Authorization to Obtain Consumer Credit Report and Criminal Background Check

As a condition of my candidacy for employment with HopeHealth, Inc., I understand that that the organization will conduct a Consumer Credit Report and/or Criminal Background Check on me for employment purposes.

By signing the release below, I hereby authorize HopeHealth to contact any and all corporations, former employers, credit agencies, educational institutions, law enforcement agencies, city, state, county, and federal courts, military services to release information about my background including, but not limited to, information about employment, education, consumer credit history, driving record, criminal record and general public records history to HopeHealth.

I release from all liability all persons, companies, schools supplying such information. I indemnify HopeHealth against any liability, which may result from making such requests. This release shall remain in effect for the length of my employment. I understand and I may have a right to request additional disclosures regarding the nature and scope of the investigation. I also understand that I will be given a copy of the consumer report and a written description of my rights under the Fair Credit Reporting Act.

I believe to the best of my knowledge that all information I have provided is accurate, true and correct and that I fully understand the terms of this release.

Name: ____________________

(Please Print) Other names used: ____________________

Current Address: ____________________

City: __________ State: __________ Zip Code: __________ Country: __________

Other Places you have lived: ____________________

Social Security Number: __________ Date of Birth: __________

Driver's License Number and State: __________ Sex: ______ Race: ______

____
(Signature of Applicant)

____
(Date)

Benefits Offered by HopeHealth, Inc.

PTO – 15 days (Increase after five years)

Holidays – 10 Paid Per Year

EAP (Employee Assistance Program)

Long Term Disability (at no cost to employee)

401K – Eligible After 6 months of Employment

Mileage / Expense Reimbursement

Wellness Program

SC Telco Credit Union Membership

Payroll Deduction – for Medications through Long's Pharmacy

No Co-Pays – For Medical Care for Employee and Dependents covered by our Health Insurance and Receive services at a HopeHealth Facility.

Reimbursement - $500.00 reimbursement after insurance deductible reached (employee only)

Supplemental Insurance (Unum) Elective Benefit

Flexible Spending Account (Medical and Dependent)

Tuition Reimbursement

Medical Coverage (Blue Cross/Blue Shield Provider Network)

- Single Coverage - $34.62 per pay period
- Employee / Spouse - $157.04 per pay period
- Employee / Child(ren) - $106.32 per pay period
- Employee / Family - $322.06 per pay period

Dental Coverage (Delta Dental)

- Single Coverage – at no cost to employee
- Employee / Spouse - $13.26 per pay period
- Employee / Child(ren) - $17.57 per pay period
- Employee / Family - $35.93 per pay period

Vision Coverage (Physician Eyecare Plan)	**Basic**	**Enhanced**
• Single Coverage per pay period	$3.32	$4.48
• Employee / Spouse per pay period	$6.51	$8.91
• Employee / Child(ren) per pay period	$6.78	$9.42
• Employee / Family per pay period	$10.38	$14.40

BASIC EMPLOYEE DATA

LEGAL NAME: ____

SSN: ____________________ DATE OF BIRTH: ________________________

ADDRESS: ________________________ PHONE #: ______________________

________________________ CELL #: ______________________

________________________ RACE: ______________________

MARITAL STATUS: ____________________

IN CASE OF EMERGENCY, NOTIFY:

NAME: ________________________ RELATIONSHIP: ________________

ADDRESS: ____

____

PHONE: ____

NAME: ________________________ RELATIONSHIP: ________________

ADDRESS: ____

____

PHONE: ____

OFFICE USE ONLY:

DATE OF HIRE: ______________ EMPLOYEE SEPARATION: ______________

DEPARTMENT: ____________________

FLSA: Non-Exempt

Exempt (specify category)

________Executive _____Professional

________Administrative _____Outreach

STATUS: Full Time Part time Volunteer

Regular Temporary Intern

Employee Health Questionnaire

Name: ______________________ Marital Status: S M W D Birth Date:__________ Sex: M / F

Address: ______________________ Telephone: __________

Position: ______________________ Hire Date: __________

Date & Reason for last visit to physician: ______________________

Family History: Nervous or Mental Illness: Y / N Diabetes: Y / N Tuberculosis: Y / N

Have you had or do you have any of the following: (Please enter "Y" - Yes or "N" - No)

Disease of or illness of any the following:

Eyes		Liver		Skin		Shortness of Breath	
Ears		Spleen		Dizziness		Chronic Cough	
Nose		Gallbladder		Fr. Headaches		Coughing up Blood	
Throat		Kidneys		Ringing Ears		Palpitations	
Heart		Bladder		Frequent Sore Throat		Allergies	
Lungs		Bone		Frequent Colds		Chronic Indigestion	
Stomach		Joints		Fainting Spells		Recurrent Nausea	
Intestines		Back (Spine)		Chest Pains		Recurrent Vomiting	
Vomiting of Blood		Kidney Stones		Arthritis		Operations	
Blood in Urine		Convulsions		Rheumatism		Diabetes	
Swollen Ankles		Bronchitis		Injuries		Pneumonia	
Jaundice		Hay Fever		Back Aches		Pleurisy	
Hernia (Rupture)		Cancer / Tumors		Chronic Sinus Infec.		Asthma	
Stomach Ulcers		Black or Bloody Bowel Movements		High Blood Pressure		Frequent or Painful urination	

Please List your current medications:

__________ __________ __________

__________ __________ __________

Please answer the following questions:

1. Please list any other serious illnesses or conditions you may have: ______________________

____

2. State details of prior injuries or operations: ______________________

____

I have read the above and declare that I have had no injury, illness or ailment other than as specifically noted:

______________________ ______________________

Signature Date

EMPLOYMENT NOTICE

Employee Name: ______________________________ Date: ________________

SSN: ____

1. Hours of Work: Monday – Friday – 8:30am – 5:30pm

   Alternate Schedule: ____________________________

2. Method of payment: Wages $ ____________ Salary $ _________________

3. Payday is bi-weekly; on the Friday after the end of the pay period.

4. Paid Time off Policy: Full-time – 120 hours per year
   Part-time – 60 hours per year

5. Paid Holidays: 10 per year: New Year's Day, MLK Jr. Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Day after Thanksgiving, Good Friday, Christmas Eve (Half Day), Christmas Day, New Year's Eve (Half Day)

6. Severance pay policy is: None.

7. Deductions to be made from wages including payments to insurance programs: (Exclude income taxes and FICA)

Any changes in these terms shall be made in writing and at least seven (7) days before they become effective.

THIS NOTICE IS PROVIDED TO YOU PURSUANT TO THE REQUIREMENTS OF SOUTH CAROLINA LAW AND IT IS NOT TO BE CONSTRUED AS IMPLYING A CONTINUED RIGHT TO EMPLOYMENT. YOU ARE CONSIDERED TO BE AN EMPLOYEE AT WILL.

____ ________________

Employee Signature Date

____ ________________

Employer Signature Date

HR 003 (05/15)

HOPEHEALTH
WITH HOPE, ALL THINGS ARE POSSIBLE

Employee Voluntary Self-Identification Form

HopeHealth is subject to certain governmental recordkeeping and reporting requirements for the administration of civil rights laws and regulations. In order to comply with these laws, HopeHealth invites employees to voluntarily self-identify their gender, race and ethnicity. Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information obtained will be kept confidential and may only be used in accordance with the provisions of applicable laws, executive orders, and regulations, including those that require the information to be summarized and reported to the federal government for civil rights enforcement. When reported, data will not identify any specific individual.

Name ____
Last, First Middle Initial

Position ______________________________

Please indicate your gender and choose either Hispanic or Latino or one of the other six racial/ethnic categories below:

☐ Male ☐ Female

☐ **Hispanic or Latino** - A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

OR

☐ **White (Not Hispanic or Latino)** - A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ **Black or African American (Not Hispanic or Latino)** – A person having origins in any of the black racial groups of Africa.

☐ **Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino)** - A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ **Asian (Not Hispanic or Latino)** - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ **American Indian or Alaska Native (Not Hispanic or Latino)** - A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.

☐ **Two or More Races (Not Hispanic or Latino)** - All persons who identify with more than one of the above races (not Hispanic or Latino).

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):

☐ 1. A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: ____________

OR

2. Form I-94 Admission Number: ____________

OR

3. Foreign Passport Number: ____________

Country of Issuance: ____________

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

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

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

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

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

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

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

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

Additional Information

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

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

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

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

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

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

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority **For persons under age 18 who are unable to present a document listed above:** 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Form W-4 (2017)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

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

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

The exceptions don't apply to supplemental wages greater than $1,000,000.

Basic instructions. If you aren't exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

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

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent . . . . . **A** ____

B Enter "1" if:
- You're single and have only one job; or
- You're married, have only one job, and your spouse doesn't work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.

. . . **B** ____

C Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . . **C** ____

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . . **D** ____

E Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . . **E** ____

F Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit . . . **F** ____
(**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.
- If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children.
- If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child. **G** ____

H Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ► **H** ____

For accuracy, **complete all worksheets that apply.**
- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

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

Form **W-4** | Department of the Treasury Internal Revenue Service

Employee's Withholding Allowance Certificate

OMB No. 1545-0074 | **2017**

► **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

1 Your first name and middle initial	Last name	2 **Your social security number**
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐	

5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2) **5** ____

6 Additional amount, if any, you want withheld from each paycheck . . . . . **6** $ ____

7 I claim exemption from withholding for 2017, and I certify that I meet **both** of the following conditions for exemption.
- Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and**
- This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability.

If you meet both conditions, write "Exempt" here . . . . . ► **7** ____

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

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

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

For Privacy Act and Paperwork Reduction Act Notice, see page 2. Cat. No. 10220Q

Deductions and Adjustments Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2017 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% of your income, and miscellaneous deductions. For 2017, you may have to reduce your itemized deductions if your income is over $313,800 and you're married filing jointly or you're a qualifying widow(er); $287,650 if you're head of household; $261,500 if you're single, not head of household and not a qualifying widow(er); or $156,900 if you're married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,700 if married filing jointly or qualifying widow(er); $9,350 if head of household; $6,350 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2017 adjustments to income and any additional standard deduction (see Pub. 505)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2017 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2017 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $4,050 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note: Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	1	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3"	2	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	3	

Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4	Enter the number from line 2 of this worksheet . . . 4 ____		
5	Enter the number from line 1 of this worksheet . . . 5 ____		
6	**Subtract** line 5 from line 4	6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	$
9	Divide line 8 by the number of pay periods remaining in 2017. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2017. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $7,000	0	$0 - $8,000	0
7,001 - 14,000	1	8,001 - 16,000	1
14,001 - 22,000	2	16,001 - 26,000	2
22,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 70,000	5
44,001 - 55,000	6	70,001 - 85,000	6
55,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 95,000	10	140,001 and over	10
95,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$610	$0 - $38,000	$610
75,001 - 135,000	1,010	38,001 - 85,000	1,010
135,001 - 205,000	1,130	85,001 - 185,000	1,130
205,001 - 360,000	1,340	185,001 - 400,000	1,340
360,001 - 405,000	1,420	400,001 and over	1,600
405,001 and over	1,600		

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

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

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Employee Information for Direct Deposit

Please print legibly

Employee Name: ______________________________ Social Security #: __________________

What portion of net pay would you like deposited?

You may have all or part of your paycheck deposited directly to your bank account(s).
Select one of the following options to indicate the portion of your total paycheck you want deposited.

☐ 100% of net pay ☐ Indicated Percent _______% ☐ Indicated Dollar Amount $__________

How do you want the direct deposit made?

Please identify up to four bank accounts where you want your check deposited, and indicate the amount or percentage of your paycheck you want deposited in each account. You must enter information in the "Account for the Balance of the Direct Deposit Amount" section.

*****Attach a voided check for each checking account*****
*****Attach a deposit slip for each savings account*****

Account for Balance of the Direct Deposit Amount:	Account for Percent or Selected Amount Deposit:
Bank Name:	Bank Name:
Bank Routing Number:	Bank Routing Number:
Bank Account Number:	Bank Account Number:
Type of Account: ☐ Checking	Type of Account: ☐ Checking
☐ Savings	☐ Savings
• The remainder of the check will be	Indicate deposit amount for this account: (select one)
Automatically deposited in this account	☐ Percent of Direct Deposit Amount ____ %
	☐ Selected Dollar Amount $ ________

Account for Percent or Selected Amount Deposit:	Account for Percent or Selected Amount Deposit:
Bank Name:	Bank Name:
Bank Routing Number:	Bank Routing Number:
Bank Account Number:	Bank Account Number:
Type of Account: ☐ Checking	Type of Account: ☐ Checking
☐ Savings	☐ Savings
Indicate deposit amount for this account: (select one)	Indicate deposit amount for this account: (select one)
☐ Percent of Direct Deposit Amount ____ %	☐ Percent of Direct Deposit Amount ____ %
☐ Selected Dollar Amount $ ________	☐ Selected Dollar Amount $ ________

Signature ____ Date ________________

For Office Use Only

Date Received: ________________ Date Prenoted: ________________ Date Accepted: ________________

South Carolina New Hire Reporting Form

If you use this form to report newly hired or rehired employees, please make and keep additional copies for future reporting.

EMPLOYER IDENTIFICATION

Employer Name: HopeHealth, Inc.		
Employer Address: 360 N. Irby Street		
City: Florence	State: South Carolina	Zip: 29501
Federal Employer Identification Number (Federal Tax ID):	Contact Name and Phone Number	

NEWLY HIRED OR REHIRED EMPLOYEE INFORMATION

Employee Name:		
Employee Address:		
City:	State	Zip
SSN :	Date of Birth:	Date of Remuneration (Date of Hire):

Employee Name:		
Employee Address:		
City:	State	Zip
SSN :	Date of Birth:	Date of Remuneration (Date of Hire):

www.scnewhire.com

Mail completed form to: South Carolina Department of Social Services, Integrated Child Support Services Division, Attn: New Hire Reporting Program, PO Box 1469, Columbia, SC 29202-1469. **You may fax completed form to: (803) 898-9100. Phone: (803) 898-9235 or 1-888-454-5294**

4.25 Appearance and Dress

Regardless of his or her position, each Hope employee is expected to maintain a neat and clean appearance. Extreme fashions are not considered appropriate business attire.

Dress, grooming, and personal cleanliness standards contribute to the morale of all employees and affect the business image Hope presents to clients and visitors.

During business hours or when representing Hope, you are expected to present a clean, neat, and tasteful appearance. You should dress and groom yourself according to the requirements of your position and accepted social standards. This is particularly true if your job involves dealing with clients or visitors in person.

If your supervisor feels your personal appearance violates these guidelines, you may be asked to leave the workplace until you are properly dressed or groomed. The time used for dress change must be PTO or leave without pay. Consult your supervisor if you have questions as to what constitutes appropriate appearance. When necessary, reasonable accommodations may be made for persons with a disability.

The following attire is considered inappropriate and cannot be worn by any Hope employee:

- Tube or halter tops
- T-shirts displaying advertising or writing other than HopeHealth or HopeHealth sponsored events
- Cotton / Fleece pants and jogging suits, shorts, tank tops or recreational attire
- Clothing with spaghetti straps; clothing revealing bare backs, midriffs or shoulders; or any revealing or provocative clothing
- Plain or pocket t-shirts
- Athletic wear
- Any clothing that reveals undergarments, i.e. low-rise pants that reveal underwear
- Spandex or Lycra
- Deck shoes or flip flops
- Beach wear
- Off-the shoulder tops
- Workout clothes
- Jeggings
- Leggings
- Jeans

HopeHealth's dress code includes guidelines for business attire, casual attire, and uniformed attire. It is management's intent that work attire should complement an environment that reflects an efficient, orderly, and professionally operated organization. This policy is intended to define appropriate 'business attire," 'casual attire' and 'uniformed attire" during normal business operations and for field /outreach work.

Appropriate Business Attire

Appropriate business attire for employees includes the following:

- Blazers, suits, or sport coats
- Dress slacks
- Ties
- Dress shirts with buttons and collars
- Dress shoes
- Sport coats or blazers
- Slacks, chinos, or Dockers
- Polo shirts with collars
- Oxford button-down shirts
- Sweaters and cardigans
- Loafers
- Dresses
- Skirts
- Blouses

Appropriate Casual Attire:

Casual attire for employees includes the following:

- Chinos, khaki's, cargo pants
- Polo shirts with collars
- Oxford button-down shirts
- Sweaters and cardigans
- Loafers
- Slacks
- Capri pants

Employees may have different dress requirements depending on department and position.

Non Clinical Staff:
All Non-Clinical staff will adhere to the business or casual attire guidelines.

Clinical Staff:

All clinical staff is expected to wear uniformed scrubs in the approved colors and brands. The embroidered HopeHealth logo on scrubs is optional. Should an employee decided to add the logo, HopeHealth will cover the cost of monogramming. The color of the embroidery is explained below. Solid-color long sleeve shirts in the approved colors may be worn under uniforms. Employees are not allowed to wear open-toed shoes in the clinic. Jewelry should not be functionally restrictive, dangerous to job performance, or excessive. Dangling jewelry is not allowed. Perfume, cologne, and aftershave lotion should be used moderately or avoided altogether, as some individuals may be sensitive to strong fragrances.

Approved brands and colors include:

Cherokee
* White (two-color logo)
* Navy (white logo)
* Gray (white logo)
* Mali-Blu (white logo)

Grey's Anatomy
* White (two-color logo)
* Indigo (white logo)
* Nickel (white logo)

Landau
* White (two-color logo)
* Navy (white logo)
* Steel (white logo)

Urbane
* White (two-color logo)
* Navy (white logo)
* Steel (white logo)

WonderWink
* White (two-color logo)
* Navy (white logo)
* Pewter (white logo)
* Malibu Blue (white logo)

Providers:

Will be permitted to wear uniformed scrubs in the approved colors/brands or business attire with the optional white lab coats. Medical providers will be allowed two lab coats with the HopeHealth's logo upon hire and two every year thereafter.

Prevention, Outreach & Case Management:

These staff members may choose to wear uniformed shirts or business attire. Staff performing field work or outreach activities is required to wear polo styled shirts and khaki pants. Foot wear must be closed toe with rubber bottoms.

Enforcement

Department managers and supervisors are responsible for monitoring and enforcing this policy. The policy will be administered according to the following action steps:

1. If questionable attire is worn in the office, the respective department supervisor / manager will hold a personal, private discussion with the employee to advise and counsel the employee regarding the inappropriateness of the attire.

2. If an obvious violation occurs, the department supervisor / manager will hold a private discussion with the employee and ask the employee to go home and change his/her attire immediately. Employees sent home to change will be required to take annual leave or leave without pay for this time.

3. Repeated policy violations will result in disciplinary action, up to and including termination.