CONTRACTOR REGISTRATION FOLDER CHECKLIST

Complete all items in checklist prior to referral to patients.

1. Independent Contractor files will be maintained according to confidential standards. A signed release will be required for the release of any medical information.
2. Contractor Registration Folders will be maintained and retained for three (3) years following the last file entry of provided service or other patient-related information.
3. Administrator or designee will be responsible for maintenance of files.
4. Medical information and disciplinary actions or patient complaints will be protected in designated secured recorded file.

Date	Document	Initials
	Application for Registration and Resume	
	Social Security Card or Work Permit	
	Copy of Valid License and Certifications	
	Proof of education (Degree, HS Diploma or Transcript)	
	Professional Liability	
	Affidavit of compliance/will inform of arrests	
	Privacy Policy, Level II Background (DCF and AHCA) compliant	
	Current Local Police Report	
	Documented proof of completion of CEU, CPR and BBP	
	Home Health Aides, evidence of completion of a home health aide training course or certification from the Florida Board of Nursing, Department of Health as a certified nursing assistant	
	W-9, I-9 and Direct Deposit documentation	
	Proof of Automobile Registration and Insurance	
	APD Training Course – Zero Tolerance, Direct Care Competencies and HIPPA	
	Good Moral Affidavit	
	Records of complaints and actions taken by the Home Health Agency	

This document and the information included will be used in accordance pursuant to Florida Statues, Chapter 400, F.S.

CNA/HOME HEALTH AIDE ACKNOWLEDGEMENT OF RECEIPT OF MATERIALS

I acknowledge that I received the following materials prior to assignment for provision of services to a patient by **PASSIONATE CARE SERVICES, LLC** I was allowed time to ask questions regarding the documents and am satisfied that I understand the content of these documents.

Date Received	Reference Number	Content
	Rule 59A-18.005, F.A.C.	Registration Policies
	Rule 59A-18.0081, F.A.C.	Certified Nursing Assistant and Home Health Aide
	Rule 59A 18.018 F.A.C.	Emergency Management Plans
	Sections of Chapter 400 F.S.	Sections 400.506, 408.809, 400.484, 400.462, 400.488 and 408.810(5), F.S. with the telephone numbers referred to in the law.
		PASSIONATE CARE SERVICES, LLC Discrimination Policy
	Confidentiality Policy	**PASSIONATE CARE SERVICES, LLC** Confidentiality Agreement

_____

Print Name and Title of Contractor

_____

Signature Date

_____

Representative of **PASSIONATE CARE SERVICES, LLC** Date

APPLICATION FOR REGISTRATION

Date: _____ Position: _____

Name: _____

Physical Address: _____

City: _____ ZIP: _____

Phone Number: (____) _____ Email: _____

Date of Birth: _____ SSN: _____

Highest level completed: High School College Other

Name and location of school/institution:

_____

Date education was completed: _____

Certificate: _____
Diploma: _____

Degree: _____

Employment History, List most recent first:

Name of Company	Dates	Position

Credentials:

License: _____ Number: _____ Exp Date: _____

Certificate: _____ Number: _____ Exp Date: _____

I attest that to the best of my knowledge the above information is true.

_____

Signature

EMERGENCY CONTACT INFORMATION

Name: _____

Relationship: _____

Address: _____

City, State, ZIP: _____

Contact phone number: (____) _____

Secondary number: (_____) _____

Email address: _____

Name: _____

Relationship: _____

Address: _____

City, State, ZIP: _____

Contact phone number: (____) _____

Secondary number: (_____) _____

Email address: _____

MEDICAL CONTACT INFORMATION

Doctor's Name: _____ Phone: (_____) _____

Dentist's Name: _____ Phone: (_____) _____

I have voluntarily provided the above contact information and authorize **Passionate Care Services, LLC**. and its representatives to contact any of the above on my behalf in the event of an emergency.

_____

Employee Signature

PHYSICAL AND MENTAL LIMITATIONS STATEMENT

You are not required to disclose information about physical or mental limitations that you believe will not interfere with your ability to do the job. However, you should disclose any physical or mental impairment for which special arrangements or accommodations are needed to enable you to perform the essential functions of the job. Your description of any impairment and suggestions for reasonable accommodations will be considered in providing reasonable accommodations.

The duties and responsibilities herein describe the general nature and level of work required. They are not intended to be construed as a complete list of all duties, responsibilities and skills required to meet requirements for this position.

I have read and understand the requirements and duties described in this job description and agree to accept the position and perform the duties as described in this job description.

_____

Signature Date

CERTIFIED NURSING ASSISTANT / HOME HEALTH AIDE REGISTRATION AGREEMENT

PASSIONATE CARE SERVICES, LLC (herein referenced as "**PASSIONATE CARE SERVICES, LLC**") and

_____

(herein "**PASSIONATE CARE SERVICES, LLC**") hereby agree as follows:

1. **CERTIFIED NURSING ASSISTANT / HOME HEALTH AIDE** is a duly trained **CERTIFIED NURSING ASSISTANT / HOME HEALTH AIDE**, pursuant to Florida statutes, Chapter 400, Part IV, F.S., who requests to be registered with **PASSIONATE CARE SERVICES, LLC** for the purpose of receiving referrals from individuals or organizations that need home health **CERTIFIED NURSING ASSISTANT/ HOME HEALTH AIDE** services as defined and authorized under Chapter 400, Part IV, F.S. As a Contractor, please be advised that you are an independent contractor and the home health agency is not obligated to monitor, supervise, manage or train caregivers. However, if there is a violation of state laws or a deficiency in the caregiver's credentials that the home health agency becomes aware of, the home health agency will do the following:
   - advise the patient to terminate the referred individual's services,
   - provide the Contractor with the reason for termination
   - cease to refer the contractor to other patients or facilities, and,
   - if there are practice violations, notify the appropriate licensing board of the specifics of the violations.

2. **PASSIONATE CARE SERVICES, LLC** will register **CERTIFIED NURSING ASSISTANT / HOME HEALTH AIDE** and will perform the following services:
   - Supply an Information packet, the terms of which are hereby incorporated herein and made a part of this Agreement.
   - Refer appropriate requests for services when an individual or organization contacts **PASSIONATE CARE SERVICES, LLC** for home health services that can be provided by the **CERTIFIED NURSING ASSISTANT / HOME HEALTH AIDE**. The **CERTIFIED NURSING ASSISTANT / HOME HEALTH AIDE** will choose whether to accept the referral or decline it.
   - Maintain a record, as required by law, on each patient who receives services from a **CERTIFIED NURSING ASSISTANT / HOME HEALTH AIDE**.
   - Collect the payment for services on the **CERTIFIED NURSING ASSISTANT's / HOME HEALTH AIDE**'s behalf, maintain said funds in a general escrow account, and pay **CERTIFIED NURSING ASSISTANT / HOME HEALTH AIDE** for services provided each week. For purposes of these payments the cut-off for calculation of the amount to be paid is three (3) days prior to the date of payment. Payment rates shall be as stated in the table below and may be revised, from time to time, subject to the agreement of both parties. Changes in the compensated rate will be documented, dated, and verified by both parties.

- The **CERTIFIED NURSING ASSISTANT / HOME HEALTH AIDE** will be compensated as follows

Hourly Rate	$
Live In Rate	$
Visit Rate	$
Mileage Agreement	Rate of $0. _____Per mile reported

- Payment will be generated when all required documentation has been submitted to the Nurse Registry and is subject to approval of accuracy of applicable records.

3. **CERTIFIED NURSING ASSISTANT / HOME HEALTH AIDE** agrees to:
   - Abide by the terms and provisions in the HOME HEALTH AGENCY Licensure law, Chapter 400.506, F.S. and Rule 59A-18.
   - Follow **PASSIONATE CARE SERVICES, LLC** policies and procedures including, but not limited to, those that follow state requirements for record keeping, those that specify the documentation required for the **CERTIFIED NURSING ASSISTANT**'s/ **HOME HEALTH AIDE**'s Qualifications File and those that describe and define the **CERTIFIED NURSING ASSISTANT**'s/ **HOME HEALTH AIDE**'s responsibilities for procedures for patient safety and continuing care during emergency conditions as contained in **PASSIONATE CARE SERVICES, LLC** Emergency Management Plan, to which Contractor hereby acknowledges receiving orientation.
   - Will not solicit for **CERTIFIED NURSING ASSISTANT/ HOME HEALTH AIDE** services to any patient or client to whom **CERTIFIED NURSING ASSISTANT/ HOME HEALTH AIDE** is referred by **PASSIONATE CARE SERVICES, LLC** until ninety (90) days has passed since the termination of **CERTIFIED NURSING ASSISTANT**'s/ **HOME HEALTH AIDE's** services to the patient or client. In the event **CERTIFIED NURSING ASSISTANT/ HOME HEALTH AIDE** violates this non-solicitation clause, both parties hereby agree that **CERTIFIED NURSING ASSISTANT / HOME HEALTH AIDE** shall pay the sum of two thousand dollars ($2,000) to **PASSIONATE CARE SERVICES, LLC** as liquidated damages for each violation.
   - Execute a Business Associate Contract if required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
   - When services are to be terminated, the patient or client shall be notified of the date of termination and the reason for termination and these shall be documented in the client's record, notification will be provided to the contactor.

4. Both parties understand and agree that the **CERTIFIED NURSING ASSISTANT/ HOME HEALTH AIDE** is an independent contractor and is solely responsible for **CERTIFIED NURSING ASSISTANT**'s/ **HOME HEALTH AIDE's** federal tax obligations, including any required payments for self-employment estimated taxes; and any required or desired insurance coverage. **PASSIONATE CARE SERVICES, LLC** does not provide fringe benefits to independent contractors **PASSIONATE CARE SERVICES, LLC** shall issue each **CERTIFIED NURSING ASSISTANT/ HOME HEALTH AIDE** an IRS form 1099 each calendar year.

5. Both parties agree to comply with federal and state civil rights requirements and not unlawfully discriminate because of race, color, religion, sex, national origin, age, handicap, or marital status.

6. The initial term of this Agreement is for one year from the effective date written below and this Agreement shall automatically renew for successive one-year terms, until terminated by either party. Either party may terminate this Agreement by giving the other party thirty (30) days written notice of intent to terminate. Automatic renewal requires initials and dates by both parties. Both parties specifically agree that any outstanding ninety-day period for non-solicitation, described in section 3 above, shall exceed the effective termination date of this Agreement and remain in full force and effect until the ninety-day period(s) has expired.

7. This is the entire written Agreement between the parties and any amendments shall be in writing and signed by both parties before becoming effective. If any clause is found to be unlawful all other clauses shall remain in full force and effect.

Signed and effective this ___ day of _____, 202___.

CERTIFIED NURSING ASSISTANT/ HOME HEALTH AIDE

_____

Signature Date

PASSIONATE CARE SERVICES, LLC

_____

Signature Date

CERTIFIED NURSING ASSISTANT

DEFINITION:
The contracted Certified Nursing Assistant is contracted by referral to provide personal care services to patients in the home setting.

HOME HEALTH AIDE CONTRACTOR

DEFINITION:
The contracted Home Health Aide is a qualified person who is referred for contract to provide personal care services to patients in the home setting.

LINE OF AUTHORITY:
Reports patient concerns to person designated by the patient or the caregiver.

QUALIFICATIONS:

- High School diploma or equivalent required.
- Current CPR certification from an instructor that is approved to provide training by the American Heart Association or the American Red Cross.
- Proof of State of Florida certification. (Certified Nursing Assistant)
- For every home health aide registered since May 4,2015 with the home health agency, a certificate or documented evidence of successful completion of at least forty hours of training, from a public vocational technical school or a non-public postsecondary career school licensed by the Commission on Independent Education, Florida will be on file in the contractor file, home health aides registered with the home health agency May 4, 2015 who complete their training in another state must provide a certificate of completion of home health aide training from a public vocational technical school or a career education school that is licensed in that state.
- Evidence of satisfactory Level 2 Background screening
- Proof of adequate training to perform the tasks of a CNA/HHA in the home setting.
- Must demonstrate satisfactory level of competency.
- Exhibits adequate health status to perform described duties.
- Ability to safely handle body fluids and hazardous waste products.
- Must have ability to effectively communicate with patients and staff.
- Must meet contractor qualifications.

RESPONSIBILITIES AND DUTIES:

- Provides direct personal care to the patient in the home setting.
- Utilizes safety measures in provision of care.
- Maintains effective communication with agency staff regarding patient's condition.
- Follows written assignment to deliver patient services.
- Documents and submits accurate accounts of services provided.
- Observes the patient for changes in condition and behavior and reports to agency staff as indicated.
- Be responsible for observing appearance in the patient and reporting these changes to the caregiver and the nurse registry or the registered nurse responsible for assessing the case when giving care in the home or to the responsible facility employee if staffing in a facility.
- Maintains current CPR certificaion.
- Removes patient's medication container from the storage area; prepares necessary items, i.e., juice, water, cups, spoons, etc.; to assist the patient.
- Measures and preparations of special diet food items.
- Measure intake and output of fluids
- Reads and records temperature, pulse, and respiration.
- Maintain effective communication with supervisor regarding patient's condition.
- Maintains confidentiality of all patients, agency, and employee matters.
- Assist with the change of colostomy bag, reinforcement of dressing.
- Assists with use of devices for aid to daily living i.e., wheelchair or walker
- Assists with prescribed range of motion exercises.
- Adheres to all agency policies.
- Recognize emergencies and demonstrates knowledge of emergency procedures.
- Demonstrates knowledge regarding basic infection control procedures.
- Submits required documentation in a timely manner.
- Adheres to the role of the CAN/HHA in the home setting as defined in state regulation.

The CAN/HHA shall not change sterile dressings, irrigate body cavities such as giving an enema, irrigating a colostomy, or wound, perform a gastric irrigation or enteral feeding, catheterize a patient, administer medication, apply heat by any method, care for a tracheotomy tube, nor provide any personal health service which has not been included in the written assignment.

PERSONAL HEALTH INFORMATION PLEDGE OF CONFIDENTIALITY

I, _____ the undersigned, have read and understood **PASSIONATE CARE SERVICES, LLC** (hereinafter **PASSIONATE CARE SERVICES, LLC** policy on confidentiality of personal health information (PHI) as described in the Confidentiality Policy which is in accordance with relevant state and federal legislation.

I also acknowledge that I am aware of and understand the Policies regarding the security of personal health information including the policies relating to the use, collection, disclosure, storage and destruction of personal health information. In consideration of my employment or independent contractor status with **PASSIONATE CARE SERVICES, LLC** and as an integral part of the terms and conditions of my employment or contractor status, I hereby agree, pledge and undertake that I will not at any time, during my employment or association **PASSIONATE CARE SERVICES, LLC** Or after my employment or association ends, access or use personal health information, or reveal or disclose to any persons within or outside, any personal health information except as may be required in the course of my duties and responsibilities and in accordance with applicable Legislation, and policies governing proper release of information.

I understand that my obligations outlined above will continue after my employment/contract/ association/appointment with **PASSIONATE CARE SERVICES, LLC** ends.

I further understand that my obligations concerning the protection of the confidentiality of PHI relate to all personal health information whether I acquired the information through my employment or contract or association or appointment with **PASSIONATE CARE SERVICES, LLC** or with any of the entities, which have an association with this organization. I also understand that unauthorized use or disclosure of such information will result in a disciplinary action up to and including termination of employment or contract or association or appointment, the imposition of fines pursuant to relevant state and federal legislation, and a report to my professional regulatory body.

_____

Signature Date

_____

Witness Date

CONFIDENTIALITY STATEMENT

I have been formally instructed in the maintaining the confidentiality of medical records and understand that except as needed to conduct the business of the working day, the medical information regarding clients may not be discussed with anyone inside or outside the agency.

I understand that no information is to be released without the written, "Release of Information" consent signed by the client or the client's legal representative.

It is understood that breaks in the policies and procedures of **Passionate Care Services LLC.,** concerning confidentiality may result in the immediate termination of my contract of services and/ or employment without further notice.

The Health Insurance Probability and Accountability Act of 1996 (HIPAA). This federal legislation also requires the health care industry to adopt uniform codes and forms, streamlining the processing and use of health data and claims which will serve to better protect the privacy of people's health care information and give them greater access to that information.

I have been formally instructed by **Passionate Care Services LLC**., to maintain the confidentiality of every individual record and understand that the information regarding the individuals may not be discussed with anyone, inside or outside premises. I have been formally instructed in the policies and procedures of the agency regarding full compliance with the HIPPA regulations. I will also make sure that the HIPPA training once a year by DCF (Department of Children and Families).

Health Insurance Portability and Accountability Act (HIPPA)
The Health Insurance Portability and Accountability Act of 1996 (HIPPA), the federal legislation also requires the health care industry to adopt uniform codes and forms, streamlining the process and use of health data and claims which will serve to better protect the privacy of people's health care information and give them greater access to that information.

I have been formally instructed by **Passionate Care Services LLC**., to maintain the confidentiality of every individual record and understand that the information regarding the individual may not be discussed with anyone, inside, or outside premises. I have been formally instructed in the policies and procedures of the agency regarding full compliance with all HIPPA regulations. I will also make sure to take the HIPPA training once a year by DCF (Department of Children and Families).

Independent Provider Signature _____ Date _____

VERIFICATION OF LICENSE

Name: _____

FL License Number: _____

CNA License: _____

Effective date: _____

Expiration date: _____

Renewal date: _____

Please indicate if the above mentioned is active: YES NO

Verified by: _____

Method of verification: _____

_____

Signature Date

_____

Company Representative Signature Date

POLICY ON SELF-ADMINISTERED AND HANDLING OF MEDICATION

Consumer Name:_____

Medicaid ID: _____

Passionate Care Services LLC. Does not allow service providers (Sub-contractor) to administerany medication if not certified.

If parent/guardian is home with recipient, service provider should not remind guardian to administer medication. Only certified service providers such as: CNA, RN, and LPN or Certified Caretaker;may assist with medication administration. Service providers must receive a minimum of 2 hours of training (which may be part of Home Health Training) prior to assuming their responsibility. Trainings mustmeet State Law Requirements concerning procedures for assisting individuals with self-administration of medication. Service providers' supervision of recipients' self-administering of medication in the home is limited to:

1. Performing appropriate hand washing before providing medication assistance.
2. Putting on gloves, making sure that recipient does not have any latex allergies.
3. Preparing necessary items of assistance such as juice, water, cups, spoons, etc.
4. Obtaining medication from storage area for recipient and verifying the following information:

- Correct Consumer
- Correct Medication
- Correct Dosage (Amount)
- Correct Time (During the day/night)
- Correct route (oral, etc.)

Service providers are expected to remind Individuals to take their medication as prescribed. They shouldobserve recipients self-administering medication to ensure that the proper dosage has been swallowed, applied. Also, service providers may assist as follow:

- Open and/or close medication container or tear open pre-packaged medications.
- Assist recipient in self-administration process by steadying the arm hand, or other parts ofindividual's body to allow the self-administration of medication.
- Assist the recipient with placing unused medication back into the container.

Passionate Care Services LLC. Has advised Consumer/guardian or caregivers a Policy on self-administration of medication on annual basis as a reminder to follow procedures.

Signature Date

Authorization for Direct Deposit

I authorize **PASSIONATE CARE SRVICES LLC.**, to deposit my pay automatically to the account(s) indicated below and, if necessary, to adjust or reverse a deposit for any payroll entry to my account in error. This authorization will remain in effect until I cancel it in writing.

Name on bank account: _____
Bank account number: _____ Checking Savings
Bank routing number: _____
Specific amount: $ _____
Deposit entire paycheck: _____

Name on bank account: _____
Bank account number: _____ Checking Savings
Bank routing number: _____
Specific amount: $ _____
Deposit entire paycheck: _____

*Balance of pay to:
_____ Manual payment (physical check)
_____ Account described approve

SPLIT PAYMENTS ARE NOT AVAILABLE FOR CONTRACTORS

_____
Applicant's Signature Date

_____
Company Representative's Signature Date

PRIVACY POLICY ACKNOWLEDGEMENT FORM

I acknowledge that I have received a copy of the privacy policies from the Florida Department of Law Enforcement and the Federal Bureau of Investigation, which describe the exchange of information where criminal record results will become part of the Care Provider Background Screening Clearinghouse.

I understand and agree that I will read and comply with the guidelines contained in the privacy policies.

_____

Employee/Contractor Name (Printed)

_____

Employee/Contractor Signature

_____

Date

TERMINATION WITHOUT NOTICE FORM

Starting July 26, 2021, anyone that is working for **Passionate Care Services LLC.,** that does not give a one (1) week notice upon quitting will be paid only minimum wage of $8.00 per hour.

I _____, understand that if I quit Passionate Care and do not provide my supervisor with a one (1) week notice, and if I do not work my one week notice out, I will only get paid $8.00 (minimum wage) an hour.

Applicant's signature: _____ Date: _____

Supervisor's signature: _____ Date: _____

Tax Exempt Form

I,_____ hereby acknowledge that I am an independent contractor with a signed W9 on file. Therefore, I am responsible for my social security and tax, and I will receive an IRS 1099 Form for the preceding year by February 1st, of each year which is also sent to the Internal Revenue Service.

As an independent contractor, I am not eligible for any benefit such as vacation, disability or unemployment and will not be covered by Workman's Compensation.

_____

Applicant's Signature Date

_____

Company Representative's Signature Date

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

Print or type. See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☑ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► S

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)
Michelle Scott

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here | **Signature of U.S. person ►** | **Date ►**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

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

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

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

Section 2. Employer 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

ATTESTATION OF COMPLIANCE
with Background Screening Requirements

Authority: This form may be used by **all employees** to comply with:

- the attestation requirements of **section 435.05(2), Florida Statutes**, which state that every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer; **AND**

- the proof of screening within the previous 5 years in **section 408.809(2), Florida Statutes** which requires proof of compliance with level 2 screening standards that have been screened through the Care Provider Background Screening Clearinghouse created under Section 435.12, F.S., or screened within the previous 5 years by the Agency, Department of Health, Department of Elder Affairs, the Agency for Persons with Disabilities, Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S., and in accordance with the standards in Section 408.809(2), F.S., if that agency is not currently implemented in the Care Provider Background Screening Clearinghouse.

This form must be maintained in the employee's personnel file. If this form is used as proof of screening for an administrator or chief financial officer to satisfy the requirements of an **application for a health care provider license**, please attach a copy of the screening results and submit with the licensure application.

Employee/Contractor Name:
Health Care Provider/ Employer Name:
Address of Health Care Provider:

I hereby attest to meeting the requirements for employment and that I have not been arrested for ~~or~~ and been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty to any offense, or have an arrest awaiting a final disposition prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction:

Criminal offenses found in section 435.04, F.S.

(a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.

(b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.

(c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.

(d) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(e) Section 782.04, relating to murder.

(f) Section 782.07, relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child.

(g) Section 782.071, relating to vehicular homicide

(h) Section 782.09, relating to killing of an unborn quick child by injury to the mother.

(i) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.

(j) Section 784.011, relating to assault, if the victim of the offense was a minor.

(k) Section 784.03, relating to battery, if the victim of the offense was a minor.

(l) Section 787.01, relating to kidnapping.

(m) Section 787.02, relating to false imprisonment.

(n) Section 787.025, relating to luring or enticing a child.

(o) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.

(p) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.

(q) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.

(r) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.

(s) Section 794.011, relating to sexual battery.

(t) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.

(u) Section 794.05, relating to unlawful sexual activity with certain minors.

(v) Chapter 796, relating to prostitution.

(w) Section 798.02, relating to lewd and lascivious behavior.

(x) Chapter 800, relating to lewdness and indecent exposure.

(y) Section 806.01, relating to arson.

(z) Section 810.02, relating to burglary.

(aa) Section 810.14, relating to voyeurism, if the offense is a felony.

(bb) Section 810.145, relating to video voyeurism, if the offense is a felony.

(cc) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.

(dd) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

(ee) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.

(ff) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.

(gg) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.

(hh) Section 826.04, relating to incest.

(ii) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child

(jj) Section 827.04, relating to contributing to the delinquency or dependency of a child.

(kk) Former s. 827.05, relating to negligent treatment of children.

(ll) Section 827.071, relating to sexual performance by a child.

(mm) Section 843.01, relating to resisting arrest with violence.

(nn) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.

(oo) Section 843.12, relating to aiding in an escape.

(pp) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.

(qq) Chapter 847, relating to obscene literature.

(rr) Section 874.05(1), relating to encouraging or recruiting another to join a criminal gang.

(ss) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

(tt) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.

(uu) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.

(vv) Section 944.40, relating to escape.

(ww) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.

(xx) Section 944.47, relating to introduction of contraband into a correctional facility.

(yy) Section 985.701, relating to sexual misconduct in juvenile justice programs.

(zz) Section 985.711, relating to contraband introduced into detention facilities.

(3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

Attestation

Under penalty of perjury, I, _____, hereby swear or affirm that I meet the requirements for qualifying for employment in regards to the background screening standards set forth in Chapter 435 and section 408.809, F.S. In addition, I agree to immediately inform my employer if arrested or convicted of any of the disqualifying offenses while employed by any health care provider licensed pursuant to Chapter 408, Part II F.S.

_____	_____	_____
Employee/Contractor Signature	Title	Date

agency for persons with disabilities
State of Florida

ATTESTATION OF GOOD MORAL CHARACTER

Employee/Applicant/Contractor/Volunteer Name: _____

By signing this form, I affirm and attest that I meet the Moral Character requirements for employment as required pursuant to Chapter 435, Florida Statutes, and Section 393.0655, Florida Statutes.

Provider/Employer Name: _____

I have not been arrested with disposition pending or found guilty of regardless of adjudication, or entered a plea of nolo contendre (no contest) to or have been adjudicated delinquent and the record has not been sealed or expunged for, any offense prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction for any of the offenses listed below.

Criminal Offenses listed in section 435.04, F.S.

(a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.

(b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.

(c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.

(d) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(e) Section 782.04, relating to murder.

(f) Section 782.07, relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child.

(g) Section 782.071, relating to vehicular homicide.

(h) Section 782.09, relating to killing of an unborn quick child by injury to the mother.

(i) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.

(j) Section 784.011, relating to assault, if the victim of the offense was a minor.

(k) Section 784.03, relating to battery, if the victim of the offense was a minor.

(l) Section 787.01, relating to kidnapping.

(m) Section 787.02, relating to false imprisonment.

(n) Section 787.025, relating to luring or enticing a child.

(o) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.

(p) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.

(q) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.

(r) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.

(s) Section 794.011, relating to sexual battery.

(t) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.

(u) Section 794.05, relating to unlawful sexual activity with certain minors.

(v) Chapter 796, relating to prostitution.

(w) Section 798.02, relating to lewd and lascivious behavior.

(x) Chapter 800, relating to lewdness and indecent exposure.

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(aa) Section 810.14, relating to voyeurism, if the offense is a felony.

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(cc) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.

(dd) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

(ee) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.

(ff) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.

(gg) Section 825.103, relating to felony offenses for the exploitation of an elderly person or disabled adult.

(hh) Section 826.04, relating to incest.

(ii) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child.

(jj) Section 827.04, relating to contributing to the delinquency or dependency of a child.

(kk) Former s. 827.05, relating to negligent treatment of children.

(ll) Section 827.071, relating to sexual performance by a child.

(mm) Section 843.01, relating to resisting arrest with violence.

(nn) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.

(oo) Section 843.12, relating to aiding in an escape.

(pp) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institution.

(qq) Chapter 847, relating to obscene literature.

(rr) Section 874.05, relating to encouraging or recruiting another to join a criminal gang.

(ss) Chapter 893, relating to drug abuse prevention and control if the offense was a felony or if any other person involved in the offense was a minor.

(tt) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting requirements for such sexual misconduct.

(uu) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.

(vv) Section 944.40, relating to escape.

(ww) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.

(xx) Section 944.47, relating to introduction of contraband into a state correctional facility.

(yy) Section 985.701, relating to sexual misconduct in juvenile justice programs.

(zz) Section 985.711, relating to contraband introduced into detention facilities

435.04(3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

Section 393.0674(2), felony offenses for the release or use of information from juvenile records of the Agency for Persons with Disabilities for any purpose other than screening for employment

ONE OF THE FOLLOWING STATEMENTS MUST BE SIGNED:

I attest that I have read the above carefully and state that my attestation here is true and correct and that my record **does not contain any of the above listed offenses.** I understand, under penalty of perjury, all employees in such positions of trust or responsibility shall attest to meeting the requirements to the background screening standards set forth in Chapter 435 and Section 393.0655.

Signature of Affiant _____ Date _____

OR

My record **contains one or more of the applicable disqualifying** acts or offenses listed above.

Signature of Affiant _____ Date _____

Note: If you have previously been granted an APD exemption for this disqualifying offense, a copy of the APD exemption letter must be attached.

OR

I am a licensed physician, licensed nurse, or other professional licensed and regulated by the Department of Health. I will be **holding a position that is within the scope of my licensed practice**, and I am not subject to the screening provisions of section 393.0655, Florida Statutes.

Signature of Affiant _____ Date _____

Position for Provider/Employer listed on pg. 1 _____