



1723 Avenue M
Brooklyn, NY 11230

Phone. 718.252.1515
Fax. 718.252.1513

**Tan Pri sispann epi voye mande Aplikasyon an Kreyol Si
ou pa ekri aubyen li angle.**

**Пожалуйста остановитесь и попросите
русскую версию анкеты если Вы не говорите,
читаете или пишете по Английский.**

如果你不会读和看英文请问要中文的申请。谢谢。

**PO FAVOR PARE Y PIDA SU APPLICACION EN LA
VERSION EN ESPANOL SI USTED NO HABLA O ESCRIBE EL
INGLES.**



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**PLEASE READ EACH PAGE IN
APPLICATION CAREFULLY. IT IS VERY
IMPORTANT TO UNDERSTAND,
ACKNOWLEDGE AND SIGN
DOCUMENTS. PLEASE DO NOT
HESITATE TO ASK QUESTIONS AND
REQUEST EXPLANATION OF ANY
DOCUMENT THAT IS NOT CLEAR FOR
YOU.**



1723 Avenue M
Brooklyn, NY 11230

Phone. 718.252.1515
Fax. 718.252.1513

EMPLOYEE APPLICATION

Name _____

Address _____

City _____ State _____ Zip code _____

Phone _____ Cell _____

Social Security # _____ Date of Birth _____

List Other Names Used _____

Position Applied: _____ HHA _____ PCA _____ OTHER _____

Have you ever been convicted of a crime ____ Yes ____ No If so, explain below _____

How many hours do you prefer to work per day? _____ Per week _____ Week ends _____

Are you available to work live-in (sleep in) cases? ____ Yes ____ No; Only (days) _____

Do you have experience working in kosher home? ____ Yes ____ No; Prefer to learn _____

What languages do you speak? _____

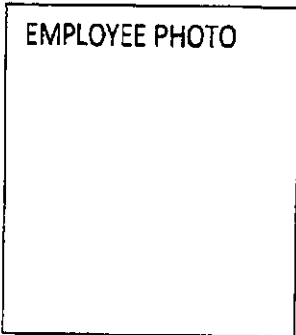
What areas are you available to work? _____

How did you hear about us? _____

I certify that I have worked as an HHA/PCA within the past two years _____ Yes _____ No

Are you currently working with another agency? ____ Yes ____ No; What days and time? _____

If we cannot reach out to you at your phone numbers you provided above, where would you like us to call to be able to talk to you and offer the job? _____



APPLICANT'S SIGNATURE _____ DATE _____



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HIPAA/HIV EMPLOYEE CONFIDENTIALITY AGREEMENT

I, the undersigned understand the importance of observing strict confidentiality policies. Therefore, I agree not to discuss/release any information obtained within the agency regarding Life Care Services, Inc business, client, any medical records, or any client's condition with any individual not directly associated with Life Care Services, Inc and/or client.

I understand that as an employee of Life Care Services, Inc, the use and disclosure of patient information is governed by the rules and regulations established under HIPAA, the Health Insurance Portability and Accountability Act of 1996. I acknowledge that during my employment or performing my assigned duties at Life Care Services, Inc I may have access to, use, or disclose confidential health information. I hereby agree to handle such information in a confidential manner at all times during and after my employment and commit to the following obligations:

- A. I will use and discuss confidential health information for the purpose of performing my tasks only to the person who is affiliated with my patient (Patient's children, doctor, spouse, etc) after confirming their identities.
- B. I will request, obtain or communicate confidential health information only as necessary to perform my assigned duties and shall refrain from requesting, obtaining or communicating more confidential health information than is necessary to accomplish my assigned duties.
- C. I will take reasonable care to secure confidential health information and will take steps to ensure that others cannot view or access such information.
- D. I will immediately report any unauthorized use or disclosure of confidential health information that I become aware of to the appropriate supervisor.
- E. All patient data, email, and other data gathered or used during my employment is the sole property of Life Care Services, Inc.

In the event I am made aware that my patient is HIV positive, I cannot disclose this information to any other individual. State Law prohibits me from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as permitted by law. Any unauthorized further disclosure is a violation of state law and may result in a fine or jail sentence or both. General authorization for the release of medical or any other information is not sufficient authorization for further disclosure.

I also understand and agree that my failure to fulfill any of the obligations set forth in this Agreement and/or my violation of any terms of this Agreement shall result in my being subject to appropriate disciplinary action.

My signature below supports this statement

APPLICANT'S NAME (PRINT) _____

SIGNATURE _____ DATE _____



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DISCLOSURE AND AUTHORIZATION

This serves to advise that in consideration for employment, a consumer report and/or investigative report may be obtained on you. This process may include verification of education; credit history; employment history; a review of any local, county, state, and federal government agency record; court public records; driving records (MVR), and employment references. Employment references may include pertaining to your general character and reputation, work habits, and other employment related characteristics. If a credit report is obtained, the source credit bureau will be Experian Consumer Credit Services. Upon request, a copy of the credit report will be provided to you at no charge.

By signing this Disclosure and Authorization:

- You acknowledge receipt of this Disclosure and Authorization, as well as receipt of the summary of your rights under the Fair Credit Reporting Act.
- You give us permission to obtain a consumer report and/or investigative consumer report on you for employment purposes.
- You give us permission to obtain any necessary medical history, including any lab results and drug screen information.

Received and Authorized by:

The following is required to conduct pre-employment verifications. Date of birth and maiden name are not considered in the employment decision. This information is utilized for accurate records verification only.

Printed full Name _____

Home Phone _____ Cell Phone _____

Social Security Number _____ Date of Birth _____

Maiden or other name used _____ Year last used _____

Driver's License Number _____ State _____

I request that this document in its original or copied form serve as my valid authorization to any and all persons, educational institution, past and/or current employers, organizations, credit reporting agencies, law enforcement or criminal record agencies, and other agencies to release information about me to Accufacts, or its designated agent, and hereby release all such persons, institutions, agencies, employers, and organizations providing such information from liability in any or all claims and damages connected with their providing any requested information.

SIGNATURE _____ DATE _____



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REFERENCE REQUEST

To (Agency Name) _____

Name of Applicant _____ Position Applied _____

Social Security # (ONLY LAST 4 DIGITS) XXX-XX- _____ Date of Birth _____

Release of information

I hereby authorize the release of all information requested by Life Care Services, Inc. I release you from all responsibilities/liability regarding the information provided by you from our past association. I agree that this information will be held in strict confidence and that I will not have access to this information.

APPLICANT'S SIGNATURE _____ **DATE** _____

The person identified above has applied for a position at Life Care Services, Inc. Would you kindly complete the reference information below and **return it back to us ASAP**. This information will be kept confidential. Thank you.

Position held at your organization: _____

Reference's relationship to applicant: _____

Dates of Employment: From _____ To: _____

Is employee currently employed? _____ YES _____ NO Would you re-employ? _____ YES _____ NO

The reason of termination if not employed anymore: _____

Applicant's work record	Satisfactory	Unsatisfactory	Unable to evaluate
Quality of work			
Productivity			
Attendance			
Punctuality			
Initiative			
Cooperation			
Dependability			
Accepts Constructive Criticism			
Appearance			

Name and title of person providing this information _____

Signature _____ Date _____ Stamp (optional)





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REFERENCE REQUEST

To (Agency Name) _____
 Name of Applicant _____ Position Applied _____
 Social Security # (ONLY LAST 4 DIGITS) XXX-XX- _____ Date of Birth _____

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APPLICANT'S SIGNATURE _____ **DATE** _____

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Reference's relationship to applicant: _____

Dates of Employment: From _____ To: _____

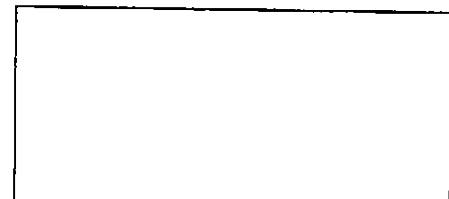
Is employee currently employed? _____ YES _____ NO Would you re-employ? _____ YES _____ NO

The reason of termination if not employed anymore: _____

Applicant's work record	Satisfactory	Unsatisfactory	Unable to evaluate
Quality of work			
Productivity			
Attendance			
Punctuality			
Initiative			
Cooperation			
Dependability			
Accepts Constructive Criticism			
Appearance			

Name and title of person providing this information _____

Signature _____ Date _____ Stamp (optional)





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NOTICE OF AUTHORIZATION FOR CRIMINAL BACKGROUND CHECKS

NAME OF APPLICANT _____

Pursuant to Title 10, Section 400.23 of New York Code of Rules and Regulations, Life Care Services, Inc is required to conduct a criminal background check of all applicants for employment in non-licensed positions providing direct resident care and/or supervision. Pursuant to these regulations we are required to notify you of the followings:

1. We will submit your fingerprints to the New York State Department of Health and request the Department of Health to forward such information to the Attorney General of the United States. The Attorney General will then conduct a full search of the records of the Federal Bureau of Investigation to ascertain if you have any records of criminal conviction.
2. The Attorney General will provide its findings to the New York States Department of Health, which will in turn forward these results to us. If the background check reveals that you have been convicted of certain enumerated crimes, your application for employment will be rejected. If you have been offered provisional employment, such employment will be terminated.
3. Pursuant to the regulations, you have the right to:
 - A. Obtain a copy of the results of the criminal background check, review the information contained and explain same.
 - B. Withdraw your application for employment without prejudice at any time before we make a decision on your application. In such an event we will destroy your fingerprint card and any information we may have obtained in connection with the criminal background check.
4. The fingerprint and criminal background checks are conducted at no cost to you.
5. Any information we receive about you as a result of criminal background check will be used only for determining your suitability for employment in a position involving direct patient care or supervision. Such information will be treated as confidential and will not be disclosed to anyone else except as permitted by law.
6. If your employment application is denied because of information obtained during the course of a criminal background check, we will provide you with a written statement of our decision and the basis thereof.

SIGNATURE _____

DATE _____



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AUTHORIZATION FOR SEARCH AND EXCHANGE OF INFORMATION

STATEMENT OF DISCLOSURE OF ABUSE OR CONVICTION

I, _____ hereby authorize Life Care Services, Inc to submit a request to the Attorney General of the United States to conduct a Search of the record of the Criminal Justice Information Services Division of the Federal Bureau of Investigation for any criminal history records corresponding to the fingerprints or other identification information submitted by me. I further authorize the exchange of such information between the Attorney General of the United States, the New York State Department of Health, and Life Care Services, Inc. This information may be used only by Life Care Services, Inc and only for the purpose of determination my suitability for employment in a position involved in direct patient care supervision.

SIGNATURE _____ DATE: _____

DISCLOSURE OF FINDINGS

I hereby affirm and/or swear under penalties of perjury that I have not been found guilty in any forum of patient and/or resident abuse and that I have not been convicted of any crime or violation, other than traffic infractions, except the following:

DATE	COURT	SECTION OF LAW VIOLATION
1.		
2.		
3.		

I have _____ have not _____ (check only one) been issued a Certificate of Relief from Civil Disabilities and Forfeitures and/or Certificate of Good Conduct in conjunction with the above offenses. A copy of any such certificate is attached herewith.

SIGNATURE _____ DATE _____

NYS Department of Health
ACKNOWLEDGEMENT AND CONSENT FORM FOR FINGERPRINTING AND DISCLOSURE OF CRIMINAL HISTORY RECORD INFORMATION

THIS FORM IS TO BE RETAINED BY THE AGENCY- DO NOT FORWARD TO THE DOH CHRC UNIT.

chrc@health.state.ny.us

The purpose of this form is to obtain consent from the subject individual for fingerprints and criminal history record information pursuant to Article 28-E of the Public Health Law and Section 845-b of the Executive Law.

SECTION 1 – SUBJECT INDIVIDUAL INFORMATION

LAST Name	FIRST Name	M.I.	
Date of Birth (mm/dd/yyyy)	Mother's Maiden Name	Alias: AKA	
Mailing Address (street)	City	State	Zip

SECTION 2 - ATTESTATION

- I have applied to an agency to provide direct care or supervision to residents or patients. I understand that as part of the application process, the Public Health Law (PHL) Article 28-E requires that the New York State Department of Health perform a criminal history check on me with the New York State Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI).
- I acknowledge and consent to having my fingerprints taken for the purpose of a criminal history record check by the DCJS and the FBI.
- I have been advised that DOH is authorized by law to receive the results of the criminal history record check from DCJS and the FBI for the purpose of developing a criminal history record summary to be provided to the agency to which I applied for a position to provide direct care or supervision to residents or patients. I have been advised that the criminal history record summary will indicate whether I have a criminal history, as maintained by DCJS or the FBI, including convictions of a crime (felony or misdemeanor) or criminal charges which do not reflect a disposition. I have been advised that by law, DOH is authorized and may be required to provide the results of the criminal history record check through a criminal history record summary to the agency. The criminal history record summary prepared by DOH and sent to the agency will contain the results of the criminal history record check performed by DCJS. I have been advised that the information shall be confidential pursuant to applicable federal and state laws, rules and regulations and shall only be disclosed to persons authorized by law.
- I hereby consent to DOH sharing with any DCJS agency to which I applied for a position to provide direct care or supervision, any criminal history record check information provided to DOH by the FBI, including the specific crime(s) for which I was convicted or charged, the date of the arrest for such charge, and/or date of conviction, and the jurisdiction in which the arrest or conviction took place.
- I have been informed of the procedures and my rights to obtain, review and seek correction of my criminal history information pursuant to regulations and procedures established by the DCJS and the FBI.
- I understand that I have the right to withdraw my application for employment, without prejudice, any time before employment is offered or declined, regardless of whether an agency, DOH or I have reviewed my criminal history information.
- I certify to the best of my knowledge and belief that I (check as appropriate):
 - Have** **Have not been convicted of a crime in New York State or any other jurisdiction**
 - Do** **Do not have a final finding of patient or resident abuse**
 If you have checked either "Have" and/or "Do", please provide a brief explanation. (Optional)

8. My current mailing or home address is indicated in Section 1 of this form.

9. I have read this form and hereby consent to the request by the agency to use my fingerprints to obtain my criminal history record, if any, from the DCJS and the FBI. I hereby consent to the redisclosure of any convictions or open charges on my criminal history record, received by DOH from DCJS, to the requesting agency. I declare and affirm that the information I have provided on this consent form is true, complete and accurate and that the fingerprints to be submitted are my own (not applicable for Expedited Review submitted pursuant to CHRC Form 104).

Applicant Signature: _____ Date: _____

Signature of Parent or Legal Guardian _____ Date: _____
 (if subject individual is under 18 years of age)

SECTION 3 – AGENCY AUTHORIZED PERSON INFORMATION

Agency Name:	PFI/Operating License Number:
Print Name of Authorized Person:	Title:
Signature of Authorized Person:	Date:



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 (See instructions)	
<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. (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**



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 Information
 (Employers or their authorized representatives must complete this section. Employers must provide the USCIS (U.S. Citizenship and Immigration Services) Office with a copy of the original or a copy 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		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
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.)

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
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Employee's Withholding Certificate

Department of the Treasury
Internal Revenue Service

▶ **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.**

2020

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) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly (or Qualifying widow(er)) <input type="checkbox"/> 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, when to use the online estimator, and privacy.

Step 2: 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.

Multiple Jobs or Spouse Works 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); or

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; 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 accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld. . . . ▶

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Sign Here

▶ 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)
	Life Care Services Inc. 1723 Avenue M Brooklyn, NY 11230		113532345



Department of Taxation and Finance

Employee's Withholding Allowance Certificate

IT-2104

New York State • New York City • Yonkers

First name and middle initial	Last name	Your Social Security number
Permanent home address (number and street or rural route)		Apartment number
City, village, or post office	State	ZIP code

Single or Head of household Married
 Married, but withhold at higher single rate
 Note: If married but legally separated, mark an X in the Single or Head of household box.

Are you a resident of New York City? Yes No
 Are you a resident of Yonkers? Yes No

Complete the worksheet on page 4 before making any entries.

1 Total number of allowances you are claiming for New York State and Yonkers, if applicable (from line 20)	1	
2 Total number of allowances for New York City (from line 35)	2	

Use lines 3, 4, and 5 below to have additional withholding per pay period under special agreement with your employer.

3 New York State amount	3	
4 New York City amount	4	
5 Yonkers amount	5	

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

Employee's signature	Date
----------------------	------

Penalty – A penalty of \$500 may be imposed for any false statement you make that decreases the amount of money you have withheld from your wages. You may also be subject to criminal penalties.

Employee: detach this page and give it to your employer; keep a copy for your records.

Employer: Keep this certificate with your records.

Mark an X in box A and/or box B to indicate why you are sending a copy of this form to New York State (see instructions):

A Employee claimed more than 14 exemption allowances for NYS A
 B Employee is a new hire or a rehire ... B First date employee performed services for pay (mm-dd-yyyy) (see instr.):

Are dependent health insurance benefits available for this employee? Yes No

If Yes, enter the date the employee qualifies (mm-dd-yyyy):

Employee's name and address (complete this section only if you are sending a copy of this form to the NYS Tax Department.) Life Care Services Inc. 1723 Avenue M Brooklyn, NY 11230	Employer identification number 113532345
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Instructions

Changes effective for 2020

Form IT-2104 has been revised for tax year 2020. The worksheet on page 4 and the charts beginning on page 5, used to compute withholding allowances or to enter an additional dollar amount on line(s) 3, 4, or 5, have been revised. If you previously filed a Form IT-2104 and used the worksheet or charts, you should complete a new 2020 Form IT-2104 and give it to your employer.

Who should file this form

This certificate, Form IT-2104, is completed by an employee and given to the employer to instruct the employer how much New York State (and New York City and Yonkers) tax to withhold from the employee's pay. The more allowances claimed, the lower the amount of tax withheld.

If the federal Form W-4 you most recently submitted to your employer was for tax year 2019 or earlier, and you do not file Form IT-2104, your employer may use the same number of allowances you claimed on your federal Form W-4. Due to differences in tax law, this may result in the wrong amount of tax withheld for New York State, New York City, and Yonkers.

For tax years 2020 or later, withholding allowances are no longer reported on federal Form W-4. Therefore, if you submit a federal Form W-4 to your

employer for tax year 2020 or later, and you do not file Form IT-2104, your employer may use zero as your number of allowances. This may result in the wrong amount of tax withheld for New York State, New York City, and Yonkers.

Complete Form IT-2104 each year and file it with your employer if the number of allowances you may claim is different from federal Form W-4 or has changed. Common reasons for completing a new Form IT-2104 each year include the following:

- You started a new job.
- You are no longer a dependent.
- Your individual circumstances may have changed (for example, you were married or have an additional child).
- You moved into or out of NYC or Yonkers.
- You itemize your deductions on your personal income tax return.
- You claim allowances for New York State credits.
- You owed tax or received a large refund when you filed your personal income tax return for the past year.
- Your wages have increased and you expect to earn \$107,650 or more during the tax year.



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HOME HEALTH AIDE ACKNOWLEDGEMENT OF OUTSIDE EMPLOYMENT ATTESTATION FORM

All Life Care Services, Inc personnel are required to follow the rules of conduct and avoid actions that may result in a conflict of interest.

Working in another Licensed Home Care Agency on the same time and date while servicing the patient of Life Care Services, Inc, either by clocking in/out or submitting duty sheets is considered a conflict of interest and fraudulent activity. If this action cannot be explained and resolved, it may result in termination of the employee. Home Health Aide/Personal Care Assistant may also be reported to higher institutions and may be excluded from participation in Federal or State health care programs.

By signing this acknowledgement, I clearly understand that I cannot work with another patient from different Licensed Home Care Agency at the same time and date while working with patient of Life Care Services, Inc.

PRINT NAME _____

SIGNATURE _____ DATE _____



YOUTH SELF-ATTESTATION FORM
Work Opportunity Tax Credit (WOTC) Program

Instructions: This Self-Attestation Form (SAF) is to be completed, signed, and dated by the new hire only. Employers or consultants submit this SAF to the State Workforce Agency with Form ETA 9061 for each certification request filed.

New Hire Name: _____

Social Security Number: _____ Date of Birth: _____

Employer Name: Life Care Services Inc.
1723 Avenue M

Employer Federal ID (EIN) Number: Brooklyn, NY 11230 113532345

Please check all the statements that apply to you. Sign and date this form where indicated below.

- In the past 6 months, I have not attended a secondary, technical or postsecondary school for more than an average of 10 hours per week, not counting periods during which the school is closed for scheduled vacations.
- I do not have a High School Diploma or GED certificate.
- I have a High-School diploma or GED certificate awarded more than 6 months ago and I have not attended or been admitted to a technical or post-secondary school. I also have not held a job (other than occasionally) since receiving my High-School diploma or GED certificate.

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

New Hire's Signature: _____ Date _____

Privacy Act Notice:

The Internal Revenue Code of 1986, Section 51, as amended and its enacting legislation, P.L. 104-188, specify that the State Workforce Agencies are the "designated" agencies responsible for administering the WOTC certification procedures of this program. The information you have provided completing this form will be disclosed by your employer to the State Workforce Agency. Provision of this information is voluntary; however the information is required to determine your employer's eligibility for the federal tax credit.

Public Burden Statement:

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. Respondents' obligation to complete this form is required to obtain or retain benefits (P.L. 111-5). Public reporting burden is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate to the U.S. Department of Labor, Division of Adult Services, Room S-4209, Washington, D.C. 20210 (Paperwork Reduction Project 1205-0371). Please do not submit completed forms to this address.



Notice and Acknowledgement of Pay Rate and Payday
Under Section 195.1 of the New York State Labor Law
Notice for Hourly Rate Employees

1. Employer Information
 Name: LifeCare Services INC
 1723 Avenue M
 Brooklyn NY 11230
 License # 1002L001

Doing Business As (DBA) Name(s):

FEIN (optional):

Physical Address: LifeCare Services INC
 1723 Avenue M
 Brooklyn NY 11230
 License # 1002L001

Mailing Address: LifeCare Services INC
 1723 Avenue M
 Brooklyn NY 11230
 License # 1002L001

Phone: (718) 252 1515

8. Employee Acknowledgement:
 On this day I have been notified of my pay rate, overtime rate (if eligible), allowances, and designated pay day on the date given below. I told my employer what my primary language is.

Check one:
 I have been given this pay notice in English because it is my primary language.
 My primary language is _____ I have been given this pay notice in English only, because the Department of Labor does not yet offer a pay notice form in my primary language.

Print Employee Name _____
 Employee Signature _____
 Date _____

3. Employee's rate of pay:
 \$ _____ per hour

4. Allowances taken:
 None
 Tips _____ per hour
 Meals _____ per meal
 Lodging _____
 Other _____

5. Regular payday: _____

6. Pay is:
 Weekly
 Bi-weekly
 Other

7. Overtime Pay Rate:
 \$ _____ per hour (This must be at least 1½ times the worker's regular rate with few exceptions.)

Medical \$2.40
 Supplement \$1.69

WAGES: \$ _____
 MEDICAL SUPPLEMENT

Nozima /HR
 Preparer's Name and Title

The employee must receive a signed copy of this form. The employer must keep the original for 6 years.

Please note: It is unlawful for an employee to be paid less than an employee of the opposite sex for equal work. Employers also may not prohibit employees from discussing wages with their co-workers.



1723 Avenue M
Brooklyn, NY 11230

Phone. 718.252.1515
Fax. 718.252.1513

Screening of Excluded individual/Entity

PRINT NAME _____ DATE _____

Screening of Excluded individual

Life Care Services, Inc is required as per our Corporate Integrity Agreement with the New York State Office of the Medicate Inspector General to routinely search the websites listed below and any other websites as determined by the OMIG for exclude or ineligible persons currently employed, prospective employees or contactors.

- www.omig-state-ny.us (OMIG)
- <http://www.oig.hhs.gov> (HHS/OIG List)
- <http://www.epls.gov> (General Services Administration's List)

Life Care Service, Inc will not knowingly employ, contract, or bill far any individual or entity that has been listed as debarred, excluded or is otherwise ineligible for the participation in Federal or State health care programs. You are required to report to us if you become excluded, debarred or ineligible to participate in federal or State health care programs or have been convicted of a criminal offense related to the provision of health care items or services.

I certify that I am not debarred or excluded, or otherwise ineligible for participation in federal or State health care programs.

Signature _____

Office Use Only

I certify that I checked all sites on this individual

Name of HR personnel:

Date:



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AFFIDAVIT

I _____ have applied for a position as a Home Health Aide with Life Care Services, Inc. All the information I have submitted is true to the best of my knowledge. All certificates are valid (or copies of originals) and all background information is correct. I authorize Life Care Services, Inc to obtain any information regarding and pertaining to my employment and health status. I understand that this may include contacting the following to obtain information to verify signatures, dates, forms and data.

- Medical providers (M.D. lab, etc)
- Previous employers
- Schools and training programs
- Personal and professional references

I further release Life Care Services, Inc of any liability that may occur as a result of my personal negligence or as a result of any information that wrongfully or fraudulently submitted to Life Care Services, Inc, or in the course of applying for a position during my association with them. I understand that any information fraudulently submitted will result in my immediate termination.

As a job applicant/employee of Life Care Services, Inc, hereby attest to the fact that I have received no special inducement, remuneration, or promises thereof to work for this agency. I understand that I will receive a salary commensurate and in line with what other employee of this agency are receiving for similar work and experience. All other benefits that I may be eligible for will be in accordance with policies established by Life Care Services, Inc.

Hiring of personnel, salaries and benefits are awarded without regard to race, religion, disability, marital status, or sexual orientation. Life Care Services, Inc is an equal opportunity employer. I have read the preceding statement and I understand and agree with its contents.

EMPLOYEE SIGNATURE _____ DATE _____



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AUTHORIATIN FOR RELEASE/PATIENT ACCESS OF MEDICAL INFORMATION

Employee Name: _____

DOB: _____ SS# _____

Address: _____

Please sign here if you do not authorize Life Care Services, Inc to access your medical information.

Signature _____ Date: _____

1. I hereby authorize the Medical Records Department staff at _____
To release from my medical records to: Life Care Services, Inc, 1723 Avenue M, Brooklyn, NY, 11230\
2. For the purpose of (Please check one)

_____ Pre-Employment _____ Employment Annual Health Assessment

3. I limit the information to be released to the following items:

_____ Diagnostic test result (e.g. Labs, X-Rays, Radiology reports)
_____ Other (Please specify) _____

Covering records from on or about (Date) _____ to (Date) _____

CONFIDENTIAL INFORMATION

4. If the requested portion of the record contains information concerning menta health and/or drug and alcohol treatment or contains HIV related information, you must specifically authorize the released of such information by initialing one or both of the following:

_____ I understand that if my record contains information concerning mental health and/or drug and alcohol treatment, such information will be released pursuant to this authorization

_____ I understand that if my record contains confidential HIV related information, such information will be released pursuant to this authorization. Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV infection, HTV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

5. This authorization will automatically expire within six months from the date of signature. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department at _____

I understand that the revocation will not apply to the information that has already been released in response to this authorization.

X _____ Date _____

Signature of Patient/Representative/or Legal Guardian



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ARBITRATION AGREEMENT

- ✓ It is understood that all claims, including wage and hour claims, under the FLSA, NYSLL, and Wage Parity Act must be submitted to arbitration and not court.
- ✓ No class or collective action claims are allowed.
- ✓ Arbitration is administrated under American Arbitration Association rules.
- ✓ Life Care Services, Inc will pay costs of the arbitration.

I have read the above and understand it. I also understand that by signing this Arbitration Agreement I am aware of that there may be ongoing company lawsuits/class actions that I might not be eligible to join by signing this Arbitration Agreement. I am under no obligation to sign this Agreement. My questions have been answered to my satisfaction.

EMPLOYEE NAME _____

EMPLOYEE SIGNATURE _____ DATE _____



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LIFE CARE SERVICES, INC PERSONNEL POLICY AND HHA/PCA RESPONSIBILITIES

1. It is your responsibility to arrive to work on time.
2. If you cannot arrive to work on time or cannot work, you must call the agency at 718-252-1515 or after office hours at 718-986-2891 (24/7 line) with a minimum 4 (four) hours of notice unless it is a medical emergency, to insure there will be appropriate patient care. You must give such notice by speaking directly to the Life Care Services, Inc coordinator. If you leave a message for the on-call coordinator you must leave a number where you can be reached. You may also text to on-call phone.
3. You are not permitted to send a replacement aide when you cannot service your patient.
4. If you do not call the office to inform us you cannot work and request replacement, it is considered a no call/no show.
5. You must call the agency if patient does not answer the door, or if you cannot locate the patient's house right at the spot without returning to your house. **DO NOT GO HOME UNLESS YOU SPEAK TO THE COORDINATOR/ON CALL COORDINATOR** and receive permission to leave.
6. Never leave an assignment until your scheduled work hours are completed, unless directed to do so by Life Care Services, Inc coordinator or Director of Patient Services (Head Nurse). In situation where the patient cannot be left alone and you have been requested by Life Care Services, Inc coordinator to stay until the replacement aide arrives, you must follow the directions.
7. While providing service to Life Care Services, Inc patient, you are not authorized to receive orders or directions to leave earlier or stay later by patient, patient's family member or anybody else except Life Care Services, Inc coordinator, Director of Patient's Services (Head Nurse), on-call coordinator, Office Manager or Life Care Services, Inc owners. If you need to leave earlier, you must contact Life Care Services, Inc coordinator and make all arrangements.
8. Life Care Services, Inc uses clock - in and clock-out system. You must clock - in when you arrive to the patient's home and clock-out before leaving the patient's home when your working shift is over. You are responsible to enter correct duties that you have provided to your patient when clocking out.
9. If you are unable to clock in/clock out due to the broken phone or any other reason, you must submit the duty sheet filled and signed by you and patient or patient's family member.
10. If the patient does not allow you to use patient's phone for clock-in and clock-out, you are responsible to report it to the agency.
11. You must strictly read and follow the patient's Plan of Care (Usually patient or patient's family member have it) for performing your correct duties based on patient's medical condition.
12. If the Plan of Care is not available, inform the agency immediately. The Plan of Care must be valid (with expiration date).
13. You must report to your coordinator or Head Nurse the change of patient's medical, physical or mental condition.



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14. In case of any medical or any other emergency situations, call 911 first, then patient's family members and Life Care Services, Inc coordinator.
15. You are not allowed to work any extra hours for your patient without Life Care Services, Inc approval.
16. Service hours cannot be changed by you, the patient or patient's family member or anybody else except Life Care Services, Inc coordinator, Director of Patient's Services, Office Manager or business owner.
17. All your documentations, Certificates, Medical Assessment Form, ID must be original and valid, unexpired and up to date.
18. You are not permitted to smoke cigarettes, marijuana, cigars or wiping in patient's house.
19. You are not permitted to sleep during the assignment unless you work on live-in case and have 8 hours of uninterrupted sleep time.
20. You are not use patient's phone for personal use.
21. You are not allowed to make private calls during your assignment without patient's permission.
22. You are not allowed to discuss any personal or working issues about the agency with your patient or patient's family members (ex: pay/hour).
23. You are now permitted to take your children to work with you or accept visitors while you are on the job.
24. You are not permitted to accept gifts, money, or have any financial dealings with patient or patient's family members.
25. You are not permitted to take any patient's belongings from patient's house.
26. You are not permitted to administer any medication or medicated lotions/creams to the patients. You are only allowed to remind the patient to take medications.
27. You are not allowed to care any patient's wound or provide any shots, such as insulin to your patient under no circumstances.
28. You are not permitted to drive your patient.
29. You are not permitted to bring your own food to a kosher home without patient's or patient family member's approval.
30. You must inform Life Care Services, Inc if your patient is hospitalized or going to vacation to avoid double Medicaid billing and fraudulent activity.

I understand if I do not abide by any of the above Life Care Services, Inc personnel policy and HHA/PCA responsibilities, the company reserves the right to terminate my employment.

PRINT NAME _____
SIGNATURE _____ DATE _____



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DEAR HOME HEALTH AIDES AND PERSONAL CARE ASSISTANT,

PLEASE READ CAREFUL AND ACKNOWLEDGE FOLLOWING:

1. WE ARE EXPERINECING DIFFICULTIES OBTAINING YOUR TIME SHEETS IN A TIMELY FASHION. WE STRONGLY ENCOURAGE YOU TO CLOCK-IN AND CLOCK-OUT SO THAT YOUR PAYCHECK IS ACCURATE. IF YOUR TIME SHEET IS LATER THAN 30 DAYS, WE WILL NOT BE ABLE TO PAY YOU FOR SERVICES RENDERED. KINDLY UNDERSTAND THAT IF WE CANNOT COLLECT MONIES FROM THE INSURANCES, WE ARE UNABLE TO PAY YOOU (MOST OF THE INSURANCE DO NOT PAY US AFTER SOME TIME OF SERVICE).
2. YOU ARE RESPONSIBLE TO FOLLOW UP WITH YOUR CLOCK-IN AND CLOCK-OUT. YOU ARE ALSO RESPONSIBLE TO SUBMIT DUTY SHEET IF YOUR CLOCK-IN/CLOCK-OUT WAS NOT SUCCESSFUL OR SKIPPED. THE COORDINATOR WILL CONTACT YOU TO NOTIFY YOU ABOUT THE REQUEST OF TIME SHEET SUBMISSION AND THIS IS YOUR RESPONSIBILITY TO PROVIDE LIFE CARE SERVICES, INC WITHIN 30 CALENDAR DAYS.
3. PLEASE BE ADVISED THAT YOU ARE RESPONSIBLE TO STAY IN COMPLIANT WITH DEPARTMENT OF HEALTH RULES AND REGULATION AND RECEIVE 12 HOURS PER ONE YEAR OF IN-SERVICE AS HOME HEALTH AIDE AND 6 HOURS PER ONE YEAR OF IN-SERVICE AS PERSONAL CASE ASSISTANT. LIFE CARE SERVICES, INC REPRESENTATIVE WILL CALL YOU TO SCHEDULE YOU FOR IN-SERVICE CLASSES WHEN IT IS TIME FOR YOU TO RECEIVE IT.
4. PLEASE BE ADVISED THAT YOU ARE REQUIRED TO STAY IN COMPLIANT WITH DEPARTMENT OF HEALTH RULES AND REGULATIONS AND RENEW YOUR HEALTH ASSESSMENT FORM AND I-9 WHEN IT EXPIRES. FAILURE TO PROVIDE UPDATED DOCUMENTATION WILL LEAD TO IMEDDIATE TERMINATION FROM YOUR POSITION.

IF YOU HAVE ANY CONCERNS, PLEASE REACH OUT TO YOU COORDINATORS.

I UNDERSTAND THE ABOVE AND WILL MAKE EVERY EFFORT TO COMPLY WITH AGENCY REQUIREMENTS.

PRINT NAME _____

SIGNATURE _____ DATE _____



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Home Health Aide Agreement "LIVE IN" Case

1. I am employed by Life Care Services, Inc ("agency") and have been assigned to a live-in case. For each 24 hour shift on this live-in case I agree to the following:
 - a) I will be paid by the agency for 13 hours worked for the client.
 - b) I am being provided 8 hours of uninterrupted sleep time and will not be paid for this time by the agency.
 - c) I am being provided 3 one hour uninterrupted duty free meal times and will not be paid for this by the agency.
2. For each 24 hour shift on this live in case, I agree to record my time and/or report it as follows:
 - a) I will record the start and end times of my 24 hour shift on the live-in case and all tasks performed for the client using the Life Care Services, Inc scheduling system.
 - b) I will immediately report to my Coordinator/Supervisor any change in the client's physical or mental condition.
 - c) I will report to my Coordinator/Supervisor immediately following each 24 hour shift if I was unable to receive 5 hours of uninterrupted sleep time, or unable to receive 3 hours uninterrupted meal time by emailing at info@lifecareservicesnyc.com or texting at 718-986-2891. If I am unable to email or text, I must come in person to Life Care Services, Inc agency and report it in written by obtaining both my signature and the signature of the person who accepted my report. I must save a copy of my report for my records. I will also identify the actual work tasks I performed during my uninterrupted time how much time I spend performing each work task.
 - d) I will report to my Coordinator/Supervisor immediately upon receipt of my paycheck for hours worked, if I believe I was paid improperly or not paid for all hours worked by emailing at info@lifecareservicesnyc.com or texting at 718-986-2891. If I am unable to email or text, I must come in person to Life Care Services, Inc agency and report it in written by obtaining both my signature and the signature of the person who accepted my report. I must save a copy of my report for my records.
 - e) I agree that I will not accept any hours of work from the client or the client's family or household in addition to any shift I am assigned by Life Care Services, Inc.
 - f) I understand, agree and will comply with this agreement.

PRINT NAME _____

SIGNATURE _____ DATE _____

POLICY AND PROCEDURES FOR LIFE CARE SERVICES, INC

Sleep and Meal Period Agreement for 24-Hour Caregivers

24-hour patient cases refer to cases involving patients whose medical professional has determined that the patient needs assistance over a 24-hour period, but that the patient's condition permits a Caregiver working with that patient to receive at least 3 hours of breaks and 8 hours of uninterrupted sleep time during the 24-hour period. Therefore, during 24-hour shifts, Caregivers are expected to provide care to the patient for only 13 hours of the 24-hour case/shift and to receive a total of 11 hours of rest/breaks. This Sleep and Meal Period Agreement ("Agreement") outlines the terms and conditions of 24-hour shifts. Caregivers who wish to work on 24-hour shifts should carefully read this Agreement. No Caregiver will be forced to work a 24-hour case and any Caregiver who wishes to work a 24-hour case must sign this Agreement, to indicate their understanding of what 24-hour cases require and consent to work under those conditions.

Terms of 24-Hour Cases: Caregivers who accept 24-hour cases will be paid for all hours worked on each 24-hour/live-in shift. As state above, however, during each 24-hour shift, it is expected that Caregivers will only be required to work for 13 hours. It is expected that Caregivers will receive a total of at least 3 hours of "Bona Fide Meal Periods" and a 8-hour "Bona Fide Sleep Period," as those are defined below, for each full 24-hour shift. The hours spent in Bona Fide Sleep Period and Bona Fide Meal Periods (total of 11 hours per 24-hour shift) will not count as hours worked. For purposes of this Agreement, the following terms are defined:

1. "Bona Fide Meal Periods" are meal periods (e.g., one each for breakfast, lunch, and dinner) that are uninterrupted, duty free, and at least 30 minutes in duration. So, on each 24-hour shift, Caregivers can take either six (6) Bona Fide Meal Periods of 30 minutes each, or Caregivers can take three (3) one-hour Bona Fide Meal Periods, on each 24-hour shift. The Bona Fide Meal Periods.

While Caregivers may not leave the patient's home during a 24-hour shift, Caregivers may leave their work area during each Bona Fide Meal Periods. Caregivers are not required to eat with the patient during their meal period or take their meal period at the same time that the patient eats his/her meal. If a Caregiver is interrupted during his/her meal periods (e.g., the patient has an emergency and calls the Caregiver for assistance), the Caregiver must note any such interruptions on his/her timesheet. The Caregiver will identify the duration of the interruption and when the interruption started and ended. If the Caregiver's regularly scheduled Bona Fide Meal Period has to be adjusted due to work flow issues on the shift, the Caregiver must correctly note this on their timesheet.

2. "Bona Fide Sleep Periods" are regularly scheduled sleep periods, which include at least 5 consecutive hours that are not interrupted by a call to duty, in adequate sleeping facilities. Caregivers will receive an 8-hour scheduled sleep period for each 24-hour shift. Caregivers are expected to be relieved of all duties and work during such scheduled 8-hour period. Caregivers are expected to receive at least 5 consecutive hours of sleep during the 8-hour scheduled sleep period.
3. "Adequate sleeping facilities" means that Caregivers have access to basic sleeping amenities (e.g., a bed and linens); enjoy reasonable standards of comfort (e.g., heat); and have access to basic bathroom and kitchen facilities, which may be shared (e.g., bathing and toilet facilities, refrigerator, stove, sink, utensils).

If Caregivers "live-in" the home of the patient, "adequate sleeping facilities" means private quarters (i.e., a living and sleeping space that is separate from the patient or other employees) in a homelike environment (i.e., a space that includes facilities for cooking and eating, a bathroom, and a space for recreation (these additional facilities may be shared by Caregivers and the patient and/or other household members).

Recordkeeping: Should Caregivers not receive a Bona Fide Meal Period and/or Bona Fide Sleep Period during a 24-hour shift, it is critical that the Caregiver report this on his/her timesheet so that the Company can pay the Caregiver for all work time. To ensure that Caregivers are paid for all hours that they work, Caregivers will be asked to certify on each weekly timesheet: (1) the start and end time of each Bona Fide Meal Period; (2) the start and end time of the Caregiver's Bona Fide Sleep Period; (3) confirmation that the Caregiver received at least 5 consecutive and uninterrupted hours of sleep during his/her Bona Fide Sleep Period; (4) confirmation that the Caregiver had adequate sleeping facilities on the 24-hour shift; (5) confirmation that the Caregiver's Bona Fide Meal Periods were not interrupted by a call to duty; (6) if a Caregiver's Bona Fide Meal Period was interrupted, the total duration of such interruption; and (7) if a Caregiver's Bona Fide Sleep Period was interrupted, the length of the interruption, and the times that the interruption(s) started and ended. If there are other circumstances or work time that a Caregiver believes should be paid, the Caregiver must write that on the timesheet so that he/she can be paid for all their work time.

If a Caregiver believes that he/she was not paid for all hours worked, the Caregiver must contact the Human Resources Department immediately and report the actual hours that he/she worked so that the Caregiver can be compensated for all hours of work.

No Retaliation: No employee will be subject to any reprisal or other adverse action for reporting missed or interrupted meal or sleep periods. But any employee who knowingly submits a false report of work time will be subject to disciplinary action, up to and including termination of employment.

By my signature on the below line, I certify that I have read, understood, and agree to the terms of this Agreement.

Employee Name (PRINT)

Employee Name (Signature)

Date

Company Witness (Print and Sign Name)

Date



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ACKNOWLEDGEMENT OF PRIVATE PAY/MLTC CASES

By signing below, you acknowledge and agree that Life Care Services, Inc may assign you to work on private pay cases (ex: cases where the patient is insured by private insurance) and/or Managed Long Term Care (MLTC) cases (cases where Medicaid is the payor of funds). You further acknowledge and agree that private pay cases are not eligible for Wage Parity and therefore you will not receive Wage Parity for any work performed on such cases. Your pay for such cases will be limited to the applicable minimum wage rate.

PRINT NAME _____

SIGNATURE _____ DATE _____



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Life Care Services, Inc Benefit Election Form

Employees who wish to elect Major Medical, please complete this page.

Employees who do not complete this form will be AUTOMATICALLY enrolled in Supplemental Benefits.

LAST NAME _____ FIRST NAME _____

Date of Birth _____ Social Security Number _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ CELL _____

Select benefit you wish to receive effective 6/1/14

_____ Medical Insurance Health Insurance

Available only to 30 hours per week employees

Please be aware of 9.86% of deduction from your paycheck

Please sign below if you want Major Medical Health Insurance

SIGNATURE _____ Date _____

Please sign below to acknowledge that you are waiving Major Medical coverage that meets minimum value under ACA as well as affordability standards

SUGNATURE _____ Date _____



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HEPATITIS B VACCINE PROGRAM

I understand that due to my occupational exposure to blood or other potential infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B Vaccine. I have also been asked if I have questions regarding this information and if I had question, they were fully answered to my satisfaction. I have been offered the opportunity to be vaccinated with the Hepatitis B Vaccine at no charge to myself.

I, _____ decline Hepatitis B vaccine at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future while employed by Life Care Services, Inc, I continue to have occupational exposure to blood or other potential infectious materials and I want to be vaccinated with Hepatitis B Vaccine, I can receive the vaccination series at no charge to me.

I do now wish to be given the Hepatitis B vaccine at this time. I am aware that vaccine later during my employment with the agency may be requested to be provided.

SIGNATURE _____ DATE _____

I have already received the Hepatitis B Vaccine

SIGNATURE _____ DATE _____

I am requesting to receive the Hepatitis B Vaccine, (complete consent below)

HEPATITIS B VACCINATION CONCENT

I, _____, have been provided with information on the Hepatitis B Vaccine and have been evaluated by an agency health professional. I have had the opportunity to ask questions about the benefits and risks of Hepatitis B Vaccination. I also understand that there is no guarantee that I will become immune and that there is a possibility that I will experience ad adverse side effect from the vaccination.

I am NOT allergic to yeast or yeast products.

I am NOT currently immunosuppressed, neither by disease nor medication.

For woman: I have been advised that studies have not been conducted to determine the effect of the vaccine on a developing fetus. Therefore, the safety of the Hepatitis B Vaccine relating to the developing fetus is currently unknown.

Employee Signature _____ Date _____



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New York City Paid Safe and Sick Leave Policy

The Company provide staff with paid safe and sick leave (generally referred to herein as "Sick Leave") in compliance with the New York City Paid Safe and Sick Time Act (the "Law"). This applies to NYC employees other than who work more than 80 hours per calendar year.

A. Sick Leave Accrual

Eligible employees begin to accrue sick leave on their first day of work. Eligible employees will accrue one (1) hour of Sick Leave for every thirty (30) hours worked, up to forty (40) hours of Sick Leave per year.

B. Use of Sick Leave

Eligible employees may begin to use accrued Sick Leave 120 days after the start of their employment, and thereafter may use it as it accrues, for the following reasons:

- The employee's own mental or physical illness, injury, or health condition, need for medical diagnosis, care, or treatment of a mental or physical illness, injury, or health condition, or need for preventive medical care; or
- Care of a family member who needs medical diagnosis, care, or treatment of a mental or physical illness, injury, or health condition or needs preventive medical care;
- Closure of the employee's place of business by order of a public official due to a

public health emergency or such employee's need to care for a child whose school or childcare provider has been closed by order of a public official due to a public health emergency; or

- An absence due to any of the following reasons when the employee or a family member has been the victim of a family offense matter, sexual



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offense, stalking, or human trafficking. When Sick Leave is used for these purposes, it may be referred to as "safe time."

- to obtain services from a domestic violence shelter, rape crisis center, or other shelter or services program for relief from a family offense matter, sexual offense, stalking or human trafficking;
- to participate in safety planning, temporarily or permanently relocate, or take other actions to increase the safety of the employee or employee's family members from future family offense matters, sexual offenses, stalking or human trafficking;
- to meet with a civil attorney or other social service provider to obtain information and advice on, and prepare for or participate in any criminal or civil proceeding, including but not limited to, matters related to a family offense matter, sexual offense, stalking, human trafficking, custody, visitation, matrimonial issues, orders of protection, immigration, housing, discrimination in employment, housing or consumer credit;
- to file a complaint or domestic incident report with law enforcement; or to meet with a district attorney's office;
- to enroll children in a new school; or
- to take other actions necessary to maintain, improve, or restore the physical, psychological, or economic health or safety of the employee or the employee's family member or to protect those who associate or work with the employee.

For purposes of this policy, "family member" of an employee includes children (biological, adopted or foster children, legal ward, children of an employee standing in loco parentis) grandchildren, spouses, domestic partners, parents, grandparents, children or parents of an employee's spouse or domestic partner, siblings (including half, adopted or step siblings), any other individual related to an employee and any other person with whom an employee has a close relationship that is like a family relationship.



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Sick Leave must be used in increments. The first increment of Sick Leave used in any work day must be in an amount equivalent to of h of the employee's scheduled work day, but not more than four hours. Any additional Sick Leave used in a day after the initial increment must be taken in increments of 30 minutes, provided such minimum increments are reasonable under the circumstances.

A maximum of 40 hours of Sick Leave may be used in any calendar year.

C. Payment of Sick Leave

Employees will be paid the same rate for Sick Leave use as they would have earned had they worked those hours. Employees will be paid for Sick Leave used no later than the payday for the next regular payroll period beginning after the Sick Leave time was used by the employee.

D. Notice and Documentation Requirements

If the need for Sick Leave is foreseeable, the employee must provide the Company a minimum of seven (7) days of advance notice. In the event of an emergent or unforeseeable need for Sick Leave, the employee must notify the Company as soon as practicable.

Documentation from one licensed health care provider will be required when an employee uses more than three consecutive workdays as Sick Leave (except when the leave is for safe leave purposes; see below). Documentation from a licensed medical provider must be submitted to the Company no more than seven (7) days following return to work; such documentation need not disclose the nature of the illness, injury or health condition. Failure to provide such documentation can lead to disciplinary action up to an including termination.

For safe time absences of more than three consecutive workdays, the employee must provide documentation that the safe time was used for a permissible reason in accordance with this policy. The documentation must be signed by an employee, agent, or volunteer of a victim services organization, an attorney, a member of the clergy, or a medical or other professional services provider from whom the employee or that employee's family member has sought assistance in addressing the matters for which safe time was used; a police or court record; or a notarized letter from the employee explaining the need for such time. The documentation need not specify the details of the family offense matter, sexual offense, stalking or human trafficking involved in the need for safe time.

E. Pay for Sick Leave



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Eligible employees who take Sick Leave will be paid the same rate for sick pay as they would have earned had they worked their scheduled hours that day. The employee will

be paid for Sick Leave used no later than next regular payroll period after the Sick Leave is taken.

F. Carryover

Accrued and unused Sick Leave will not be paid out at the end of the year. Up to 40 hours of unused accrued Sick Leave can be carried over to the following year, however, the Company limits the use of Sick Leave to 40 hours per year.

G. Separations and Transfers

The Company will not pay out any accrued and unused Sick Leave upon the employee's termination, resignation, retirement, or other separation from employment. If there is a separation from employment and the Company rehires the employee within six months of separation, previously accrued Sick Leave that was not used shall be reinstated.

H. Disciplinary Matters

Use of Sick Leave for reasons not covered by the Law will be subject to disciplinary action.

In addition, excessive absenteeism (apart from proper use of Sick Leave), failure to properly call in advance of any absence (except where not possible in circumstances like emergencies), or patterned absences may be subject to disciplinary action.

I. Confidentiality

Consistent with the requirements of the New York City Earned Safe and Sick Leave Act, the Company will not require the disclosure of details related to an employee's or his or her family member's medical condition or require the disclosure of details relating to an employee's or his or her family member's status as a victim of family offenses, sexual offenses, stalking or human trafficking as a condition of providing Sick Leave under this chapter. Health information about an employee or an employee's family member related to the foregoing shall be treated as confidential and shall not be disclosed except by the affected employee, with the written permission of the affected employee, or as required by law. However, nothing in this section shall preclude the Company from considering information provided in connection with a request for Sick Leave in connection with a request for reasonable accommodation for a disability.



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J. Non-Retaliation & Further Information

It is a violation of the New York City Paid Safe and Sick Leave Law for an employer to take any adverse action against an employee for exercising his or her rights under the Law, and any employee whose rights may have been violated may contact or file a complaint with the NYC Department of Consumer Affairs.

The Company will not retaliate or discriminate against an employee for exercising or attempting to exercise rights under the Law, including requesting or using Sick Leave, filing a complaint for or communicating with any person about alleged violations of the Law, participating in an antinutritive or judicial action regarding an alleged violation of the Law, or informing any person of his or her potential rights under the Law.

Any employee who believes that he or she has not received the appropriate time under this policy or the Law should advise the Human Resources department. The Company will promptly review the complaint to ensure that the employee has received the appropriate time and/or take appropriate remedial measures.

Also, the Company will not require an employee, as a condition of talking safe/sick time, to search for or find a replacement worker to cover the hours during which the employee is utilizing such time.

For more information on Sick Leave, please contact the Office Manager Sabina Yusupova.

Please sign and date the below to indicate that you have received and read this policy and understand its terms.

Employee Name

Employee Signature

Date

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FAMILY AND MEDICAL LEAVE AND NEW YORK PAID FAMILY LEAVE POLICY

The Company provides leave according to the Family and Medical Leave Act of 1993 (FMLA) and the New York Paid Family Leave (NYPFL) Law to covered employees in certain circumstances and as more fully described in this policy.

Eligibility

The eligibility criteria for FMLA and NYPFL differ slightly.

To qualify for FMLA leave, you must: (1) have worked for Company for at least 12 months; (2) have worked at least 1,250 hours in the last 12 months; and (3) be employed at a work site where Company has 50 or more employees within 75 miles. If you have any questions about your eligibility for FMLA leave, please contact the Human Resources Department.

To qualify for NYPFL, a New York employee whose regular schedule is 20 or more hours per week must have worked for Company for at least 26 consecutive weeks preceding the first full day leave begins. A New York employee whose regular schedule is less than 20 hours per week must have worked in Company's employment for 175 days to qualify for NYPFL. If you have any questions about your eligibility for NYPFL, please contact the Human Resources Department.

Leave Entitlement

FMLA. You may take **up to 12 weeks of unpaid** FMLA leave in a 12-month period, which is measured using a "rolling" method that is measured backward from the date you use any FMLA leave, for any of the following reasons:

- the birth of a son or daughter and in order to care for such son or daughter (leave to be completed within one year of the child's birth);
- the placement of a son or daughter with you for adoption or foster care and in order to care for the newly placed son or daughter (leave to be completed within one year of the child's placement);

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- to care for a spouse, son, daughter, or parent with a serious health condition;
- for your own serious health condition which renders you unable to perform any of the essential functions of your position; or
- a qualifying exigency of a spouse, son, daughter, or parent who is a military member on covered active duty or called to covered active duty status (or has been notified of an impending call or order to covered active duty).

You may take up to 26 weeks of unpaid FMLA leave in a single 12-month period, beginning on the first day that you take FMLA leave to care for a spouse, son, daughter, or next of kin who is a Covered Servicemember and who has a serious injury or illness related to active duty service, as defined by the FMLA regulations (see Definitions section, Military Caregiver Leave subsection below).

NYPFL. You may take up to the following amounts of NYPFL, for the reasons listed below, in a 52 consecutive week period:

- Starting January 1, 2018: 8 weeks of leave;
- Starting January 1, 2019: 10 weeks of leave; and
- Starting January 1, 2021: 12 weeks of leave.

The 52 consecutive week period is measured using a “rolling” method that is measured backward from the date you use any NYPFL.

NYPFL may be taken for the following reasons:

- To care for a spouse, domestic partner, child, parent (including in-laws), grandparent, or grandchild with serious health condition;
- To bond with a child during the first 12 months after the child’s birth or placement for adoption or foster care or to meet adoption or foster care obligations (leave to be completed within one year of the child’s birth or placement); or
- To meet qualifying exigencies arising from the fact that your spouse, domestic partner, child, or parent is on active duty or “has been notified of an impending call to active duty” in the U.S. Armed Forces.

Note that NYPFL is not available for the employee’s own serious health condition.

During NYPFL, paid benefits will be provided by Company’s NYPFL insurance carrier, at the following levels provided by law:

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- January 1, 2018: 50% of the employee's Average Weekly Wage (AWW), up to 50% of the NYS Average Weekly Wage (NYS AWW).
- January 1, 2019: 55% of the employee's AWW, up to 55% of the NYS AWW.
- January 1, 2020: 60% of the employee's AWW, up to 60% of the NYS AWW.
- January 1, 2021: 67% of the employee's AWW, up to 67% of the NYS AWW.

The NYS Average Weekly Wage is the average weekly wage paid across New York State during the previous calendar year and is determined and published by the New York State Department of Labor each year.

Pay under NYPFL is available from the first day of the leave (no waiting period). The insurance carrier, not Company, is responsible for approving and paying benefits under the NYPFL Law. To receive such benefits, you will be required to file a claim with the carrier and to follow the carrier's requirements with respect to claim filing, certification, and supporting documentation (see NYPFL Claim and Certification Procedure section below).

If you are eligible for leave under both the FMLA and the NYPFL, your leaves under both of these laws will run concurrently to the maximum extent permitted by law. Company's FMLA policy will continue to apply to all FMLA leave.

Family Members Working for Company

FMLA. Where eligible spouses both work for Company, they will be limited to a *combined* total of 12 weeks of FMLA leave in a 12-month period for the birth/placement of and bonding with a child and the care of a parent with a serious health condition. The spouses will also be limited to a *combined* total of 26 weeks of FMLA leave in a 12-month period to care for a Covered Servicemember with a serious injury or illness (see Definitions section, Military Caregiver Leave subsection below).

NYPFL. Company will not permit more than one employee to take NYPFL at the same time to care for the same family member (e.g., where both spouses or other qualifying relatives work for Company).

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Definitions

Serious Health Condition – FMLA. For FMLA purposes, “serious health condition” means an illness, injury, impairment, or physical or mental condition that involves: (a) inpatient care; or (b) continuing treatment by a health care provider.”

- Inpatient care means an overnight stay in a hospital, hospice, or residential medical care facility, including any period of incapacity, as defined by the law, or any subsequent treatment in connection with such inpatient care.

- A serious health condition involving continuing treatment by a health care provider requires any one or more of the following:

1. A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves: (a) treatment two or more times, within 30 days of the first day of incapacity, unless extenuating circumstances exist, by a health care provider, a nurse under direct supervision of a health care provider, or a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or (b) treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider;

2. Any period of incapacity due to pregnancy or for prenatal care;

3. Any period of incapacity or treatment for such incapacity due to a chronic serious health condition;

4. A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective; and

5. Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or a provider of health care services under orders of, or on referral by, a health care provider.

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Serious Health Condition – NYPFL. For NYPFL purposes, “serious health condition” means illness, injury, impairment, or physical or mental condition that involves: (a) inpatient care in a hospital, hospice, or residential health care facility; or (b) continuing treatment or continuing supervision by a health care provider.

- A serious health condition involving continuing treatment or continuing supervision by a health care provider requires any one or more of the following:

1. More than 3 consecutive full days of inability to work, attend school, perform regular activities, or other incapacity due to a condition, plus any subsequent treatment or period of incapacity that involves treatment two or more times, or treatment at least once that results in a regimen of continuing treatment under the supervision of a health care provider.

2. Any period of inability to work, attend school, perform regular activities, or other incapacity due to a chronic serious health condition that requires periodic visits for treatment by a health care provider, continues over an extended period of time (including recurring episodes of an underlying condition), and may cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy).

3. A long-term or permanent period of inability to work, attend school, perform regular activities, or other incapacity due to a condition for which treatment may not be effective (e.g., Alzheimer’s, severe stroke, or terminal disease). The family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider.

4. A period of inability to work, attend school, perform regular activities, or other incapacity due to treatment (including any period of recovery therefrom) by a health care provider for restorative surgery, or for a condition that would likely result in more than 3 consecutive full days of incapacity without treatment (e.g., cancer, severe arthritis, kidney disease).

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Qualifying Exigency. For purposes of both FMLA and NYPFL, "qualifying exigency" means a situation arising out of the fact that the employee's spouse, child, or parent is a military member in the United States Armed Forces, Reserves, or National Guard on covered active duty or who has been notified of an impending call or order to covered active duty status ("Military Member").

"Covered active duty," for members of the Regular Armed Forces, means duty during deployment of the Military Member with the Armed Forces to a foreign country.

"Covered active duty," for members of National Guard or Reserves, means duty during the deployment of the Military Member with the Armed Forces to a foreign country under a call or order to active duty in support of a "contingency operation," as defined by law.

A "qualifying exigency" exists where one of the following events occurs:

1. *Short-notice deployment.* To address any issue that arises from the fact that the Military Member is notified of an impending call or order to covered active duty, for a period of seven (7) or less calendar days from the date of notification;
2. *Military events and related activities.* To attend any official ceremony, program, or event sponsored by the military that is related to the covered active duty or call to covered active duty status of the Military Member, or family support or assistance programs and informational briefings sponsored or promoted by the military, military service organizations, or the American Red Cross that are related to the covered active duty or call to covered active duty status of the Military Member;
3. *Childcare and school activities.* To attend to certain childcare and school activities that are necessitated by the Military Member's active duty or call to active duty status, such as: (i) arranging for alternative childcare; (ii) providing childcare on an urgent, immediate need basis (but not on a routine, regular, or everyday basis); (iii) enrolling in or transferring to a new school or daycare facility; and (iv) attending meetings with employees at a school or daycare facility;

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4. *Financial and legal arrangements.* To make or update financial and legal arrangements to address the Military Member's absence while on covered active duty or call to covered active duty status;

5. *Counseling.* To attend counseling provided by someone other than a health care provider, for oneself, for the Military Member, or for the biological, adopted, or foster child, a stepchild, or a legal ward of the Military Member, or a child for whom the Military Member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA leave is to commence, provided that the need for counseling arises from the covered active duty or call to covered active duty status of the Military Member;

6. *Rest and recuperation.* To spend time with a Military Member who is on short-term, temporary, rest and recuperation leave during deployment for up to fifteen (15) calendar days;

7. *Post-deployment activities.* To attend arrival ceremonies, reintegration briefings and events, and any other official ceremony or program sponsored by the military for a period of 90 days following the termination of the Military Member's covered active duty status; and to address issues that arise from the death of a Military Member while on covered active duty status;

8. *Parental care.* To provide certain care to a Military Member's parent who is incapable of self-care, and where each instance of the care provided is necessitated by the Military Member's covered active duty. Covered activities provided to the parent of a Military Member under this provision include: (1) arranging for alternative care for a parent of the Military Member; (2) providing care for a parent of the Military Member on an urgent, immediate need basis; (3) admitting or transferring the parent of a Military Member to a care facility; and (4) attending meetings with employees at a care facility where the parent of a Military Member resides or stays; or

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9. *Additional activities.* To address other events which arise out of the Military Member's covered active duty or call to covered active duty status, provided that Company and employee agree that such leave shall qualify as an exigency, and both agree to the timing and duration of such leave.

FMLA Military Caregiver Leave. For purposes of Military Caregiver Leave under the FMLA, "Covered Servicemember" means:

- A current member of the Armed Forces (including a member of the National Guard or Reserves) who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness ("Current Servicemember"); or
- A veteran who: (1) is undergoing medical treatment, recuperation, or therapy for a serious injury or illness; (2) was a member of the Armed Forces (including a member of the National Guard or Reserves); (3) was discharged within the five-year period before the eligible employee first takes FMLA leave to care for him or her; and (4) was discharged or released from the Armed Forces under conditions other than dishonorable ("Covered Veteran"). An eligible employee must commence leave to care for a Covered Veteran within five years of the Covered Veteran's active duty service.

For purposes of Military Caregiver Leave under the FMLA "serious injury or illness" means:

- In the case of a Current Servicemember, an injury or illness that was incurred by him or her in the line of duty on active duty in the Armed Forces (or that existed before the beginning of his or her active duty and was aggravated by service in the line of duty on active duty in the Armed Forces) and that may render the Covered Servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating; and
- In the case of a Covered Veteran, an injury or illness that was incurred or aggravated by him or her in the line of duty, while on active duty in the Armed Forces, and which manifested itself before or after he or she became a veteran, and is:

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1. A continuation of a serious injury or illness that was incurred or aggravated when the Covered Veteran was a member of the Armed Forces and rendered him or her unable to perform the duties of his or her office, grade, rank, or rating;

2. A physical or mental condition for which the Covered Veteran has received a VA Service Related Disability Rating ("VASRD") of 50 percent or greater and such VASRD rating is based, in whole or in part, on the condition precipitating the need for leave;

3. A physical or mental condition that substantially impairs the Covered Veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service or would do so absent treatment; or

4. An injury, including a psychological injury, on the basis of which the Covered Veteran has been enrolled in the Department of Veterans Affairs Program of Comprehensive Assistance for Family Caregivers.

Important limitation: If an employee does not take all of his or her 26 workweeks of leave entitlement to care for a Covered Servicemember during the 12-month period, the remaining part of his or her 26 workweeks of leave is forfeited.

Maximum duration of leave in any 12-month period: The Military Caregiver Leave is applied on a per-Covered-Servicemember, per-injury, basis such that an employee may be entitled to take more than one period of 26 workweeks of leave if the leave is to care for different Covered Servicemembers or to care for the same Covered Servicemember with a subsequent serious injury or illness, except that no more than 26 workweeks of leave may be taken within any single 12-month period.

"Next of kin": An employee is "next of kin" of a Covered Servicemember if he or she is the nearest blood relative of the Covered Servicemember (other than the Covered Servicemember's spouse, parent, or child). Unless the Covered Servicemember has specifically designated in writing a particular blood relative as his or her nearest blood

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relative for the purposes of the Military Caregiver Leave, the following is the order of priority used to identify the nearest blood relatives of the Covered Servicemember: (a) blood relatives who have been granted legal custody of the Covered Servicemember; (b) siblings; (c) grandparents; (d) aunts and uncles; and (e) first cousins. When no such designation is made, and there are multiple family members with the same level of relationship to the Covered Servicemember, all such family members shall be considered the Covered Servicemember's next of kin and may take FMLA leave to provide care to the Covered Servicemember, either consecutively or simultaneously. When such designation has been made, the designated individual shall be deemed to be the Covered Servicemember's only next of kin.

Intermittent and Reduced Schedule Leave

FMLA. If medically necessary, FMLA leave occasioned by a serious health condition may be taken intermittently (in separate blocks of time due to a serious health condition) or on a reduced leave schedule (reducing the usual number of hours you work per workweek or workday). Medically necessary means that there must be a medical need for the leave and the leave can best be accomplished through an intermittent schedule. FMLA leave may also be taken intermittently or on a reduced leave schedule for a qualifying exigency relating to covered military service.

If FMLA leave taken intermittently is unpaid, Company will reduce the employee's salary based on the amount of time actually worked. In addition, while an employee is on an intermittent or reduced schedule leave, Company may temporarily transfer him or her to an available alternative position that better accommodates his or her leave schedule and has equivalent pay and benefits.

When intermittent FMLA leave is needed to care for an immediate family member or the employee's own illness, and is for planned medical treatment, the employee must attempt to schedule treatment so as to minimize disruption to Company's operations. Employees should consult with Company prior to scheduling the treatment in order to arrange a schedule that best

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suits the needs of the employee and Company.

NYPFL. Eligible employees may take NYPFL intermittently in no less than daily increments.

The maximum number of days of NYPFL available to an employee is calculated based on the average number of days the employee works per week. For example, a worker with a schedule of 5+ days per week can take up to the then-applicable maximum weeks of leave multiplied by 5 days (in 2018, the maximum is 8 weeks, so the worker would be eligible for up to 40 days of leave in a 52-week period). For an employee who works 3 days per week (60% of the work week) can receive only 60% of the then-applicable maximum leave (in 2018, this would be 60% of 40 days, so the employee would be eligible for up to 24 days of leave in a 52-week period).

Concurrent Leave. Where FMLA and NYPFL run concurrently, intermittent leave will be immediately deducted from the employee's FMLA entitlement. Because intermittent NYPFL is measured in daily increments, intermittent leave will be deducted from the employee's NYPFL entitlement each time the hours taken under FMLA add up to the number of hours in an employee's usual work day.

NYPFL Contributions and Waivers

Consistent with the NYPFL Law, Company will fund the NYPFL insurance policy through deductions from the pay of all employees, except those who have filed valid waivers in accordance with this policy. Company will make the maximum deductions permitted by law.

Employees whose regular schedule is 20 or more hours per week but who will not work 26 consecutive weeks, and employees whose regular schedule is less than 20 hours per week and who will not work 175 days in a 52-consecutive-week period, may file a waiver of NYPFL benefits. Upon filing a waiver, the employee will be exempt from making contributions to NYPFL and thus will not be subject to payroll deductions. However, the employee will be ineligible for NYPFL benefits.

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If the work schedule of an employee who has filed a waiver changes so that he or she will work 26 consecutive weeks, or 175 days in a 52-consecutive-week period, the waiver will be automatically revoked within 8 weeks of the change. The employee will then be obligated to make contributions, including any retroactive amounts due from date of hire.

Waiver forms and additional information can be obtained from the Human Resources Department.

Application for FMLA Leave and/or NYPFL

To take FMLA leave or NYPFL, an employee must provide Company with advance notice of the need for leave as follows:

- **Foreseeable Leave.** Where the need for leave is foreseeable (e.g., planned medical treatment, expected birth or placement of a child, planned medical treatment for a serious injury or illness of a family member, etc.), an employee must provide Company with at least 30 days advance notice of the need for leave.

- ✓ If 30 days advance notice is not possible (e.g., because of lack of knowledge of approximately when the leave will be required to begin, a change in circumstances, or a medical emergency), the employee must at least provide notice as soon as practicable under the circumstances. Normally, it should be practicable for the employee to provide notice of the need for leave either the same day he or she becomes aware of a qualifying event or the next business day.

- ✓ Whether FMLA leave is to be continuous or is to be taken intermittently or on a reduced schedule basis, notice need only be given one time, but the employee shall advise Company as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. To qualify for NYPFL, employees must provide Company with notice as soon as practicable before each day of intermittent leave.

- **Unforeseeable Leave.** When the approximate timing of the qualifying event and the need

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for leave is not foreseeable, the employee must provide notice as soon as practicable under the facts and circumstances of the qualifying event. Absent unusual circumstances, it generally should be practicable for the employee to provide notice **at least sixty (60) minutes prior to the start of his or her regular shift** as required by Company's Attendance and Punctuality Policy (Section VI(f)) and Employee Call-In Procedure Policy (Section VI(g)) contained in the Employee Handbook.

✓ An employee who fails to provide advance notice in compliance with these policies must explain to Company why he or she was unable to do so. Absent unusual circumstances, an employee's failure to follow these policies will result in FMLA leave and/or NYPFL being denied or delayed and the employee receiving points pursuant to the Attendance and Punctuality policy. In such circumstances, such denied or delayed leave will not be considered FMLA or NYPFL leave, and thus, will not be considered an "Unscheduled Excused Absence" under the Attendance and Punctuality Policy.

✓ The notice rules apply to each use of intermittent leave under the FMLA and each day of intermittent leave under the NYPFL.

If an employee is planning a medical treatment or a series of treatments under FMLA or NYPFL or is taking Military Caregiver Leave under the FMLA, he or she must consult with Company first regarding the dates of such treatment to work out a schedule that best suits the needs of both the employee or the Covered Military Member, if applicable, and Company.

Applications for leave under FMLA and/or NYPFL should be submitted in writing to the Benefits Administrator. Application forms are available in the Human Resources Department. In addition, employees seeking NYPFL will be required to file a claim with Company's NYPFL insurance carrier (see NYPFL Claim and Certification Procedure section, below).

Failure to provide proper notice of your need for FMLA leave and/or NYPFL may result in the denial or delay of protected leave, depending on the particular facts and circumstances.

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FMLA Certification Procedure

If an employee is requesting FMLA leave because of his or her own or a covered relation's serious health condition, the employee and the relevant health care provider must supply appropriate medical certification. Employees may obtain Medical Certification forms from the Human Resources Department. When an employee requests leave, Company will notify him or her of the requirement for medical certification and when it is due (at least 15 days after leave is requested). If the employee provides at least 30 days' notice of medical leave, he or she should also provide the medical certification before leave begins. Failure to provide requested medical certification in a timely manner may result in denial of FMLA-covered leave until it is provided.

Company, at its expense, may require an examination by a second health care provider designated by Company. If the second health care provider's opinion conflicts with the original medical certification, Company, at its expense, may require a third, mutually agreeable, health care provider to conduct an examination and provide a final and binding opinion. Company may require subsequent medical recertification. Failure to provide requested certification within the required timeframe may result in delay of further leave until it is provided.

Company also reserves the right to require certification from a covered military member's health care provider if an employee is requesting military caregiver leave and certification in connection with military exigency leave.

NYPFL Claim and Certification Procedure

To obtain NYPFL benefits, you must file a claim with Company's NYPFL insurance carrier on the carrier's prescribed form(s). The employee will also be required to provide the NYPFL insurance carrier with sufficient certification of the need for leave and supporting documentation as provided by the NYPFL Law, the relevant insurance policy, and the carrier's own requirements. For example, the employee may be required to provide:

- Certification from a health care provider regarding the serious health condition for which

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the employee needs leave;

- Documentation such as a birth certificate establishing the birth of a child;
- Documentation such as court documents or placement letters establishing that the employee is in the process of adopting or has adopted a child or is fostering a child; or
- Certification of military exigencies and supporting military orders.

When you inform Company of the need for NYPFL, Company will provide you with a copy of the relevant claim form(s) and complete any employer portion(s). You can also obtain and file the claim form(s) directly through our NYPFL insurance carrier, SHELTER POINT, 1225

FRANKLIN AVE, STE 475, GARDEN CITY, NY 11530. PHONE: 516.504.6436

www.shelterpoint.com. Contact the carrier if you have any questions about the forms and documents you must submit in support of your claim for benefits.

Reporting While on Leave

While you are on NYPFL, you should notify Company and/or the NYPFL insurance carrier as soon as practicable (within two business days, if feasible) if there is any change in your circumstances or if your dates of leave change or were initially unknown and become known or estimated.

Conditions of FMLA Leave and NYPFL

The following conditions apply to leave taken under FMLA and/or NYPFL pursuant to this policy, except where otherwise required by applicable law:

- An employee taking an approved leave of absence may not engage in other work or employment during the leave of absence. If an employee engages in other work or employment during the leave of absence, the employee will be considered to have violated the terms of the leave of absence, and to have voluntarily terminated his or her employment with Company.
- An employee on approved leave who fails to return to work at the end of his or her leave will be required to reimburse Company for all health insurance premium payments

LIFE CARE SERVICES, INC
POLICY AND PROCEDURE

expended by Company on the employee's behalf during the leave, unless the reason the employee does not return to work is due to: (a) the continuation, recurrence, or onset of a serious health condition of the employee or the employee's spouse, son, daughter, or parent; (b) the serious injury or illness of a spouse, son, daughter, or parent, or next of kin, who is a Covered Servicemember; or (c) other circumstances beyond the employee's control.

- Employees will not receive holiday pay during leave except as required by applicable law.
- An employee may be subject to termination during a leave for reasons including but not limited to falsification of reason for or status of the circumstances surrounding the leave of absence.
- If business conditions require a reduction in force, employees on an approved leave of absence will be considered for lay-off and treated in the same manner as active employees.

Employee Compensation and Benefits during FMLA and/or NYPFL

Compensation during FMLA. As noted above, FMLA leave is unpaid. However:

- Nothing in this policy prevents an employee from applying for worker's compensation or NYS Disability benefits. Leave which is covered by workers' compensation or disability benefits will be designated as FMLA leave to the maximum extent permitted by law.
- Employees not receiving workers' compensation or disability benefits (including STD benefits) will be required to use their accrued paid time off (sick, personal, and vacation time) during FMLA leave, and such leaves will run concurrently with the employee's FMLA leave. Employees will also be required to use any accrued paid time during any waiting periods for disability benefits or workers' compensation benefits.

Compensation during NYPFL. As noted above, NYPFL is paid by Company's NYPFL insurance carrier in accordance with the insurance policy, the maximum benefits set forth in the law, and the carrier's own rules and procedures.

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Where leave is taken under NYPFL, the employee may but is not required to use accrued paid time off (sick, personal, and vacation time) during the leave. Use of accrued paid time off will allow the employee to receive full pay during the leave until paid time off is exhausted.

Where an employee is paid for accrued paid time off during NYPFL (whether concurrent with FMLA or not), Company will be entitled to receive the NYPFL payment from the NYPFL carrier as reimbursement for the NYPFL portion of the amount paid to the employee. In no event shall an employee's use of accrued paid time off during NYPFL result in the employee's receipt of more than 100% his or her average weekly wage.

Health Insurance during FMLA and/or NYPFL. To the extent required by law, Company will maintain group health insurance benefits for employees on FMLA and/or NYPFL leave on the same basis as coverage would have been provided if the employee had been actively working during the leave period.

Any share of group health plan premiums which had been paid by the employee prior to leave must continue to be paid by the employee during the leave period. Where the employee is receiving pay directly from Company (i.e., using sick, personal, or vacation time), deductions for group health insurance will continue to be made on the same basis as if the employee was actively working. Where the employee is not receiving pay from Company, arrangements will be made for employees to pay their share of the group health insurance premiums while on leave. If Company pays the employee's share of any premium payments, Company reserves the right to recover the full value of those payments made in any manner permitted by law.

An employee whose health insurance coverage is maintained pursuant to this policy during an approved FMLA and/or NYPFL leave will be subject to any changes in Company's group health plan that occur while he or she is on leave (e.g., changes in coverage, premiums, deductibles). If an employee's premium payment is more than thirty (30) days late, his or her group health

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insurance benefits may be terminated, and the employee will be extended continuing coverage opportunities in accordance with COBRA. However, if coverage is terminated for this reason and the employee returns to work from FMLA leave, the employee's group health insurance benefits will be reinstated, to the same extent the employee would have been entitled to those benefits had he or she not taken leave.

If an employee gives unequivocal notice of his or her intent not to return to work, Company's obligation to continue group health insurance benefits will cease, subject to COBRA.

Other Benefits. An approved FMLA leave and/or NYPFL pursuant to this policy will not result in the loss of any employment benefit that may have accrued before the date the leave of absence started. For all periods when an employee uses accrued paid time off concurrently with FMLA or NYPFL, benefits that are accumulated on an accrual basis (e.g., paid time off) will continue to accrue to the extent they would have otherwise, and deductions for group health insurance will continue to be made on the same basis as if the employee was not on leave. Employees will not accrue or receive any benefits (other than group health insurance benefits as noted above) for periods where FMLA and/or NYPFL is not run concurrently with use of the employee's accrued paid time off.

Return from an Approved FMLA Leave and/or NYPFL

Unless the employee's employment was or would have been terminated for reasons unrelated to the leave (e.g., reorganization, lay off, reduction in force, etc.), Company will restore an employee who returns from approved FMLA and/or NYPFL leave to the same position that the employee held prior to the leave or to an equivalent position with substantially similar duties, conditions, responsibilities, privileges, and status as the original position, subject to the terms, limitations, and exceptions provided by law.

Before returning from an approved FMLA leave granted as a result of an employee's own serious health condition, an employee must present a written fitness-for-duty certification from

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his or her medical care provider. An employee's failure to provide such certification at the time the employee attempts to return to work may result in a delay or denial of job restoration.

Employees are expected to return to work when the FMLA leave and/or NYPFL ends, unless an employee requests and is granted an extension of leave as an accommodation or pursuant to another Company policy. If an employee does not return to work on the agreed upon date after expiration of FMLA leave and/or NYPFL, and an extension of leave was not granted to the employee, the employee will be considered to have voluntarily terminated his or her employment.

With respect to certain "highly paid" or "key" employees, there may be specified and limited circumstances Company may refuse to reinstate such individuals following FMLA leave. This determination will be made in accordance with applicable law.

Further Information

Employees wanting further information regarding this policy should consult with the Human Resources Department.

Company will not interfere with, restrain, or deny an employee the exercise of any right provided under the FMLA or discriminate against any person for opposing any practice made unlawful by the FMLA or for being involved in any proceeding under or relating to the FMLA. If a prohibited act has occurred, or the FMLA was not followed, a complaint may be filed with the United States department of labor or a private action instituted.

Company will not discriminate or retaliate against an employee because he or she claimed NYPFL benefits, attempted to claim NYPFL benefits, or testified or is about to testify in a proceeding under the NYPFL Law.

This policy is intended to implement the FMLA and the NYPFL and their accompanying

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regulations. To the extent this policy is inconsistent therewith, the law and regulations will govern. Further, to the extent any state or local law provides for additional leave benefits, Company will comply with any such requirements.

Acknowledgement

I acknowledge that I have received a copy of the Family and Medical Leave and New York Paid Family Leave Policy and that I read it, understood it, and agree to abide by its terms.

Employee Name (Print)

Employee Signature

Date

LIFE CARE SERVICE, INC

Compliance and Ethics Program Acknowledgement

This is to acknowledge that I have received and reviewed LifeCare Services LLC's Compliance and Ethics Manual and Overview and have completed initial training for the Compliance and Ethics Program ("the Program"). I understand that I am obligated to read and understand the written and verbal information regarding the Program and seek guidance and clarification if necessary. I understand that I am also obligated to report any known or suspected violations of the law or the Program, as well as possible instances of fraud, waste and abuse and weaknesses in company procedures. I am aware that there are several avenues of communication available to me as part of the Program – including the anonymous toll-free Compliance and Ethics Hotline – and that inquiries and reports communicated through any of these avenues will be granted protection from any form of retaliation and confidentiality to the extent permissible.

I pledge to faithfully follow the letter and spirit of the Program and all related policies and procedures and future amendments thereto as is expected as part of my continued employment or association with LifeCare Services LLC and understand that no one has the authority to instruct me otherwise. I recognize that I am responsible for my own actions, as well as my own failures to act, and face the possibility of disciplinary and/or legal action if I violate the law or Program, as set forth in the Overview and Manual.

Signature

Date

Printed Name

PAID TIME OFF POLICY

Purpose: Aides working for the Life Care Services, Inc (“Agency”) will receive paid time off (“PTO”) as part of their wage parity package. This policy describes how PTO will accrue.

Eligibility for the Benefit: All aides who work on wage parity cases will accrue PTO for each hour of work that they work on a case. The PTO under this policy will constitute \$ ____/hour of your total Wage Parity package.

About the PTO: Aides will accrue paid time off to be used when they are sick (“SICK PTO”) and for vacation (“VACATION PTO”). The PTO will begin to accrue on the first day that an aide starts work for the Agency. PTO will accrue for the first 40 hours worked each week. In no event will the rate of accrual be lower than 1 hour of PTO for every 30 hours worked.

There is no waiting period before an aide can start to use the PTO that has been accrued.

For purposes of this policy, “Annual” or “Year” means the 12-month period starting on the first day that the aide performs any work for the Agency. A Year ends on the aide’s anniversary of hire. Also, for purposes of this policy, a “week” begins on December 31, 2018 and ends on December 30, 2019.

Designation of Accrued PTO: The first 40 PTO hours accrued under this policy will be designated by the Agency as SICK PTO. The remaining hours accrued under this policy will constitute VACATION PTO.

1. Sick PTO. Aides can use Sick PTO for all reasons permitted under the New York City Earned Sick Time Act, which may be amended from time to time, including: (1) the aide’s own illness; (2) preventative care; (3) lack of work due to a public health emergency or public disaster; (4) care of a family member who is ill or needs preventative care; or (5) care of a child whose school or child care facility is closed due to a public health emergency or public disaster.

For purposes of this policy, a family member means a child (biological, adopted, or foster child; legal ward; child of an employee standing in loco parentis), grandchild, spouse, domestic partner, parent, grandparent, child or parent of an employee’s spouse or domestic partner, and sibling (including a half, adopted, or step sibling).

Aides using Sick PTO for more than three (3) consecutive days of absence will be required by the Agency to present written confirmation that they have used Sick PTO for one of the purposes stated above, and, in the case of the aide’s own illness or need for preventative care, or the aide’s family member’s illness or need for preventative care, the aide must also provide a doctor’s note confirming the need for such leave.

2. Vacation PTO. Vacation PTO may be used for any personal or vacation reason requested by the aide. However, to receive Vacation PTO, the aide must request – in writing - Vacation PTO two (2) weeks in advance of the day off. If no written request is provided by the aide to the Agency, the time off will not be paid as Vacation PTO. Aides can submit their requests in writing or by email. The maximum Vacation PTO that is permitted to any aide during a single Year is 40 hours.

Use of PTO: Aides can use PTO accrued under this policy as soon as the PTO is accrued – there is no waiting period for using PTO. All accrued and unused PTO will be forfeited after 12 months from the date that it is

accrued. Thus, the Agency will provide aides 12 months to use PTO accrued under this policy. PTO first accrued will be PTO first used. For example, PTO accrued for work performed on March 5, 2019 must be used by the aide March 5, 2020. Aides will not be paid for unused PTO.

Using PTO: PTO may not be used in increments of less than 8 hours, except that Sick PTO may not be used in increments of less than 4 hours. Time taken off as PTO will not be considered hours worked for purposes of overtime pay.

Leaves of Absence: Aides on leave pursuant to federal, state, or local law, such as the Americans with Disabilities Act or the Family and Medical Leave Act, may be required to use any accrued PTO for such absences. PTO will not accrue during any leave of absence or time off from work.

Forfeiture and Carry-Over of PTO: Accrued and unused PTO may not be carried over from one Year to the next, except that up to 40 hours of Sick PTO may be carried over to the next Year. This means that (with the exception of Sick PTO), on each anniversary of the Aides' hire, the aide will have a zero balance in his/her PTO "bank." Aides will not be allowed to use more than 40 hours of Sick PTO in a single year, regardless of whether they have carried additional time over from a previous Year.

All accrued and unused PTO will be forfeited at the time of termination of employment, regardless of the reason or date of termination. However, if the aide has not used at least 3 paid days off in the 12 months preceding the termination of his/her employment from the Agency, 3 PTO days will be paid out to him/her. The PTO will be paid at the minimum wage rate in effect when it is paid.

Questions: Please contact our office if you have questions about your PTO balance.

By my signature below, I confirm having received, read, and understood the above policy regarding my paid time off package as part of my wage parity. I accept these benefits voluntarily and knowingly as part of my wage parity.

Employee Signature

AMENDMENT TO PAID TIME OFF POLICY

Effective May 5, 2018, the Agency's Paid Time Off Policy is amended to allow you to take SICK PTO for "safe time." The New York City Earned Sick Time law defines "safe time" as time that employee may take off from work: (a) To obtain services from a domestic violence shelter, rape crisis center, or other shelter or services program; (b) to participate in safety planning, temporarily or permanently relocate, or take other actions to increase the safety of the employee or employee's family members from future harm; (c) to meet with an attorney or other social service provider to obtain information and advice on, and prepare for or participate in, any criminal or civil proceeding, including matters related to a family offense matter, sexual offense, stalking, human trafficking, custody, visitation, matrimonial issues, orders of protection, immigration, housing, discrimination in employment, housing or consumer credit; (d) to file a complaint with law enforcement; (e) to meet with a district attorney's office; (f) to enroll children in a new school; or (g) to take other actions necessary to maintain, improve, or restore the physical, psychological, or economic health or safety of the employee or the employee's family member.

By my signature below, I acknowledge receiving, reading, and understanding the above Amendment to the Agency's Paid Time Off Policy.

Employee Name & Signature

Date



1723 Avenue M
Brooklyn, NY 11230

Phone: 718.252.1515
Fax: 718.252.1513

EMPLOYEE ACKNOWLEDGEMENT

I _____ am an employee of Life Care Services, Inc.
During my Registration, I have received the full information packet and all my questions were answered by Life Care Services, Inc representative regarding the following:

- **Clock in and Clock out**
All Employees must clock in when their shift starts and clock out when their shift ends.
- **Use of Duty Sheet when clock in system is not available.** There must be a written explanation by the patient or patient family member why duty sheets will be used.
- **Paid Sick leave**
All employees are eligible for paid sick leave as soon as their employment starts. They must request a sick leave day and pay by contacting their coordinator. Employees accrue sick leave at the rate of one hour for every 20 hours worked, up to a maximum 40 hours of sick leave per calendar year. Up to 40 hours of unused sick leave can be carried over to the next year. However, your employer is only required to let you use up to 40 hours of sick leave per calendar year.
- **Wage Parity and Health Insurance Benefits**
In addition to the minimum wage, a supplemental benefit accrued to each regular hour worked. (Not applicable for Overtime hour). All employees are offered enrollment in a Major Medical Plan to receive health Insurance. The monthly deduction of 9.86% of salary will be applied to the employees check. The minimum required hours to be eligible for Major Medical are 130 hours per month. The employee may refuse the Major Medical Plan but accept Minimum Essential Plan in order to stay in Compliance with Obama Care. In case of total declination of all medical coverage, the employee must sign the declination form and may provide Life Care Services, Inc with the copy of their Medical Insurance Plan. In this case, the employee will receive their wage parity amount in addition to their minimum pay rate. If they refuse the wage parity added to their minimum rate, they may request it in the end of the year. Please note, that each employee must request their Paid Time Off accrued (that includes \$1.69 per each hour for vacation, holidays and etc) calculation and payment not later than March 1 of the following year. Otherwise, Paid Time Off is subject to be lost if not used.

EMPLOYEE NAME _____

SIGNATURE _____ DATE _____



1723 Avenue M
Brooklyn, NY 11230

Phone: 718.252.1515

Fax: 718.252.1513

- **Minimum Wage and Over Time**
Currently minimum wage is \$15 (Thirteen Dollars) per hour. Overtime pay is calculated based on base rate calculated by one and half time. (For example, if minimum rate is \$15, then multiplied by 1.5= \$22.5 is Overtime pay per hour)
- **Billing and Payroll**
The payroll processes every week. All duty sheets must be submitted by 1pm every Monday in order to be processed and correctly paid on pay day (Friday).
- **Spread of Hours**
SOH is additional one hour pay per day if an employee works more than 10 hours per day.
- **Travel Time**
In case the employee provides service for more than one patient that live in different locations, up to 1.5 hour of travel time between those patients is paid based on minimum wage.
- **Complaints**
Do you have a complaint? Please feel free to reach out to your coordinator at Life Care Services or the office manager. You may also contact Compliance and Ethics Hotline at 866-485-0115.
- **Annual Physical Examination Policy**
All employees must renew their yearly physical assessment form before the expiration of the previous. All employees will receive the notice and a blank form one month prior to the expiration of their physical assessment form. Failure to compliance with the Department of Health requirement to have a valid medical health assessment may lead to temporary or permanent termination of the employment.
- **Employee I-9 Policy**
All employees must have a valid I-9 or proof of US Citizenship in order to remain in compliance.
- **Policy Against Sexual Harassment and Discrimination as well as Model Complaint Form for Reporting Sexual Harassment.**

EMPLOYEE NAME _____

SIGNATURE _____ DATE _____



1723 Avenue M
Brooklyn, NY 11230

Phone. 718.252.1515

Fax. 718.252.1513

Compliance and Ethics Program Acknowledgement

This is to acknowledge that I have received and reviewed LifeCare Services LLC's Compliance and Ethics Manual and Overview and have completed initial training for the Compliance and Ethics Program ("the Program"). I understand that I am obligated to read and understand the written and verbal information regarding the Program and seek guidance and clarification if necessary. I understand that I am also obligated to report any known or suspected violations of the law or the Program, as well as possible instances of fraud, waste and abuse and weaknesses in company procedures. I am aware that there are several avenues of communication available to me as part of the Program – including the anonymous toll-free Compliance and Ethics Hotline – and that inquiries and reports communicated through any of these avenues will be granted protection from any form of retaliation and confidentiality to the extent permissible.

I pledge to faithfully follow the letter and spirit of the Program and all related policies and procedures and future amendments thereto as is expected as part of my continued employment or association with LifeCare Services LLC and understand that no one has the authority to instruct me otherwise. I recognize that I am responsible for my own actions, as well as my own failures to act, and face the possibility of disciplinary and/or legal action if I violate the law or Program, as set forth in the Overview and Manual.

Signature

Date

Printed Name

Pre-Screening Notice and Certification Request for the Work Opportunity Credit

OMB No. 1545-1500

► Information about Form 8850 and its separate instructions is at www.irs.gov/form8850.

Job applicant: Fill in the lines below and check any boxes that apply. Complete only this side.

Your name _____ Social security number ► _____

Street address where you live _____

City or town, state, and ZIP code _____

County _____ Telephone number _____

If you are under age 40, enter your date of birth (month, day, year) _____

- 1 Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.
- 2 Check here if **any** of the following statements apply to you.
 - I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
 - I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
 - I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
 - I am at least age 18 but **not** age 40 or older and I am a member of a family that:
 - a. Received SNAP benefits (food stamps) for the past 6 months; or
 - b. Received SNAP benefits (food stamps) for at least 3 of the past 5 months, but is no longer eligible to receive them.
 - During the past year, I was convicted of a felony or released from prison for a felony.
 - I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
 - I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.
- 3 Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.
- 4 Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.
- 5 Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.
- 6 Check here if you are a member of a family that:
 - Received TANF payments for at least the past 18 months; or
 - Received TANF payments for any 18 months beginning after August 5, 1997, and the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years; or
 - Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.
- 7 Check here if you are in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation.

Signature—All Applicants Must Sign

Under penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

Job applicant's signature ► _____

Date _____

For Employer's Use Only

Employer's name _____ Telephone no. _____ EIN ▶ _____

Street address _____

City or town, state, and ZIP code _____

Person to contact, if different from above _____ Telephone no. _____

Street address _____

City or town, state, and ZIP code _____

If, based on the individual's age and home address, he or she is a member of group 4 or 6 (as described under Members of Targeted Groups in the separate instructions), enter that group number (4 or 6) ▶ _____

Date applicant:

Gave information _____ Was offered job _____ Was hired _____ Started job _____

Under penalties of perjury, I declare that the applicant provided the information on this form on or before the day a job was offered to the applicant and that the information I have furnished is, to the best of my knowledge, true, correct, and complete. Based on the information the job applicant furnished on page 1, I believe the individual is a member of a targeted group. I hereby request a certification that the individual is a member of a targeted group.

Employer's signature ▶

Title

Date

Privacy Act and Paperwork Reduction Act Notice

Section references are to the Internal Revenue Code.

Section 51(d)(13) permits a prospective employer to request the applicant to complete this form and give it to the prospective employer. The information will be used by the employer to complete the employer's federal tax return. Completion of this form is voluntary and may assist members of targeted groups in securing employment. Routine uses of this form include giving it to the state workforce agency (SWA), which will contact appropriate sources to confirm that the applicant is a member of a targeted group. This form may also be given to the Internal Revenue Service for administration of the Internal Revenue laws, to the Department of Justice for civil and

criminal litigation, to the Department of Labor for oversight of the certifications performed by the SWA, and to cities, states, and the District of Columbia for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file this form will vary depending on individual circumstances. The estimated average time is:

- Recordkeeping . . . 6 hr., 27 min.
Learning about the law or the form 24 min.
Preparing and sending this form to the SWA 31 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making this form simpler, we would be happy to hear from you. You can send us comments from www.irs.gov/formspubs. Click on "More Information" and then on "Give us feedback." Or you can send your comments to:

Internal Revenue Service
Tax Forms and Publications
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224

Do not send this form to this address. Instead, see When and Where To File in the separate instructions.

Please fill these forms out slowly and legibly.

This company participates in various federal and state tax credit programs. This information in no way will negatively impact any hiring, retention decision. Your responses to the questions will only be shared with your employer's management and federal, state, local governmental agencies as needed in the administration of these programs. By completing the form, you knowingly and voluntarily waive any objection to providing your social security number. Any information provided will be used in a manner consistent with the American Disability Act.

Rev. 12/10

PRINT (NO SCRIPT)

Company LifeCare Services Hourly Wage _____ \$	Have you worked for this employer before? Yes _____ No _____ If YES, enter last date of employment _____
First Name _____ Last Name _____ Social Security Number _____ Phone Number (____) _____	Address _____ City _____ State _____ Zip _____ Date of Birth ____ / ____ / AGE ____

BOX #1
Have you or family a member received Supplemental Nutritional Assistance Program (SNAP) (Food Stamps) benefits for the past 6 months before you were hired? Yes ___ No ___
Are you still receiving food stamps? Yes ___ No ___

Enter name of primary recipient.
First _____ Last _____
and city and state where benefits were received City _____ State _____

BOX #2
Are you a member of a family that received TANF or Welfare assistance within the last 24 months before you were hired? Yes ___ No ___

Enter name of primary recipient.
First _____ Last _____
and city and state where benefits were received City _____ State _____

Are you no longer receiving this because you have collected for the maximum allowed? Yes ___ No ___

BOX # 3

Are you a Veteran of the U.S. Armed Forces?

Yes ___ No ___

If YES, are you a member of a family that received SNAP

(Food Stamps; benefits the 15 months for at least 3 months during before you were hired? Yes ___
No ___

BOX # 4

Did you receive Supplemental Security income (SSI) benefits for any month ending within 60 days before you were hired?

Yes ___ No ___

BOX # 5

Have you worked in the past sixty days?

Yes ___ No ___

If YES, then answer

Did you work less or more than 40 hours in the past sixty days?

Less ___ More ___

BOX # 6

Are you at least 16 or Under 25?

Yes ___ No ___

IF NO, CONTINUE TO THE BOTTOM OF THE PAGE, SIGN AND DATE THE FORM

PLEASE FILL OUT THE YOUTH FORM on the next page IF YOU ARE BETWEEN 16 and under 25 of age.

The following questions will help you fill out the form

Did you attend secondary, technical, or post-secondary school for more than 10 hours per week in the last 6 months?

(IF NO, CHECK THE FIRST BOX ON THE NEXT PAGE)

Yes ___ No ___

Do you have a High School Diploma or GED?

(IF NO, CHECK SECOND BOX ON THE NEXT PAGE)

Yes ___ No ___

DO NOT CHECK THE THIRD BOX.

BOX # 7

Under Penalty of perjury, certify that this information is true and correct to the best of my knowledge. I hereby authorize this company's management, and federal, state Tribal and local government agencies to provide information to Tax Opportunities America and for SWA, to determine eligibility. I understand that the information above may be subject to verification.

Signature _____

DATE _____

Please fill these forms out slowly and legibly.

PRINT (NO SCRIPT) Exp. 7/30/17 First Work Date

Have you worked for this employer before?

If YES, enter last date of employment _____

Yes ___ No ___

BOX # 1

Have you or a family member received Supplemental Nutritional Assistance Program (SNAP) (Food Stamps) benefits at all in the past 6 months before you were hired?

Yes ___ No ___

OR, received SNAP benefits for at least a 3-month period within the last 5 months but are no longer receiving them?

Yes ___ No ___

If YES to either question, Enter name of primary recipient and city and state where benefits were received:

First _____ Last _____
City _____ State _____

Social Security # of the recipient _____

Box # 2

Are you a member of a family that received TANF (Welfare assistance) within the last 24 months before you were hired? Yes ___ No ___

OR, are you a member of a family that received TANF (Welfare assistance) benefits for any 18 months beginning after August 5, 1997, and the earliest 18-month period beginning after August 5, 1997, ended within 2 years before you were hired?

Yes ___ No ___

OR, did your family stop being eligible for TANF (Welfare assistance) within 2 years before you were hired because a Federal or state law limited the maximum time those payments could be made?

Yes ___ No ___

If NO, are you a member of a family that received TANF (Welfare assistance) for any 9 months during the 18 month period before you were hired?

Yes ___ No ___

If YES to either question, Enter name of primary recipient and city and state where benefits were received:

First _____ Last _____
City _____ State _____

Social Security # of the recipient _____

BOX # 3.

Are you a veteran of the U.S. Armed Forces?

Yes ___ No ___

If YES, are you a member of a family that received SNAP (Food Stamps) benefits for a 5 month period that ended within the last 3 months before you were hired?

Yes ___ No ___

Are you a veteran unemployed for a combined period of at least 6 months (whether or not consecutive) during the year before you were hired?

Yes ___ No ___

Are you a veteran unemployed for a combined period of at least 4 weeks but less than 6 months (whether or not consecutive) during the year before you were hired?

Yes ___ No ___

Box #4 Have you received unemployment compensation for at least 27 consecutive weeks since you were last employed? Yes ___ No ___

Box # 5

Were you referred to an employer by a Vocational Rehabilitation Agency approved by a State?
OR, by an Employment Network under the Ticket to Work Program?
OR, by the Department of Veterans Affairs?

Yes ___ No ___

Yes ___ No ___

Yes ___ No ___

Box # 6

Have you ever been convicted for a felony?

Yes ___ No ___

PRINT NAME _____

SSN# _____

This Company participates in various federal and state tax credit programs. This information in no way will negatively impact any hiring, retention decision. Your responses to the questions will only be shared with your employer's management and federal, state, local governmental agencies as needed in the administration of these programs. By completing the form, you knowingly and voluntarily waive any objection to providing your social security number. Any information provided will be used in a manner consistent with the American Disability Act. Under Penalty of perjury, I certify that this information is true and correct to the best of my knowledge. I hereby authorize this company's management, and federal, state Tribal and local government agencies to provide information to Tax Opportunities America and /or SWA, to determine eligibility. I understand that the information above may be subject to verification.

Signature _____

DATE _____