HR Alliance West & HR Alliance West I
DBA: HR Alliance

1029 J Street, Suite 480 ● Sacramento, CA 95814
Tel: 833-331-8112, Ext. 802 ● Fax: 833-882-5100

Application Packet

1. **Application for Employment:**
   Complete all required fields and sign and date.

2. **Employee Information Sheet:**
   Employer completes **Payroll Information** section. Employee completes and signs the rest of the form.

3. **Direct Deposit Form**:
   HR Alliance requires all employees to set up direct deposit with their bank account. If you do not have a bank account, we can set you up with a pay card which your paycheck can be deposited to. Complete all required information and attach a void check.

4. **Driver's License:**
   Copy of valid Driver's License or State ID is required.

5. **Social Security Card:**
   Copy required.

6. **1-9 Employment Eligibility Verification:**
   Employee needs to complete, sign and date *Section 1*.
   Employer needs to complete, sign and date *section 2*.

7. **W-4 IRS:**
   Completing this form allows HR Alliance to withhold the correct Federal income tax.

8. **DE-4 CA:**
   Completing this form allows HR Alliance to withhold the correct California income tax.

9. **Transportation Services Form:**
   Complete form to verify that you qualify to provide transportation. If using your own vehicle, you must provide copies of valid auto registration and auto insurance.

10. **Notification and Auth. to Release Info. for Employment Purposes:** Complete all fields and sign and date.

11. **Employment Agreement:**
    This form is an agreement between Employee and Employer. Employee completes and sign's **Employee Responsibilities** section. Employer completes and sign's **Employer Responsibilities** section.

12. **Medi-Cal Provider Agreement:**
    This form is an agreement between the employee and the Alta Regional Center. The employee and Coordinator must both sign and date this form.

When you have completed the application and copies of required documents, mail to HR Alliance. Once your application has been received, it may take up to **5 business days** to complete and process your paperwork. When everything has been processed, we will notify the consumer whether or not you are authorized to work.

Mandatory Certification and Requirements

- CPR and First Aid Certification (Mandatory)

  - As with all California regional centers, Alta California Regional Center (ACRC) requires that individuals providing CLS and Respite care have valid and up-to-date certification in CPR and First Aid. This certification must be from a recognized organization, such as the American Red Cross or the American Heart Association.

- Live Scan Background Check (Mandatory)

  - ACRC mandates that all direct service providers must pass a criminal background check through the Live Scan system. This ensures that individuals providing services to vulnerable populations, such as those with developmental disabilities, have been cleared of any disqualifying criminal history. The fingerprinting process is required by the Department of Developmental Services (DDS).

- FMS Approval (Mandatory for SDP)

  - All individuals providing CLS and Respite services under the Self-Determination Program through ACRC must work with an FMS provider. The FMS is responsible for ensuring that care providers meet the necessary requirements and for managing payroll, taxes, and other administrative tasks.

  - The provider must be approved by the FMS, which may require additional documentation or proof of training, depending on the FMS provider.

- HIPAA Compliance (Mandatory)

  - Providers must also comply with HIPAA (Health Insurance Portability and Accountability Act) regulations, which protect the privacy and security of individuals' health information. Though this is not always a certification, understanding HIPAA and confidentiality rules is essential for anyone providing services to SDP recipients.

Recommended or Specific Trainings

- Specific Direct Service Training (As Required by IPP)

  - While there is no formal certification program specific to SDP providers, Alta California Regional Center often requires certain training for care providers, especially if the individual receiving services has specific needs. For instance:

  Behavioral Training: If the recipient has behavioral challenges, the provider may need training on managing challenging behaviors or specific behavioral intervention techniques.

  Medical or Health-Related Training: Providers may need to complete training related to any specific medical conditions (e.g., managing diabetes, medication administration, or seizure protocols).

- Person-Centered Training (Recommended)

  -ACRC strongly emphasizes person-centered practices, which means that the services provided should be focused on the needs, preferences, and goals of the individual receiving care. While this training is not always formalized, ACRC may recommend that providers undergo person-centered planning training to ensure that they can effectively support the individual in achieving their personal goals.

- Additional Information:

  - Alta California Regional Center may have more specific requirements for particular services or cases, which can be discussed with the service coordinator or during the initial planning process.

  - The FMS provider will often assist in guiding the individual through these requirements and ensure compliance.

You must complete all required Training and submit copies of the Certifications within the allowed period from the date of hire. Completed application and copies of certifications can be faxed to:

Fax: 833-882-5100

Original application must be mailed to:

HR Alliance

Attn: FMS Department
1029 J Street, Suite 480, Sacramento, CA 95814

APPLICATION FOR EMPLOYMENT

Consumer/Employer Name: _____

I: Personal Information

_____

Last Name First Name Middle Name

_____

Address Apartment/Unit #

_____

City State Zip Code

_____ _____

Date of Birth Social Security Number

_____ _____

Telephone Number Email Address

Have you used another name for employment or any other purpose? ☐ Yes ☐ No

If you answered Yes, please provide specifics: _____

_____

_____

II: Education

	School Name/Address	Years Attended	Degree/Certification
High School			
College			
Technical School			
Other Training/Certification			

III: References (Excludes Relatives)

Name	Relationship	Years Known	Phone Number

IV: Employment History
Include ALL employment for the past 5 Years beginning with the most recent. If you need more space, please attach a separate sheet.

Employer Name Dates Employed

Employer Address City State Zip Code

Manager/Supervisor Name Telephone Number

Position/Responsibilities

Reason for Leaving

Employer Name Dates Employed

Employer Address City State Zip Code

Manager/Supervisor Name Telephone Number

Position/Responsibilities

Reason for Leaving

Authorization

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that if employed, falsified statements and/or deliberate omissions of relevant facts on this application shall be grounds for dismissal.

I authorize the investigation of all statements contained herein as may be necessary in arriving at an employment decision. I further authorize the references and employers listed above lo give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, as may be reasonably and legally requested by you.

Signature of Applicant/Provider **Date**

HR Alliance
Education Verification Form

Name:
Social Security Number:
Date of Birth:

Please list the High School, College, or University from which you received highest level of education.

Name of School	Office of the Registrar Address	Credits Earned	Degree Obtained/ Degree to be Obtained

Release of Education Information Consent Form

I hereby authorize HR Alliance to contact the institution listed on my application for employment or Curriculum Vitae to verify attendance and degree status.

Name: _____ Date: _____

Signature: _____

****** APPLICANT, PLEASE DO NOT WRITE BELOW THIS LINE ******

To be completed by the University or College

Please check one of the following boxes:

	I certify that the above information is correct.
	The following information is incorrect. (Please note the correct information)
	The following student was not a student at our school.

Name: _____ Date: _____

Signature: _____

Notes:

Please fax the completed form to Attention: HR Department at 833-882-5100

Job Description

Date	
Provider/Employee Name	
Consumer/Employer Name	
Position/Title	**Community Living Support/Respite Care**

Position Summary

Provides Community Living Support and/or Respite Services under the direction of a client and/or authorized guardian or representative.

Standard Requirements

1. Must be at least 18 years of age at the time of hire.
2. Must obtain a criminal records clearance from Community Mental Health Agency
3. Has completed training required by Community Mental Health
4. Understands HIPAA and Recipient Rights
5. Is knowledgeable of the individualized service plan for the client (IPOS) and provides support to the client according to the service plan.

Essential Functions

Provide skill development related to activities of daily living by assisting, reminding, observing, guiding, or training the beneficiary with:

- Meal Preparation
- Laundry
- Activities of daily living such as bathing, eating, dressing, personal hygiene and etc.
- Routine household care and maintenance
- Shopping for food and other necessities of daily living
- Skill developmental to achieve or maintain mobility, sensory-motor, communication, and socialization.

***Performs other related duties and responsibilities as deemed necessary.**

_____ _____

Provider/Employee Signature **Date**

Employee Information Sheet

Consumer/Employer: _____

Check One

☐ New Hire ☐ Rehire ☐ Other Change: _____

Hire Date: _____ Payroll Start Date: _____

Employee Information

Provider/Employee Name: _____

Social Security Number: _____ Date of Birth: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Mailing Address *(If different)*: _____

_____

City: _____ State: _____ Zip: _____

Telephone No.: _____

Email: _____

Payroll Information

Position Description/Job Title:_____

Will the Provider/Employee Receive: ☐ CLS Hours ☐ Respite Hours ☐ Other: _____

Base Rate per Hour $ _____

☐ Other Compensation: Dollar Amount/Description: _____

Will the Provider/Employee Require Training: ☐ Yes ☐ No

Required Training: ☐ CPR ☐ First Aid ☐ Emergency Preparedness ☐ Bloodborne Pathogens ☐ Recipient Rights ☐ Other: _____

Direct Deposit: ☐ Yes *(If Yes, Employee must complete a Direct Deposit Form)* ☐ No

Tax Information

Federal: ☐ Single ☐ Married No. of Exemptions: _____ Extra Income Tax Withheld: $ _____

State: ☐ Single ☐ Married No. of Exemptions: _____ Extra Income Tax Withheld: $ _____

(Employee MUST complete CURRENT year IRS Form W-4)

As the individual receiving services, or the authorized representative of the individual, I certify that the foregoing information is true, accurate and complete.

_____ _____

Provider/Employee Signature **Date**

Direct Deposit Form

1. Complete the Employee Information section. 2. Complete the Bank Information section. 3. Sign the Form and Return to your HR Office. 4. Keep a copy for your Records. 5. If any of this Information changes, complete a New DD Form	ATTACH: A VOIDED Check or Bank Specification Sheet or Bank Letter

Employee Information

Name: _____

Social Security Number: _____

Please deposit my wages/salary into the following bank account(s):

Bank Information 1

Checking 1:	**Savings 1:**
Bank Name: _____	Bank Name: _____
Account. No: _____	Account. No: _____
Routing No.: _____	Routing No.: _____
Account Allocation:	Account Allocation:
☐ Entire Paycheck or	☐ Entire Paycheck or
☐ _____ % of Net or	☐ _____ % of Net or
☐ Dollar Amount: $ _____.00	☐ Dollar Amount: $ _____.00

Bank Information 2

Checking 2:	**Savings 2:**
Bank Name: _____	Bank Name: _____
Account. No: _____	Account. No: _____
Routing No.: _____	Routing No.: _____
Account Allocation:	Account Allocation:
☐ Entire Paycheck or	☐ Entire Paycheck or
☐ _____ % of Net or	☐ _____ % of Net or
☐ Dollar Amount: $ _____.00	☐ Dollar Amount: $ _____.00

By signing this form, I agree to and accept the following:

I authorize HR Alliance (HRA) each pay period for which I receive a payroll check to initiate automatic deposits for credit to my account at the financial institution (Bank) indicated above. In addition, I authorize the Bank to accept and credit to my account any deposits initiated by HRA. In the event HRA deposits funds in error into my account, I authorize HRA to debit my account for an amount for an amount not to exceed the amount of the erroneous credit.

This authorization will remain in effect until revoked by me, in written form, in a time and manner as to afford HRA a reasonable opportunity to act on it. This authorization bears my signature as is dated.

_____ _____

Provider/Employee Signature **Date**

Transportation Service

Does Not Provide Transportation

☐ I do not require to provide transportation services for the client.

_____ _____

Provider/Employee Signature **Date**

Does Provide Transportation

Please check box that applies to you:

☐ I am authorized to provide transportation services to the client and the client will provide the vehicle for my use when I am providing care for the client.

☐ I am authorized to provide transportation services to the client and will be using my own vehicle to use while I am providing care for the client.

All employees who provide transportation as a part of their job function or assigned task must complete this form and have the following qualifications:

☐ I have a valid California Driver's License.

☐ I am at least 18 years of age.

☐ I am free of physical and/or mental impairment that would adversely affect my driving

☐ I have no Driving Under the Influence (DUI) convictions or chargeable (at fault) accidents within the previous two years.

☐ I have valid auto insurance policy and vehicle registration.

I attest that I meet each of these qualification in order to complete my driving requirements.

_____ _____

Provider/Employee Signature **Date**

Please provide copies of the following with this form:

- Valid California Driver's License (front and back)
- Valid Car Insurance Policy
- Valid Vehicle Registration

These documents are necessary in order to verify that the employee is qualified to perform transportation services. Without these documents, the employee cannot provide transportation.

MVR
Motor Vehicle Record

AUTHORIZATION FOR RELEASE OF INFORMATION FOR EMPLOYMENT SCREENING

Driver Record Screening Disclosure
I hereby authorize HR Alliance and its designated representatives to conduct a comprehensive review of my driver record background through a consumer report and/or an investigative consumer report to be generated for employment, promotion, reassignment, or retention as an employee. I understand that the scope of the consumer report/investigative consumer report may include information about my names, motor vehicle records, license verification. Upon request, HR Alliance will supply a copy of the completed consumer report along with a copy of an individual's rights under the Fair Credit Reporting Act.

Authorization and Release
I hereby authorize the complete release of these records or data pertaining to me which an individual, company, firm, corporation, or public agency may have. I authorize the full release of the information described above, without any reservation, throughout any duration of my employment at HR Alliance. I certify that all information provided below is correct to the best of my knowledge. This authorization and consent shall be valid in original, fax, or copy form. The following information is required by law enforcement agencies and other entities for identification purposes when checking records. It is confidential and will not be used for any other purpose.

Complete Legal Name:

First Name Middle Name Last Name Suffix

Date of Birth: _____
Month / Day / Full Year

Driver's License Number: _____

State of Issue: _____ Expiration Date: _____

_____ _____
Provider/Employee Signature **Date**

Notification and Authorization to Release Information for Employment Purposes

Notification:
The position for which I am being considered requires me to consent to a Background Check as a condition of employment. Such Background Check may include , nut may not be limited to: (1) consumer credit history, (2) criminal history, (3) fingerprint (State and Federal) records, (4) driving record, (5) employment history, (6) military history, (7) education references, and (8) general public records in order to provide information concerning my character, general reputation and mode of living. The Criminal History Check searches for felony and misdemeanor convictions at the county and federal levels of every jurisdiction where I currently reside or where I have resided during the past seven (7) years and searches the sex offender registry at the county and federal levels in every jurisdiction where I currently reside or where I have resided.

Authorization:
I hereby authorize HR Alliance to conduct the Background Check described above. In connection with this, I also authorize the use of law enforcement agencies and/or private background check organizations to assist HR Alliance in collecting this information. I am also aware that records of arrests on pending charges and/or convictions are not an absolute bar to employment. Such information will be used to determine whether the results of the Background Check bear on my trustworthiness or my ability to perform the duties of my position in a manner which is safe for HR Alliance clients, employees, and other community members. I hereby authorize my former employers, educational institutions and any individuals so named to furnish all information pertaining to my employment and/or educational record. I also release my former employers, supervisors, workers, and references from any and all liability that may arise from furnishing information to HR Alliance or its duty authorized agents.

Please Print (for clarity and identification purposes)

Complete Legal Name: _____
First Middle Last

Other Names/Aliases (Used for Any Purpose): _____
(List all other names used in the past seven (7) years. If you need additional space, attach a separate sheet.)

Current Address: _____

Other Addresses: _____
(List all other addresses used in the past seven (7) years. If you need additional space, attach a separate sheet.)

Social Security Number: _____ Date of Birth: _____
Month / Day / Full Year

Driver's License Number: _____ State of Issue: _____
(If you do not have a Driver's License, List your State-Issued Identification Card.)

Gender: Male _____ Female _____ Phone Number: _____

Acknowledgement
To the best of my knowledge, the information provided in this Notice and Authorization and any attachments there is true and complete. I understand that the any falsification or omission of information may disqualify me for this position and/or may serve as grounds for severance of my employment with HR Alliance and any of its affiliated companies. Should I wish to obtain a copy of any report that derives from this Background Check(s), such report(s) will be provided to me within three (3) days upon written request to HR Alliance. In addition to those rights, I understand that I have a right to appeal and adverse employment decision made by HR Alliance on my Background Check information within five (5) business days upon written request of such appeal.

By signing below, I hereby provide my authorization to HR Alliance to conduct a Background Check.

_____ _____
Provider/Employee Signature **Date**

FOR OFFICE USE ONLY:

Background Check Completed By: _____

Date: _____

Authorization to Disclose Employee Information and Release of Liability

CMH Agency Name: _____

I, _____, authorize Alliance HR Alliance and CMH Office of Recipient Rights
(Provider/Employee Print Full Name)
to disclose to the Provider/Consumer listed below all information in possession of CMH regarding any violation of recipients' rights committed by me.

I, _____, authorize Alliance HR Alliance and CMH, its Officers, its Agents, and
(Provider/Employee Print Full Name)
its employees from and all liability claims, suites and actions of any nature brought against _____
(CMH/Agency Name)
and the CMH Office of Recipient Rights, its officers its agents and its employees, etc. for disclosing information requested by/about me and I shall indemnify and hold harmless should any claim, suits or actions be filed against them.

Previous place of Employment:

1. Agency Name: _____

   Address: _____

   City: _____ State: _____ County: _____ Zip:_____

   Dates of Employment: _____ to _____
2. Agency Name: _____

   Address: _____

   City: _____ State: _____ County: _____ Zip:_____

   Dates of Employment: _____ to _____
3. Agency Name: _____

   Address: _____

   City: _____ State: _____ County: _____ Zip:_____

   Dates of Employment: _____ to _____

_____ _____
Provider/Employee Signature **Date**

_____ _____
Consumer/Employer or Witness Signature & Title **Date**

Please Return via Mail or Fax to:
HR Alliance
1029 J Street, Suite 480,
Sacramento, CA 95814
FAX: 833-882-5100

EMPLOYMENT AGREEMENT

This agreement is made on _____ (Date) between _____

("Consumer/Employer") and _____ ("Provider/Employee") to describe the supports that hat

employee will provide to the employer and the terms and conditions of employment.

Article I
EMPLOYEE RESPONSIBILITIES

I, _____ (Provider/Employee) acknowledge and agree that the employment conditioned on my employer's participation in the Choice Voucher System administered by the Alta Regional Center. If my employer ends participation in the Choice Voucher System, my employment may end. I agree to the following terms of employment:

1. During the term of this Agreement, I shall provide support to my employer by performing the duties outlined in this agreement and any attachments to it.

2. I agree to assist my employer in maintaining the documentation and records required by my employer or the Alta Regional Center. I agree to complete all necessary paperwork to secure mandatory payroll deductions from my pay day. All records I may have or assist in maintaining are the property of my employer. I will keep these records confidential, release them only with the consent of my employer, and return them to my employer if my employment ends. In addition, I will complete illness and incident reports, when necessary, as required or requested by the Alta Regional Center or my employer.

3. In the event pf a medical emergency I agree to notify my employer's contact person and to provide immediate medical attention. I will also notify my employer's contact person before taking my employer to the physician, except in case of an emergency.

4. I agree to participate in any meetings if requested to do so by my employer.

5. I agree to abide by all my employer's rules and Alta Regional Center regulations (described below) regarding my employment duties to the employer through the Choice Voucher System, and I acknowledge receipt of the following rules and regulations:

a. Attachment A to this Agreement which outlines the supports that I will provide to my employer.
b. Recipient Rights Booklet. I agree to assist my employer in filing right complaints upon request. I also understand that I have a responsibility to report rights violations of which I am aware or any potential abusive or neglectful situations I observe, I understand that I may be requested to cooperate with a recipient rights investigation and/ or assist my employer with exercising his or her rights.
c. Employers House Rules. Employer will give any additional rules.
d. Additional information and procedures for the Choice Voucher System issues by the Alta Regional Center.
e. Reporting and documentation requirements for verifying hours worked.

6. I understand that this is an employment at will relationship, which can be terminated by me or by my employer at any time. However, my employer cannot terminate my employment on the basis of my race, religion, sex, disability, or other protected status under federal or California law. In addition, I agree to give _____ days written notice to my employer if I terminate my employment.

7. I understand and acknowledge that my employer is my sole employer and that I am not an employee of the Alta Regional Center, which authorizes the supports I provide, or the Financial Management Service (FMS), which is the financial administrator of Choice Voucher System funds used to pay me.

8. I agree not to sue the Financial Management Service (FMS) for its role as the financial administrator of my employer's Choice Voucher System funds and the Alta Regional Center for its role in administering the Choice Voucher System.

9. I agree to the following compensation for the services I shall perform: $ _____/hour.

Benefits: (If any) _____

10. I agree to execute a Medi-Cal Provider Agreement with the Alta Regional Center and acknowledge that this agreement does not alter the fact that the Alta Regional Center is only the project administrator of the Choice Voucher System, and that my employer is _____ (Consumer/Employer Name). I understand that my employment is contingent on completing this agreement.

Article II
EMPLOYER RESPONSIBILITIES

I, _____ (Consumer/Employer) agree to the following:

1. I will provide my Financial Management Service (FMS) with the necessary documentation to assure timely compensation of my employee.

2. I will compensate my employee in the following manner: $ _____/hour.
Benefits will include:
_____ Payroll will be managed by my Financial Management Service (FMS) HR Alliance Care, which will withhold all necessary tax, unemployment, and other withholdings from the employee's paychecks.
3. I will assure my employee receives appropriate training.

4. I will evaluate the performance of my employees and provide appropriate feedback on an annual basis to assure that I am receiving quality supports.
5. I will assure that my employee executes as Medi-Cal Provider Agreement with Alta Regional Center.

_____ _____
Provider/Employee Signature **Date**

_____ _____
Consumer/Employer Signature **Date**

HIPAA Compliance Agreement by Employee

Provider/Employee Printed Name: _____ Date: _____

The following information relates to confidentiality and HIPAA Compliance. Please read this document, you will be required to comply with the standards listed in this document.

1. Employee may use and disclose protected health information created or received by the Employee on behalf of HR Alliance if necessary for the proper management and administration of Employee or to fulfill Employee legal responsibilities, provided that any disclosure is:

    a. Required by law, or
    b. Employee obtains reasonable assurances from the person to whom the protected health information is disclosed that:

        I: The protected health information will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person; and
        II: Employee will be notified of any instances of which the person is aware in which the confidentiality of the information is breached.

2. Employee hereby agrees to maintain the security and privacy of all protected health information in a manner consistent with State of California and Federal Laws and Regulations, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Regulations there under, and all other applicable law.

3. Employee further agrees not to use or disclose protected health information except as expressly permitted by this AGREEMENT or applicable law.

4. Employee agrees to use appropriate safeguards to prevent use or disclosure of protected health information not permitted by this AGREEMENT or applicable law. All electronic storage of PHI will be kept in password protected and/encrypted formats. Use of portable media storage to store PHI is prohibited.

5. Employee agrees to report to HR Alliance any unauthorized use or disclosure of protected health information by Employee.

6. Upon termination of employment, Employee shall return or destroy all protected health information received from HR Alliance or created or received by Employee on behalf of HR Alliance and that Employee maintains in any form and shall retain no copies of such information.

7. Employee shall, to the fullest extent permitted by law, protect, defend, indemnify and hold harmless HR Alliance and his/her respective employees, directors, and agents (Indemnities) from and against any and all losses, costs, claims, penalties, fines, demands, liabilities, legal actions, judgements, and expenses of every kind (including reasonable attorney fees, including at trial and on appeal) asserted or imposed against any indemnities arising out of the acts or omissions of Employee or any subcontractor of or consultant of Employee or any of Employee employees, directors, or agents related to the performance or nonperformance of this Agreement.

By signing this document, I indicate that I understand the confidentiality and HIPAA standards stated above and I agree to follow the procedures stated above. I attest that I have also been trained in HIPAA (or will participate in the appropriate HIPAA training within the required time frame.

_____ _____

Provider/Employee Signature **Date**

_____ _____

HR Alliance Representative **Date**

MEDI-CAL PROVIDER AGREEMENT

This agreement is made on (Date)_____ between (Agency/CMH Name)_____

Alta Regional Center and (Provider/Employee Name)_____ Employee/Medi-Cal Provider. The purpose of this agreement is to define the roles and responsibilities of the above-named parties. This agreement shall remain in effect until such time it must be terminated or modified. Any party can initiate a termination or modification by providing written notice to the other of the desire to terminate or modify this agreement.

Upon receipt of this agreement, the Alta Regional Center will certify the Medi-Cal Provider as available to provide services to individuals who receive services and/or supports in accordance with their individual plans of services and supports developed in a person-centered planning process, authorized by the Alta Regional Center or one of its subcontractors, and financed through California's Medi-Cal Specialty Pre-paid Mental Health Plan.

The Medi-Cal Provider stipulates that it agrees to the following:

1. To keep any records required by the participant or the Alta Regional Center regarding the services provided to participants and to provide such information and any related invoices or billings, upon request, to the participant, Alta Regional Center, the state Medi-Cal Agency, the Secretary of the Department of Health and Human Services or the state Medi-Cal fraud control unit.

2. To comply with the ownership disclosure requirements specified in 42 CFR 455, subpart B, as applicable.
3 To comply with intent of the advance directive requirements specified in 42 CFR 489, Subpart I and 42 CFR 417.436 (d), as applicable, by finding out if a participant has an advance directive to refuse life sustaining medical treatment, and informing the participant, before the provider starts work, whether or not the provider will carry out that advance directive so the participant can make an informed choice during the hiring process.

Both parties expressly acknowledge that the sole purpose of this agreement is to assure compliance with 42 USC 1902 (a) 27. Further, both parties recognize and reaffirm that the Alta Regional Center is not the employer of the Medi-Cal Provider, and that the participant is the sole employer of the Medi-Cal Provider.

This agreement sets forth the entire understanding between the parties with respect to the subject matters, and supersedes any and all other arrangements, either oral or in writing between the parties pertaining to these matters. No change or modification of the terms of this agreement is valid unless it is in writing and signed by the parties.

_____ _____

Executive Director or Self-Determination Coordinator **Date**

_____ _____

Provider/Employee **Date**

Zero Drug Tolerance Policy for FMS Providers

Purpose: The purpose of this policy is to ensure a safe, professional, and effective service environment for all participants and providers within the California Self-Determination Program. The use of illegal drugs and the misuse of prescription drugs can impair judgment, performance, and safety, which is incompatible with our commitment to providing high-quality services.

Scope: This policy applies to all Financial Management Services (FMS) providers, including employees, contractors, and volunteers, who are part of the California Self-Determination Program.

Policy:

1. **Prohibited Conduct:**
    - The use, possession, sale, distribution, or manufacture of illegal drugs, drug paraphernalia on any premises where services are provided or while performing any duties related to the program is strictly prohibited.
    - Providers are prohibited from being under the influence of illegal drugs or misused prescription drugs during work hours or while on any premises where services are provided.
    - The misuse of prescription drugs, including taking medication not prescribed to the individual or in a manner inconsistent with the prescription, is prohibited.
2. **Prescription Medication:**
    - Providers must inform their supervisor if they are taking prescription medication that may impair their ability to perform their duties safely and effectively.
    - The program may require a medical evaluation to determine if it is safe for the provider to continue working while taking the medication.
3. **Drug Testing:**
    - The program reserves the right to conduct drug testing under the following circumstances:
        - Pre-employment screening
        - Random testing
        - Post-incident testing
        - Reasonable suspicion testing
    - Providers who refuse to submit to a drug test or test positive for illegal drugs or misused prescription drugs will be subject to disciplinary action, up to and including termination of their contract or employment.
4. **Disciplinary Action:**
    - Any provider found to be in violation of this policy will face disciplinary action, which may include suspension, mandatory participation in a drug rehabilitation program, or termination of their contract or employment.

- The severity of the disciplinary action will depend on the nature of the violation and the provider's work history.

5. **Confidentiality:**
   - All information related to drug testing and the results will be kept confidential and shared only with individuals who have a legitimate need to know.
6. **Support and Rehabilitation:**
   - The program encourages providers with drug-related problems to seek help voluntarily before they are subject to disciplinary action.
   - Providers may be eligible for leave to participate in a rehabilitation program, subject to the program's leave policies and applicable laws.

Acknowledgment: All providers are required to sign an acknowledgment form confirming that they have read, understood, and agree to comply with this Zero Drug Tolerance Policy.

Provider Acknowledgment Form

I, _____, have read and understand the Zero Drug Tolerance Policy for FMS Providers. I agree to comply with the policy and understand that any violation may result in disciplinary action, up to and including termination of my contract or employment.

Provider Signature: _____ Date: _____

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

Physical Address Required (No P.O. Box)

(a) First name and middle initial | Last name | **(b) Social security number**

Address

City or town, state, and ZIP code

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*.

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

If applicable -->

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

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

Step 3: Claim Dependent and Other Credits

Required field even if "0".

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

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

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

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

Step 4 (optional): Other Adjustments

Optional. Please refer to the instructions.

(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)** $

If filing exempt, leave Steps 2, 3 & 4 blank. Write EXEMPT here --->

Step 5: Sign Here

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

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

Employers Only

Employer Name Here

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

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2024 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2025.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Expect to work only part of the year;

2. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

3. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

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

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

Instead, if you (and your spouse) have a total of only two jobs, you may check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2024 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . **2b** $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3**

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . **4** $

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2024 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $29,200 if you're married filing jointly or a qualifying surviving spouse
- $21,900 if you're head of household
- $14,600 if you're single or married filing separately

. . . . . **2** $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . **3** $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . **4** $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . **5** $

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 with no other entries on the form; 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 territories 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.

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$780	$850	$940	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,370
$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$240	$870	$1,020	$1,020	$1,020	$1,540	$1,870	$1,870	$1,870	$1,870	$1,910	$2,040
$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$510	$850	$1,020	$1,020	$1,020	$1,020	$1,220	$1,870	$1,870	$1,870	$1,960
$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230

Employment Development Department
State of California

Clear Form

Employee's Withholding Allowance Certificate

Complete this form so that your employer can withhold the correct California state income tax from your paycheck.

Enter Personal Information	
First, Middle, Last Name	Social Security Number
Address City State ZIP Code	Filing Status ☐ Single or Married (with two or more incomes) ☐ Married (one income) ☐ Head of Household

1. Use Worksheet A for Regular Withholding allowances. Use other worksheets on the following pages as applicable.
   - 1a. Number of Regular Withholding Allowances (**Worksheet A**)
   - 1b. Number of allowances from the Estimated Deductions (**Worksheet B**, if applicable.)
   - 1c. Total Number of Allowances you are claiming 0
2. Additional amount, if any, you want withheld each pay period (if employer agrees), **(Worksheet C)**

   OR

Exemption from Withholding

3. I claim exemption from withholding for 2024, and I certify I meet both of the conditions for exemption. (Check box here) ☐

   OR
4. I certify under penalty of perjury that I am **not subject** to California withholding. I meet the conditions set forth under the Service Member Civil Relief Act, as amended by the Military Spouses Residency Relief Act and the Veterans Benefits and Transition Act of 2018. (Check box here) ☐

Under the penalties of perjury, I certify that the number of withholding allowances claimed on this certificate does not exceed the number to which I am entitled or, if claiming exemption from withholding, that I am entitled to claim the exempt status.

Employee's Signature _____ Date _____

Employer's Section: Employer's Name and Address	California Employer Payroll Tax Account Number

Purpose: The *Employee's Withholding Allowance Certificate* (DE 4) is for **California Personal Income Tax (PIT)** withholding purposes only. The DE 4 is used to compute the amount of taxes to be withheld from your wages, by your employer, to accurately reflect your state tax withholding obligation.

Beginning January 1, 2020, *Employee's Withholding Allowance Certificate* (Form W-4) from the Internal Revenue Service (IRS) will be used for federal income tax withholding **only.** You must file the state form DE 4 to determine the appropriate California PIT withholding.

If you do not provide your employer with a DE 4, the employer must use Single with Zero withholding allowance.

Check Your Withholding: After your DE 4 takes effect, compare the state income tax withheld with your estimated total annual tax. For state withholding, use the worksheets on this form.

Exemption From Withholding: If you wish to claim exempt, complete the federal Form W-4 and the state DE 4. You may claim exempt from withholding California income tax if you meet both of the following conditions for exemption:

1. You did not owe any federal/state income tax last year, and
2. You do not expect to owe any federal/state income tax this year. The exemption is good for one year.

If you continue to qualify for the exempt filing status, a new DE 4 designating **exempt** must be submitted by February 15 each year to continue your exemption. If you are not having federal/state income tax withheld this year but expect to have a tax liability next year, you are required to give your employer a new DE 4 by December 1.

Member Service Civil Relief Act: Under this act, as provided by the Military Spouses Residency Relief Act and the Veterans Benefits and Transition Act of 2018, you may be exempt from California income tax withholding on your wages if

(i) Your spouse is a member of the armed forces present in California in compliance with military orders;

(ii) You are present in California solely to be with your spouse; and

(iii) You maintain your domicile in another state.

If you claim exemption under **this** act, **check the box on Line 4.** You may be required to provide proof of exemption upon request.

The *California Employer's Guide* (DE 44) (edd.ca.gov/pdf_pub_ctr/de44.pdf) provides the income tax withholding tables. This publication may be found by visiting Payroll Taxes - Forms and Publications (edd.ca.gov/Payroll_Taxes/Forms_and_Publications.htm). To assist you in calculating your tax liability, please visit the Franchise Tax Board (FTB) (ftb.ca.gov).

If you need information on your last *California Resident Income Tax Return* (FTB Form 540), visit the FTB (ftb.ca.gov).

Notification: The burden of proof rests with the employee to show the correct California income tax withholding. Pursuant to section 4340-1(e) of Title 22, California Code of Regulations (CCR) (govt.westlaw.com/calregs/Search/Index), the FTB or the EDD may, by special direction in writing, require an employer to submit a Form W-4 or DE 4 when such forms are necessary for the administration of the withholding tax programs.

Penalty: You may be fined $500 if you file, with no reasonable basis, a DE 4 that results in less tax being withheld than is properly allowable. In addition, criminal penalties apply for willfully supplying false or fraudulent information or failing to supply information requiring an increase in withholding. This is provided by section 13101 of the California Unemployment Insurance Code (leginfo.legislature.ca.gov/faces/codes.xhtml) and section 19176 of the Revenue and Taxation Code (leginfo.legislature.ca.gov/faces/codes.xhtml).

Worksheets

Instructions — 1 — Allowances*

When determining your withholding allowances, you must consider your personal situation:
- — Do you claim allowances for dependents or blindness?
- — Will you itemize your deductions?
- — Do you have more than one income coming into the household?

Two-Earners/Multiple Incomes: When earnings are derived from more than one source, under-withholding may occur. If you have a working spouse or more than one job, it is best to check the box "SINGLE or MARRIED (with two or more incomes)." Figure the total number of allowances you are entitled to claim on all jobs using only one DE 4 form. Claim allowances with **one** employer.

Do **not** claim the same allowances with more than one employer. Your withholding will usually be most accurate when all allowances are claimed on the DE 4 filed for the highest paying job and zero allowances are claimed for the others.

Married But Not Living With Your Spouse: You may check the "Head of Household" marital status box if you meet all of the following tests:
(1) Your spouse will not live with you **at any time** during the year;
(2) You will furnish over half of the cost of maintaining a home for the entire year for yourself and your child or stepchild who qualifies as your dependent; **and**
(3) You will file a separate return for the year.

Head of Household: To qualify, you must be unmarried or legally separated from your spouse and pay more than 50% of the costs of maintaining a home for the **entire** year for yourself and your dependent(s) or other qualifying individuals. Cost of maintaining the home includes such items as rent, property insurance, property taxes, mortgage interest, repairs, utilities, and cost of food. It does not include the individual's personal expenses or any amount which represents value of services performed by a member of the household of the taxpayer.

Worksheet A — **Regular Withholding Allowances**

(A)	Allowance for yourself — enter 1	(A)
(B)	Allowance for your spouse (if not separately claimed by your spouse) — enter 1	(B)
(C)	Allowance for blindness — yourself — enter 1	(C)
(D)	Allowance for blindness — your spouse (if not separately claimed by your spouse) — enter 1	(D)
(E)	Allowance(s) for dependent(s) — do not include yourself or your spouse	(E)
(F)	Total — add lines (A) through (E) above and enter on line 1a of the DE 4	(F)

Instructions — 2 — (Optional) Additional Withholding Allowances

If you expect to itemize deductions on your California income tax return, you can claim additional withholding allowances. Use Worksheet B to determine whether your expected estimated deductions may entitle you to claim **one or more additional** withholding allowances. Use last year's FTB Form 540 as a model to calculate this year's withholding amounts.

Do not include deferred compensation, qualified pension payments, or flexible benefits, etc., that are deducted from your gross pay but are not taxed on this worksheet.

You may reduce the amount of tax withheld from your wages by claiming one additional withholding allowance for each $1,000, or fraction of $1,000, by which you expect your estimated deductions for the year to exceed your allowable standard deduction.

Worksheet B — **Estimated Deductions**

Use this worksheet **only** if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income not subject to withholding.

1.	Enter an estimate of your itemized deductions for California taxes for this tax year as listed in the schedules in the FTB Form 540		1.
2.	Enter $10,726 if married filing joint with two or more allowances, unmarried head of household, or qualifying widow(er) with dependent(s) or $5,363 if single or married filing separately, dual income married, or married with multiple employers	–	2.
3.	Subtract line 2 from line 1, enter difference	=	3.
4.	Enter an estimate of your adjustments to income (alimony payments, IRA deposits)	+	4.
5.	Add line 4 to line 3, enter sum	=	5.
6.	Enter an estimate of your nonwage income (dividends, interest income, alimony receipts)	–	6.
7.	If line 5 is greater than line 6 (if less, see below [go to line 9]); Subtract line 6 from line 5, enter difference	=	7.
8.	Divide the amount on line 7 by $1,000, round any fraction to the nearest whole number enter this number on line 1b of the DE 4. Complete Worksheet C, if needed, otherwise **stop here.**		8.
9.	If line 6 is greater than line 5; Enter amount from line 6 (nonwage income)		9.
10.	Enter amount from line 5 (deductions)		10.
11.	Subtract line 10 from line 9, enter difference. Then, complete Worksheet C.		11.

*Wages paid to registered domestic partners will be treated the same for state income tax purposes as wages paid to spouses for California PIT withholding and PIT wages. This law does not impact federal income tax law. A registered domestic partner means an individual partner in a domestic partner relationship within the meaning of section 297 of the Family Code. For more information, please call our Taxpayer Assistance Center at 1-888-745-3886.

Worksheet C **Additional Tax Withholding and Estimated Tax**

1.	Enter estimate of total wages for tax year 2024.	1.
2.	Enter estimate of nonwage income (line 6 of Worksheet B).	2.
3.	Add line 1 and line 2. Enter sum.	3.
4.	Enter itemized deductions or standard deduction (line 1 or 2 of Worksheet B, whichever is largest).	4.
5.	Enter adjustments to income (line 4 of Worksheet B).	5.
6.	Add line 4 and line 5. Enter sum.	6.
7.	Subtract line 6 from line 3. Enter difference.	7.
8.	Figure your tax liability for the amount on line 7 by using the 2024 tax rate schedules below.	8.
9.	Enter personal exemptions (line F of Worksheet A x $158.40).	9.
10.	Subtract line 9 from line 8. Enter difference.	10.
11.	Enter any tax credits. (See FTB Form 540).	11.
12.	Subtract line 11 from line 10. Enter difference. This is your total tax liability.	12.
13.	Calculate the tax withheld and estimated to be withheld during 2024. Contact your employer to request the amount that will be withheld on your wages based on the marital status and number of withholding allowances you will claim for 2024. Multiply the estimated amount to be withheld by the number of pay periods left in the year. Add the total to the amount already withheld for 2024.	13.
14.	Subtract line 13 from line 12. Enter difference. If this is less than zero, you do not need to have additional taxes withheld.	14.
15.	Divide line 14 by the number of pay periods remaining in the year. Enter this figure on line 2 of the DE 4.	15.

Note: Your employer is not required to withhold the additional amount requested on line 2 of your DE 4. If your employer does not agree to withhold the additional amount, you may increase your withholdings as much as possible by using the "single" status with "zero" allowances. If the amount withheld still results in an underpayment of state income taxes, you may need to file quarterly estimates on Form 540-ES with the FTB to avoid a penalty.

These Tables Are for Calculating Worksheet C and for 2024 Only

Single Persons, Dual Income Married or Married With Multiple Employers

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER		OF AMOUNT OVER...	PLUS
$0	$10,412	1.100%	$0	$0.00
$10,412	$24,684	2.200%	$10,412	$114.53
$24,684	$38,959	4.400%	$24,684	$428.51
$38,959	$54,081	6.600%	$38,959	$1,056.61
$54,081	$68,350	8.800%	$54,081	$2,054.66
$68,350	$349,137	10.230%	$68,350	$3,310.33
$349,137	$418,961	11.330%	$349,137	$32,034.84
$418,961	$698,271	12.430%	$418,961	$39,945.90
$698,271	$1,000,000	13.530%	$698,271	$74,664.13
$1,000,000	and over	14.630%	$1,000,000	$115,488.06

Unmarried/Head of Household

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER		OF AMOUNT OVER...	PLUS
$0	$20,839	1.100%	$0	$0.00
$20,839	$49,371	2.200%	$20,839	$229.23
$49,371	$63,644	4.400%	$49,371	$856.93
$63,644	$78,765	6.600%	$63,644	$1,484.94
$78,765	$93,037	8.800%	$78,765	$2,482.93
$93,037	$474,824	10.230%	$93,037	$3,738.87
$474,824	$569,790	11.330%	$474,824	$42,795.68
$569,790	$949,649	12.430%	$569,790	$53,555.33
$949,649	$1,000,000	13.530%	$949,649	$100,771.80
$1,000,000	and over	14.630%	$1,000,000	$107,584.29

Married Persons

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER		OF AMOUNT OVER...	PLUS
$0	$20,824	1.100%	$0	$0.00
$20,824	$49,368	2.200%	$20,824	$229.06
$49,368	$77,918	4.400%	$49,368	$857.03
$77,918	$108,162	6.600%	$77,918	$2,113.23
$108,162	$136,700	8.800%	$108,162	$4,109.33
$136,700	$698,274	10.230%	$136,700	$6,620.67
$698,274	$837,922	11.330%	$698,274	$64,069.69
$837,922	$1,000,000	12.430%	$837,922	$79,891.81
$1,000,000	$1,396,542	13.530%	$1,000,000	$100,038.11
$1,396,542	and over	14.630%	$1,396,542	$153,690.24

If you need information on your last California Resident Income Tax Return, FTB Form 540, visit (FTB) (ftb.ca.gov).

The DE 4 information is collected for purposes of administering the PIT law and under the authority of Title 22, CCR, section 4340-1, and the California Revenue and Taxation Code, including section 18624. The Information Practices Act of 1977 requires that individuals be notified of how information they provide may be used. Further information is contained in the instructions that came with your last California resident income tax return.

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No.1615-0047
Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)

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

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears 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.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

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		**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		**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. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**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		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**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. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **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 individual's status or parole 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.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		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		
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				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

Supplement A,
Preparer and/or Translator Certification for Section 1

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

Supplement B,
Reverification and Rehire (formerly Section 3)

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

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial
Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.			
Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	
Additional Information (Initial and date each notation.)		☐ Check here if you used an alternative procedure authorized by DHS to examine documents.	

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial
Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.			
Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	
Additional Information (Initial and date each notation.)		☐ Check here if you used an alternative procedure authorized by DHS to examine documents.	

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial
Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.			
Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	
Additional Information (Initial and date each notation.)		☐ Check here if you used an alternative procedure authorized by DHS to examine documents.	