9. **ENTIRE AGREEMENT/SEVERABILITY**. This Agreement replaces all prior agreements regarding the arbitration of disputes and is the full and complete agreement relating to the resolution of disputes covered by this Agreement. If any portion of this Agreement is deemed unenforceable, the unenforceable provision will be severed from the Agreement and the remainder of the Agreement will be enforceable. This Agreement will survive the termination of Employee's employment and the expiration of any benefit. This Agreement will also continue to apply notwithstanding any change in Employee's duties, responsibilities, position, or title, or if Employee transfers to any affiliate of the COMPANY. This Agreement does not alter the "at-will" status of Employee's employment. Notwithstanding any contrary language in any COMPANY policy or employee handbook, this Agreement may not be modified or terminated absent consent by both parties.

CONSIDERATION. The COMPANY and Employee agree that the mutual obligations by the COMPANY and Employee to arbitrate disputes provide adequate consideration for this Agreement.

AGREED:

RECEIVED AND AGREED:

_____ _____

APPLICANT/EMPLOYEE SIGNATURE DATE

_____

APPLICANT/EMPLOYEE NAME PRINTED

Home Care of Baltimore

Annual TB Questionnaire

The Annual Tuberculosis Questionnaire is used to evaluate your current TB status. We cannot utilize the tuberculin skin test (PPD or Mantoux), because you have a positive reaction to the test. A position skin test means that sometime during your life you came into contact with tuberculosis or have had a vaccination to prevent you from contracting tuberculosis. It does not mean that you have TB now.

In the past yearly chest x-rays were performed; however, recent studies show that they are unnecessary. Instead, this health survey will assist Employee Health to monitor possible TB Symptoms. Chest x-rays are required every two years.

TB symptoms can progress slowly and/or mimic other diseases. You can develop symptoms of TB a few weeks after contracting the bacteria – or not until years after the initial infection. This questionnaire targets some of the most common symptoms. Please familiarize yourself with them. You are the first to know when you are not feeling well and may have TB symptoms.

Tuberculosis Health Check Survey

Have you ever experienced any of the following symptoms **NOT** associated with a specific illness (i.e. flu or cold) and lasting 3 weeks or longer?

Cough	☐ Yes ☐ No
Blood Streaked Sputum (phlegm)	☐ Yes ☐ No
Loss of Weight (unplanned)	☐ Yes ☐ No
Night Sweats	☐ Yes ☐ No
Fever	☐ Yes ☐ No
Anorexia (loss of appetite)	☐ Yes ☐ No

This authorization will expire one year from the dated signature below.

_____

Print Name

_____

Signature Date

EMPLOYEE/CONTRACTOR PHYSICAL EXAMINATION

(Need to be completed within 30 days of employment)

Name:_____ Telephone:_____

Address:_____

General: Age_____ Weight_____ Height_____

Temperature_____ Pulse_____ Respiration_____

Blood Pressure: Systolic_____ Diastolic_____ Respiration_____

_X_ if findings are normal _O_ if findings are abnormal (describe)

Skin	_____	Speech	_____
Head/Neck	_____	Chest/Breast	_____
Eyes/Ears/Nose	_____	Abdomen	_____
Mouth/Throat	_____	Blood Vessels	_____
Lymph Nodes	_____	Neurological	_____
Lungs	_____	Extremities	_____
Heart	_____	Mental Health	_____

Is patient free of communicable diseases? Yes_____ No_____

TBT Test: Date _____

Please circle one Chest X-Ray PPD

Result_____

Hepatitis B Test: Date_____

Result _____

Name and Signature of examining physical_____

Date_____ Phone_____

Home Care of Baltimore

AGENCY PRIVACY REQUIREMENTS FOR NONCRIMINAL JUSTICE APPLICANTS

Authorized governmental and non-governmental agencies/officials that conduct a national fingerprint-based criminal history record check on an applicant for a noncriminal justice purpose (such as employment or a license, immigration or naturalization matter, security clearance, or adoption) are obligated to ensure the applicant is provided certain notices and that the results of the check are handled in a manner that protects the applicant's privacy. All notices must be provided in writing.[1] These obligations are pursuant to the Privacy Act of 1974, Title 5, United States Code (U.S.C.), Section 552a, and Title 28, Code of Federal Regulations (CFR), Section 50.12, among other authorities.

- **Officials must ensure that each applicant receives an adequate written FBI Privacy Act Statement (dated 2013 or later) when the applicant submits his/her fingerprints and associated personal information.[2]**
- **Officials must advise all applicants in writing that procedures for obtaining a change, correction, or update of an FBI criminal history record are set forth at 28 CFR 16.34. Information regarding this process may be found at https://www.fbi.gov/services/cjis/identity-history-summary-checks and https://www.edo.cjis.gov.**
- **Officials must provide the applicant the opportunity to complete or challenge the accuracy of the information in the FBI criminal history record.**
- **Officials should not deny the employment, license, or other benefit based on information in the FBI criminal history record until the applicant has been afforded a reasonable time to correct or complete the record or has declined to do so.**
- **Officials must use the FBI criminal history record for authorized purposes only and cannot retain or disseminate it in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council.[3]**

The FBI has no objection to officials providing a copy of the applicant's FBI criminal history record to the applicant for review and possible challenge when the record was obtained based on positive fingerprint identification. If agency policy permits, this courtesy will save the applicant the time and additional FBI fee to obtain his/her record directly from the FBI by following the procedures found at 28 CFR 16.30 through 16.34. It will also allow the officials to make a more timely determination of the applicant's suitability.

Each agency should establish and document the process/procedures it utilizes for how/when it gives the applicant the FBI Privacy Act Statement, the 28 CFR 50.12 notice, and the opportunity to correct his/her record. Such documentation will assist State and/or FBI auditors during periodic compliance reviews on use of FBI criminal history records for noncriminal justice purposes.

sign/date

[1] Written notification includes electronic notification, but excludes oral notification.
[2] See https://www.fbi.gov/services/cjis/compact-council/privacy-act-statement
[3] See 5 U.S.C. 552a(b); 28 U.S.C. 534(b); 34 U.S.C. § 40316 (formerly cited as 42 U.S.C. § 14616), Article IV(c); 28 CFR 20.21(c), 20.33(d), 50.12(b) and 906.2(d).

STATE OF MARYLAND
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES
CRIMINAL JUSTICE INFORMATION SYSTEMS – CENTRAL REPOSITORY

LIVESCAN PRE-REGISTRATION APPLICATION

APPLICANT INFORMATION *(PLEASE TYPE OR PRINT CLEARLY)*

Name:			
Date of birth:	SSN:	Gender: ☐ Male ☐ Female *(Please check)*	
Height: ft. inches	Weight: lbs.	Eye Color:	Hair Color:
Race: ☐ Black ☐ White ☐)Asian/Pacific Islander ☐ Native American ☐ Other *(Please check)*			
Place of Birth:		Citizenship:	
Current address:			
City:		State:	ZIP Code: -
Daytime Phone:	Evening Phone:	Driver's License #:	

AGENCY INFORMATION

Agency Authorization #: 1100006320	
ORI # (if required):	Reason fingerprinted?
Position Applied for: Personal Caregiver	

Request Type: *(Choose one ONLY)*

- ☑ Adult Dependent Care
- ☐ Attorney/Client
- ☐ Child care
- ☐ Criminal Justice
- ☐ Gold Seal/ Adoption
- ☐ Gold Seal/Letter/VISA
- ☐ Government Employment
- ☐ Government Licensing or Certification
- ☐ Immigration/VISA
- ☐ Individual Challenge
- ☐ Individual Review
- ☐ MSP Licensing
- ☐ Private Party Petition
- ☐ Public Housing

Mail Response to:
(Mailing option only available for Visa Gold Seal and/or Individual Review)

Name: Home Care of Baltimore

Address: 2 Reservoir Circle, Suite 102

City, State, Zip code: Pikesville, MD 21208