



## APPLICATION REQUIREMENTS:

Name: \_\_\_\_\_

**OFFICE USE ONLY**

- \_\_\_\_\_ 1. Employment Application
- \_\_\_\_\_ 2. Agreement for Homacare Duty
- \_\_\_\_\_ 3. Marketing and Recruiting
- \_\_\_\_\_ 4. Influenza Immunization
- \_\_\_\_\_ 5. Handbook Acknowledgement
- \_\_\_\_\_ 6. Form W-4
- \_\_\_\_\_ 7. Healthcare Worker Background Check
- \_\_\_\_\_ 8. Employment Eligibility Verification (I-9)
- \_\_\_\_\_ 9. HS Diploma/GED; or Relevant Work Experience
- \_\_\_\_\_ 10. Social Security Card
- \_\_\_\_\_ 11. Copy of Driver's License/State I.D. Expires: \_\_\_\_\_
- \_\_\_\_\_ 12. Copy of Auto Insurance Expires: \_\_\_\_\_
- \_\_\_\_\_ 13. Orientation on company policies done on date of application.
- \_\_\_\_\_ 14. Tax Credit Screening #: \_\_\_\_\_

### EMPLOYEE STATUS

Date of Hire: \_\_\_\_\_

DO NOT DEDUCT F.P

**ADMIN USE ONLY  
DO NOT WRITE IN THIS  
BOX**



## Qualifications required to be a HOME CARE AIDE

Per the Illinois Admin Code 240.1535 (b)(2), the qualifications of a homecare aide shall include:

- A) one of the following type of **education** or **experience**:
- i) a high school diploma or general education diploma; or
  - ii) one year of employment in a comparable human service capacity, or experience in care for a dependent child or adult family member; or
  - iii) demonstration of continued progress towards meeting the educational requirements of a general education diploma by current registration and evidence of successful completion of course work (successful completion means achievement of grade of "C" or higher); and
- B) the **training** required in subsection (b)(3).
- 3) Homecare aides shall meet the following training requirements:
- A) new employees shall receive 24 hours of initial pre-service training, including agency orientation of not more than 2 hours, prior to assignment to provide services to a CCP client without a supervisor or trainer present (not to exceed a 6-month period from the training to first assignment). Initial homecare aide training shall be subject to a competency evaluation conducted by agency and include all in-home services.
- B) a new employee may be **exempt** from pre-service training if the employee:
- i) had had previous documented and supervised training within the past 2 years prior to this employment, equivalent to 24 hours of homecare aide pre-service training, as determined by the provider with appropriate documentation in the employee's personnel file; or
  - ii) has successfully completed RN, LPN, MD, physician assistant or CNA training in the past and has been employed in the field within the past 2 years; or
  - iii) has been employed as CCP homecare aide within the past year.
- C) thereafter, a minimum of 12 hours per calendar year of interaction, in-service training approved by the provider agency shall be mandatory for all homecare aides. Pre-service training shall fulfill the first 3 hours of in-service training required for new employees, except for homecare aides exempted under subsection (b)(3)(B).



# NORTH LIGHT Care Services LTD

Visit Us: 1328 Main St. Lowe Level A Crete, IL 60417

Call Us: 708-576-1191

Send An Email: connect@northlightcareservices.org

Fax Us: 207-857-5127

## EMPLOYMENT APPLICATION

An Equal Opportunity Employer: *We consider applicants for all positions without regard to race, color, religion, creed, gender, national origin, age, disability, marital of veteran status, or any other legally protected status. In order to be considered an applicant, you must complete this form.*

### General Information

Date of Application: \_\_\_\_\_

### Please select

Position Applying for:  Homecare Supervisor  Home Care Aide  Homemaker  Family Caregiver

Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Number Street City State Zip Code

1. Do any of your friends or relatives work here?  YES  NO  
If yes, state full name and relationship. \_\_\_\_\_
2. Are you legally eligible for employment in this country? (Proof of citizenship or immigration status will be required upon employment)  YES  NO
3. Have you been convicted of a felony within the last 7 years?  YES  NO
4. Are you currently employed?  YES  NO
5. If you are currently employed, may we contact your employer?  YES  NO

### Work Preferences & Availability

1. Are you looking for a full-time or part-time position? \_\_\_\_\_
2. Are you available to work weekends? \_\_\_\_\_
3. Are you willing and able to service clients throughout the Chicagoland area/ Will County, Lake County (whether by driving or using public transportation)? \_\_\_\_\_

### Education

TYPE OF SCHOOL	NAME OF SCHOOL	LOCATION (City, State)	NUMBER OF YEARS COMPLETED	MAJOR & DEGREE
High School				
College				
Bus. Or Trade School				
Professional School				



# NORTH LIGHT Care Services LTD

Visit Us: 1328 Main St. Lowe Level A Crete, IL 60417

Call Us: 708-576-1191

Send An Email: [connect@northlightcareservices.org](mailto:connect@northlightcareservices.org)

Fax Us: 207-857-5127

## Questions :

Have you ever been convicted of a crime?  YES  NO

If yes, explain number of conviction(s), nature of offense(s) leading to conviction(s), how recently such offense(s) was/were committed, sentence(s) imposed, and type(s) of rehabilitation (A conviction will not necessarily result in the denial of employment):

Have you ever worked under a different name?  YES  NO

If YES, what was it and what was the reason?

Do you have any relatives or friends that work for the Company?  YES  NO

If YES, what is their name?

## In Case of Emergency, Please Contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## Previous Employment/Work History

Company Name: _____	Telephone Number: _____
Supervisor: _____	Date Started: _____
Job Title: _____	Date Ended: _____
Job Duties: _____	Reason for Leaving: _____
Address: _____	

Company Name: _____	Telephone Number: _____
Supervisor: _____	Date Started: _____
Job Title: _____	Date Ended: _____
Job Duties: _____	Reason for Leaving: _____
Address: _____	

Company Name: _____	Telephone Number: _____
Supervisor: _____	Date Started: _____
Job Title: _____	Date Ended: _____
Job Duties: _____	Reason for Leaving: _____
Address: _____	



# NORTH LIGHT Care Services LTD

Visit Us: 1328 Main St. Lowe Level A Crete, IL 60417

Call Us: 708-576-1191

Send An Email: connect@northlightcareservices.org

Fax Us: 207-857-5127

## Reference:

NAME	Position Title	Company Name	Phone Number	Email Address	Relationship to Reference

## Regarding Employment Application for, North Light Care Services LTD

*I certify that the information contained in this application and in any resume provided by me or any party representing my interests is correct and complete to the best of my knowledge. I understand that any false statements, misinterpretations, or omissions made by me on this application or any supplement to it, will be sufficient grounds for rejection of this application or discharge after employment.*

*I grant North Light Care Services the right to obtain pertinent information concerning me from former employers, educational institutions, and others, and I release all those providing or requesting such information from any liability that may arise by truthful disclosures or such investigations.*

*If I am hired, I understand that I am free to resign at any time, with or without cause and without prior notice, and the Company reserves the same right to terminate my employment at any time with or without cause and without prior notice, except as may be required by law. This application does not constitute an agreement or contract for employment for any specified period or definite duration.*

*I understand that no representative of the Company, other than an authorized officer, has the authority to make any assurances to the contrary. I further understand that any such assurances must be in writing and signed by an authorized officer. I understand it is the Company's policy not to refuse to hire a qualified individual with a disability because of that person's need for reasonable accommodation as required by the Americans with Disabilities Act.*

*I also understand that if I am hired, I will be required to provide proof of identity and legal work authorization.*

*Your signature acknowledges you have read and agree to the above.*

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

## Skill Information :

PLEASE PRINT ALL INFORMATION REQUESTED EXCEPT SIGNATURE

*How would you rate yourself on your experience with the following aspects of caregiving? 1 = No Experience  
2 = Some Experience 3 = Good Experience 4 = Excellent Experience*

- |                     |                         |                         |                         |                         |
|---------------------|-------------------------|-------------------------|-------------------------|-------------------------|
| Meal Preparation    | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Light House Keeping | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Bathing             | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Showering/ Dressing | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Grooming            | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Transferring        | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Incontinence Care   | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Dementia            | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |
| Alzheimer's Care    | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |



# NORTH LIGHT Care Services LTD

Visit Us: 1328 Main St. Lowe Level A Crete, IL 60417

Call Us: 708-576-1191

Send An Email: connect@northlightcareservices.org

Fax Us: 207-857-5127

## TRANSPORTATION

Many caregiver positions require the caregiver to transport a client.

Do you have dependable transportation?  
 YES  NO

Car Model \_\_\_\_\_

License Plate # \_\_\_\_\_

Driver License # \_\_\_\_\_

Auto Insurance Policy # \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Agent Name \_\_\_\_\_

Insurance Agent Phone # \_\_\_\_\_

## EMPLOYEE AUTOMOBILE RELEASE OF LAIBILITY

I \_\_\_\_\_, understand that at my discretion I will be using my automobile as part of the duties in the care of patients assigned to me.

I acknowledge that I have the primary responsibility for my automobile insurance. I agree to hold NORTH LIGHT CARE SERVICES LTD harmless in the event that there is an accident in which there is damage to my automobile or injury to its occupants.

I hereby provide a copy of my car insurance card.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

## CONFIDENTIALITY OF CLIENT INFORMATION

Please read carefully as this is a legally binding document.

By accepting employment with NORTH LIGHT CARE SERVICES LTD, I agree to carefully refrain from discussing any client's condition or personal affairs with anyone outside the agency, unless expressly authorized to do so. I will not share any medical information with other clients or visitors without clear instruction provided to the agency. I acknowledge that all information seen or heard regarding clients, directly or indirectly, is completely confidential and is not to be discussed, even with my family and coworkers. My job as an employee requires that I govern myself by high ethical standards. Failure to recognize the importance of confidentiality is not only a breach of professional ethics, but can also involve an employee in legal proceedings. I will not share any information about clients or the agency with the media. This is essential for protection of both the client and Agency.

I have read and fully understand the above statement and agree to abide by these policies.

I understand that a breach of policy may result in disciplinary action and possible dismissal from employment.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date



## AUTHORIZATION TO PERFORM CRIMINAL BACKGROUND CHECK

I, \_\_\_\_\_, authorize NORTH LIGHT CARE SERVICES LTD to perform a criminal background check on me for purposes of employment only. I understand that I may request, in writing, a copy of the results of my criminal background check processed by NORTH LIGHT CARE SERVICES LTD.

\_\_\_\_\_  
Signature Of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
North Light Care Services Witness

\_\_\_\_\_  
Date

**A conviction on your criminal background history does not affect NORTH LIGHT CARE SERVICES LTD decision for employment provided you have supporting documentation to waive the conviction statement on your criminal record history.**



## EMPLOYEE AGREEMENT FOR HOMECARE DUTY

This Agreement shall be between NORTH LIGHT CARE SERVICES LTD represented by its executive director JOANNA OLARTE RN, BSN, and \_\_\_\_\_ referred to as the EMPLOYEE.

1. EMPLOYEE must undergo an introduction period of six (6) months from date of hire. This period shall be used to assess EMPLOYEE's ability to do the job assigned to them. At the end of this period or sooner, the EMPLOYEE's performance shall be evaluated whether or not they are fit to continue working for the company.
2. EMPLOYEE acknowledges that they are an "employee at will" and NORTH LIGHT CARE SERVICES LTD may terminate their employment at any time for any reason.
3. If EMPLOYEE decides to terminate their employment with NORTH LIGHT CARE SERVICES LTD, it is requested that they give written notice of at least two (2) weeks from the intended date of resignation.
4. EMPLOYEE agree to perform the services assigned to them as included in their job description.
5. NORTH LIGHT CARE SERVICES LTD has the sole right to establish the wages and benefits, if any, of its employees assigned to its clients, and assumes responsibility for the payment of such compensation, the withholding of the federal and state taxes, and payment of all required payroll taxes.
6. EMPLOYEE must not, in any manner at any time, divulge, disclose, or use, whether for personal or another person's benefit, any information about NORTH LIGHT CARE SERVICES LTD or its clients to anyone not connected with NORTH LIGHT CARE SERVICES LTD including their family members. This information is confidential. Any violation shall result in disciplinary action, including termination, depending on the gravity of the offense. This is without prejudice to NORTH LIGHT CARE SERVICES LTD right to claim damages with the appropriate courts.
7. EMPLOYEE hereby authorize NORTH LIGHT CARE SERVICES LTD to administer pre-employment drug screens and random drug screens (when necessary). Should a prohibited substance be detected, this policy will be deemed to have been violated and the company reserves the right to discipline EMPLOYEE, up to and including immediate termination, irrespective of when or where the prohibited substances entered the EMPLOYEE'S system.
8. EMPLOYEE are not allowed to work for a client when the latter is confined to a hospital or nursing home. EMPLOYEE must inform their supervisor immediately if their client is confined in said facilities. Any work done in excess of the authorized work hours shall be paid.
9. EMPLOYEE acknowledges that NORTH LIGHT CARE SERVICES LTD, through the use of the Portal/Mobile App, records GPS coordinates at the time of clock-in and clock-out. EMPLOYEE hereby agrees to share their location with NORTH LIGHT CARE SERVICES LTD during work hours to confirm that EMPLOYEE is in the vicinity of the client's premises.
10. EMPLOYEE agrees to receive text messages, including mass text messages, from NORTH LIGHT CARE SERVICES LTD on their personal cellphone for work-related matters. EMPLOYEE understand they can unsubscribe from mass text messaging at any time. Standard messaging rates apply.
11. EMPLOYEE agrees to receive emails and other online communications from NORTH LIGHT CARE SERVICES LTD relating to the company and their employment. EMPLOYEE understands they can unsubscribe from emails and other online communications at any time.
12. EMPLOYEE authorizes the use and disclosure of their name, audio/video/photographic materials, and/or testimonial for marketing purposes by NORTH LIGHT CARE SERVICES LTD.
13. EMPLOYEE shall abide by all the policies and procedures of NORTH LIGHT CARE SERVICES LTD.

IN WITNESS WHEREOF, this Agreement has been duly executed by the above-named parties or the date set forth below

**JOANNA OLARTE, RN BSN**  
**Administrator**  
**North Light Care Services**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**



## HOME CARE AIDE TRANSPORTATION AGREEMENT

*If HCA will NOT be driving, do not proceed; Complete "Do Not Drive" Waiver*

A Home Care Aide (HCA) driving for North Light Care Services LTD clients in any vehicle must adhere to safe driving standards, including compliance with all traffic laws and DMV regulations. The use of hand-held devices for calls, texting, emailing, or browsing while driving is prohibited. HCAs may use their personal vehicles for Company business only if the vehicle is well-maintained and in safe condition. Any vehicle accident, damage, or traffic violation must be reported to both the Case Supervisor and their insurance carrier within 24 hours. HCAs must notify the insurer of business use of their vehicle and ensure the Company is not excluded from their personal insurance. HCAs are responsible for any deductibles and must carry personal vehicle insurance meeting State requirements. HCA's insurance is primary, with Company insurance as excess coverage. The Company will not reimburse the HCA for theft, road damage, collision, or any tickets and other violations.

I agree to comply with the above and understand that any violation thereof may result in disciplinary action up to and including termination.

I represent and warrant I will drive Company clients in my personal vehicle only if my vehicle is in safe operating condition and has received regular maintenance

\_\_\_\_\_  
(Initials)

I agree to carry personal vehicle insurance, covering liability and physical damage, in amounts sufficient to satisfy any requirements under state law.

\_\_\_\_\_  
(Initials)

I accept the risks of driving for the Company and waive any claims against the Company for bodily injury or property damage related to such driving. I agree to indemnify, defend, and hold harmless the Company, its officers, employees, and successors from any related liability.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**JOANNA OLARTE, RN BSN**  
**Administrator**  
**North Light Care Services**



State of Illinois  
Illinois Department on Aging

## ACKNOWLEDGEMENT OF LIMITATIONS ON MARKETING AND RECRUITING ACTIVITIES UNDER THE COMMUNITY CARE PROGRAM (HOMECARE AIDES) TRAINING

As a Homecare Aide under the Community Care Program (CCP), you represent the public face of your employer and the Illinois Department on Aging. It is your responsibility to provide approved in-home service in a professional and ethical manner to the older adults who receive services as participants in this program.

I \_\_\_\_\_, have viewed the Limitations on Marketing and Recruiting Activities Under the Community Care Program (Homecare Aides) and acknowledge my understanding of and responsibility to comply with the following non-exhaustive list of requirements under the CCP as set forth by federal and State laws, the 1915(c) Medicaid Waiver for the Elderly, regulations/rules, policies/procedures, the provider service certification, and the provider service agreement:

- An individual may choose at any time to not receive services for which eligibility has been determined under the CCP.
- An individual has the right to select a provider of his or her choice based on availability in the service area at any time during participation in the CCP.
- All information about an individual's case is to be kept confidential under the CCP. This information may be used ONLY for purposes directly related to the administration of this program. This information cannot and should not be shared between provider agencies.
  - Confidential case information includes, but is not limited to, the following items: Name, SSN, Date of Birth, Address, Medicaid Number and Status, Family/Guardian Name(s) and Contact Information, Phone Numbers, Financial Account Numbers, and Medication(s) or other health information.
  - This information may be maintained in any form or medium (i.e., electronic, oral, or paper).
  - Confidentiality continues beyond the termination of employment.
- The CCP prohibits the use of unsolicited telephone calls (cold-calling) and door-to-door solicitations; sales activities at community meetings, educational events and health care facilities; and cross-selling of non-CCP-related services to current and prospective program clients.
- Failure to comply with program requirements may subject you and/or your employer to sanctions imposed by the Department or other government officials with oversight responsibilities. Possible sanctions include, but are not limited to:
  - Participation in additional mandatory trainings.
  - Imposition of a ban on continued employment in the capacity as a caregiver under the CCP and other publicly funded programs in Illinois.
  - Placement of name on the Adult Protective Service Registry.

➤ **ORIGINAL OF THIS ACKNOWLEDGEMENT SHOULD BE MAINTAINED IN EACH EMPLOYEE'S PERSONNEL FILE.**

Agency Name: NORTH LIGHT CARE SERVICES

Signature:

Date:



## SEXUAL HARASSMENT TRAINING ACKNOWLEDGEMENT FORM

I, \_\_\_\_\_, acknowledge that I have completed 1 hour of Sexual Harassment Training as required by the Illinois Human Rights Act while working at NORTH LIGHT CARE SERVICES LTD. I understand that this training is mandatory for all employees and I have completed the training in accordance with the Company's policies and procedures.

I acknowledge that sexual harassment in the workplace is prohibited by law and is not tolerated by NORTH LIGHT CARE SERVICES LTD. I understand that I have a responsibility to maintain a workplace free from sexual harassment and to report any instances of sexual harassment to my supervisor or Human Resources department.

I understand that sexual harassment can take many forms, including but not limited to, unwanted sexual advances, requests for sexual favors, inappropriate physical contact, and verbal or physical conduct of a sexual nature. I understand that such behavior is unacceptable and may result in disciplinary action, up to and including termination of employment.

I understand that it is important to recognize the signs of sexual harassment and to know how to respond if it occurs. I have received training on how to recognize, prevent, and report sexual harassment in the workplace.

By signing below, I acknowledge that I have completed the sexual harassment training and that I understand my responsibilities as an employee of NORTH LIGHT CARE SERVICES LTD in maintaining a workplace free from sexual harassment.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisor Signature

\_\_\_\_\_  
Date



## ELECTRONIC SIGNATURE AGREEMENT

This Electronic Signature Agreement ("Agreement") is made and entered into by and between NORTH LIGHT CARE SERVICES ("Company"), and staff \_\_\_\_\_ ("Signer"), for the purpose of electronic signature for documentation purposes.

### Purpose

The purpose of this Agreement is to allow Signer to use electronic signature to sign Company's documents for documentation purposes.

### Consent to Use Electronic Signature

By signing this Agreement, Signer consents to the use of electronic signatures for all Company's documents that require Signer's signature. Signer acknowledges that electronic signatures are legally binding and have the same effect as signatures in writing.

### Method of Electronic Signature

Signer's electronic signature will be accomplished by using a secure and approved electronic signature system. Signer understands that electronic signatures are subject to authentication and security measures to prevent unauthorized use.

### Responsibility for Security

Signer is responsible for maintaining the security and confidentiality of their electronic signature, including keeping passwords or other access codes confidential and not sharing them with others.

### Signature Authentication

Signer's electronic signature is deemed to be valid and enforceable to the same extent as a handwritten signature once Signer has been authenticated through the electronic signature system.

### Revocation of Signature

Signers have the right to revoke their electronic signature at any time by providing written notice to the Company. Such revocation will not affect the validity of any signed documents before the revocation.

### Confirmation of Signature

Signer acknowledges and agrees that their electronic signature will constitute confirmation of the contents of the document signed, and will not dispute the validity or enforceability of the document based solely on the use of electronic signature.

### Entire Agreement

This Agreement constitutes the entire understanding and agreement between the Company and Signer concerning the use of electronic signatures for documentation purposes.

### Governing Law

This Agreement shall be governed by and construed in accordance with the laws of the state in which the Company operates.

### Acceptance of Agreement

By electronically signing this Agreement, Signer acknowledges that they have read, understood, and agreed to be bound by all the terms and conditions contained in this Agreement.

Staff Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## JOB DESCRIPTION: HOMEMAKER

### Description:

- Homemakers provide service to individuals in their own homes and communities, who need assistance caring for themselves as a result of old age, sickness, disability, and/or other inflections. Home care may include housecleaning, laundry, meal preparation, transportation, companionship, and respite,
- Homemakers are responsible for ensuring that service is delivered in a caring and respectful manner, in accordance with relevant Agency policies and industry standards.

### Reporting Relationship

- Reports to Supervisor.

### Responsibilities/Activities:

- Teach/perform meal planning and preparation, routine housekeeping activities such as making/changing beds, dusting, vacuuming, washing floors, cleaning kitchen and bathroom, laundry/linen service including ironing and folding clothes.
- Perform/assist with essential shopping/errands in accordance with the care plan and under the observation of the Supervisor.
- Assist with following a written, special diet plan and reinforcement of diet maintenance, which is provided under the direction of a Physician and as identified in the care plan.
- Escort the client to medical facilities, errands, shopping, and outings as specified in the care plan.
- Provide companionship for the client. This includes accompanying clients on walks, trips to social/recreational activities, assistance with hobbies etc.
- Assist clients with communication by writing or typing correspondence for them or researching information for them.
- Participate on the Care Team by providing input and making suggestions.
- Ensure service is delivered in accordance with all relevant policies, procedures, and practices.
- Monitor supplies and resources.
- Evaluate the program and make recommendations to it, as indicated.
- Follow the written care plan.
- Carry out duties as assigned by the Supervisor.
- Observe the client's functioning and report to the Supervisor.
- Complete and maintain records of daily activities, observations, and direct hours of service.
- Attend orientation, in-service training sessions and staff meetings.
- Develop and maintain constructive and cooperative working relationships with others.
- Make decisions and solve problems.
- Communicate with Supervisor and co-workers.
- Observe, receive, and obtain information from relevant sources.

### Required Knowledge

- Knowledge of home management skills.
- Knowledge of principles and processes for providing client and personal services, including needs determinants, meeting quality standards and evaluation of client satisfaction.
- Knowledge of the English language.
- Knowledge of information and techniques on basic first aid and CPR.
- Knowledge of clerical procedures such as maintaining records and completing forms.



## Required Skills/Abilities

- The ability to be aware of other people's reactions and understand why they react as they do.
- The ability to establish and maintain relationships.
- The ability to teach others.
- The ability to apply reason and logic to identify strengths and weaknesses of possible solutions.
- The ability to identify problems and determine effective solutions.
- The ability to understand written and oral instructions.
- The ability to communicate information orally so others understand.
- The ability to communicate in writing so others understand.
- The ability to listen and understand the spoken word.
- The ability to work independently and in cooperation with others.
- The ability to determine or recognize when something is likely to go wrong.
- The ability to suggest several ideas on a subject.
- The ability to perform activities that use the whole body.
- The ability to handle and move objects and people.
- The ability to provide advice and consultation to others.
- The ability to observe and recognize changes in clients.
- The ability to establish and maintain harmonious relations with clients/families/co-workers.

## Physical and Mental Demands:

- Good physical and mental health.
- Flexible, sensitive to the needs of others.
- Physical ability to stand, walk, use hands and fingers, reach, stoop, kneel, crouch, talk, hear, and see.
- Mental fortitude and stability to handle stress.
- Physical and mental ability to drive a vehicle.

## Qualifications/Education

- High School Diploma or GED required
- Has a reliable car and current driver's license..
- Proper Vehicle Insurance Coverage.

## Training/Experience:

- May require related experience.

I have read and understand the job description and agree to fulfill the position's responsibilities.

\_\_\_\_\_  
Homemaker Signature

\_\_\_\_\_  
Date



## ACKNOWLEDGMENT OF JOB DESCRIPTION

**North Light Care Services LTD** does not discriminate on the basis of race, color, religion, national origin, sex, handicap or age.

- I have read this job description and fully understand the requirements set forth therein.
- I hereby accept the position of Home Service Worker and agree to perform the identified essential functions in a safe manner and in accordance with **North Light Care Services LTD** established procedures.
- I understand that as a result of my employment, I may be exposed to blood, body fluids, infectious diseases, air contaminants, and hazardous chemicals and that **North Light Care Services LTD** will provide to me instruction on how to prevent and control such exposure.
- I further understand that I may also be exposed to the Hepatitis B virus and that **North Light Care Services LTD** will make available to me, free of charge, the Hepatitis B vaccination.
- I understand that my employment is at will, and thereby understand that my employment may be terminated at-will either by **North Light Care Services LTD** or myself and that such determination can be made with or without notice.

---

Signature - Home Service Worker



## PRE-SERVICE EXEMPTION

**EMPLOYEE NAME:** \_\_\_\_\_

Reason new employee is exempt from pre-service training:

- Has had previous documented and supervised training within the past 2 years prior to this employment, equivalent to 24 hours of homecare aide pre-service training, as determined by the provider with appropriate documentation in the employee's personnel file; or
- Has successfully completed RN, LPN, MD, physician assistant or CNA training in the past and has been employed in the field within the past 2 years; or
- Has been employed as a CCP homecare aide within the past year, verification by supervisor with signed statement in HR file; (complete verification form and attach)

This form completed by:

\_\_\_\_\_  
**Homecare Supervisor**



## INFLUENZA VACCINATION/DECLINATION

My employer, NORTH LIGHT CARE SERVICES LTD, requires that I receive influenza vaccination to protect patients and staff in my work location.

I acknowledge that I have been advised of the following facts:

- Influenza is a serious respiratory disease that kills an average of 36,000 persons and hospitalizes more than 200,000 persons in the United States each year.
- Influenza vaccination is required to protect patients and staff from influenza disease, its complications, and death.
- If I contract influenza, I will shed the virus for 24–48 hours before influenza symptoms appear. My shedding virus can spread influenza disease to patients in this facility.
- If I become infected with influenza, even when my symptoms are mild or non-existent, I can spread severe illness to others.
- The strains of virus that cause influenza infection change almost every year, which is why a different influenza vaccine is recommended each year.
- I cannot get influenza from the influenza vaccine.
- My refusal to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including patients, coworkers, family, and community.

Despite these facts, I am choosing to decline influenza vaccination right now for the following reasons:

- Medical contraindication
- Religious objection
- Personal choice
- Other (please specify): \_\_\_\_\_

I understand that:

- I can change my mind at any time and accept influenza vaccination, if a vaccine is available.
- My declination will result in certain educational requirements. I have read the ***Policy on Influenza Vaccination for North Light Care Services Employees*** as it relates to the educational requirements.

I have read and fully understand the information on this declination form.

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_



## **DIRECT DEPOSIT FORM**

### **Employee Information:**

Full Name: \_\_\_\_\_

### **Banking Information:**

Bank Name: \_\_\_\_\_

Routing Number: \_\_\_\_\_

Account Number: \_\_\_\_\_

Account Type:  Checking /  Savings (Select one)

I hereby authorize **NORTH LIGHT CARE SERVICES LTD** to initiate credit entries to my account indicated above, and to credit the same to such account. I acknowledge that the amount of credit may be adjusted as necessary to correct any errors in processing.

I certify that the above information is true and correct to the best of my knowledge. I understand that it is my responsibility to notify **NORTH LIGHT CARE SERVICES LTD** promptly of any changes to my banking information.

\_\_\_\_\_  
**Employee Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**HR Representative Signature**

\_\_\_\_\_  
**Date**

# 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.

**2025**

<b>Step 1:</b> <b>Enter Personal Information</b>	(a) First name and middle initial	Last name	(b) Social security number
	Address		<b>Does your name match the name on your social security card?</b> If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to <a href="http://www.ssa.gov">www.ssa.gov</a> .
	City or town, state, and ZIP code		
	(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

**TIP:** Consider using the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to determine the most accurate withholding for the rest of the year if: you are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

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

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

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

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

<b>Step 3:</b> <b>Claim Dependent and Other Credits</b>	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 . . . . .	<b>3</b>	\$ _____
<b>Step 4 (optional): Other Adjustments</b>	(a) <b>Other income (not from jobs).</b> 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 . . . . .	<b>4(a)</b>	\$ _____
	(b) <b>Deductions.</b> 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 . . . . .	<b>4(b)</b>	\$ _____
	(c) <b>Extra withholding.</b> Enter any additional tax you want withheld each <b>pay period</b> . . . . .	<b>4(c)</b>	\$ _____

**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**

<b>Employers Only</b>	Employer's name and address	First date of employment	Employer identification number (EIN)

## 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-4, such as legislation enacted after it was published, go to [www.irs.gov/FormW4](http://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 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 **and** you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 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 2025 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 17, 2026.

**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](http://www.irs.gov/W4App) if you:

1. Are submitting this form after the beginning of the year;
2. Expect to work only part of the year;
3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;
4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or
5. Prefer the most accurate withholding for multiple job situations.

**TIP:** Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

**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](http://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. Submit a separate Form W-4 for each job.

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 2025 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
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
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
c Add the amounts from lines 2a and 2b and enter the result on line 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.
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)

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



- 1 Enter an estimate of your 2025 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
2 Enter: { \$30,000 if you're married filing jointly or a qualifying surviving spouse; \$22,500 if you're head of household; \$15,000 if you're single or married filing separately }
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-"
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
5 Add lines 3 and 4. Enter the result here and in Step 4(b) of Form W-4

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	\$700	\$850	\$910	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020
\$10,000 - 19,999	0	700	1,700	1,910	2,110	2,220	2,220	2,220	2,220	2,220	2,220	3,220
\$20,000 - 29,999	700	1,700	2,760	3,110	3,310	3,420	3,420	3,420	3,420	3,420	4,420	5,420
\$30,000 - 39,999	850	1,910	3,110	3,460	3,660	3,770	3,770	3,770	3,770	4,770	5,770	6,770
\$40,000 - 49,999	910	2,110	3,310	3,660	3,860	3,970	3,970	3,970	4,970	5,970	6,970	7,970
\$50,000 - 59,999	1,020	2,220	3,420	3,770	3,970	4,080	4,080	5,080	6,080	7,080	8,080	9,080
\$60,000 - 69,999	1,020	2,220	3,420	3,770	3,970	4,080	5,080	6,080	7,080	8,080	9,080	10,080
\$70,000 - 79,999	1,020	2,220	3,420	3,770	3,970	5,080	6,080	7,080	8,080	9,080	10,080	11,080
\$80,000 - 99,999	1,020	2,220	3,420	4,620	5,820	6,930	7,930	8,930	9,930	10,930	11,930	12,930
\$100,000 - 149,999	1,870	4,070	6,270	7,620	8,820	9,930	10,930	11,930	12,930	14,010	15,210	16,410
\$150,000 - 239,999	1,870	4,240	6,640	8,190	9,590	10,890	12,090	13,290	14,490	15,690	16,890	18,090
\$240,000 - 259,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
\$260,000 - 279,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
\$280,000 - 299,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
\$300,000 - 319,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,170	19,170
\$320,000 - 364,999	2,040	4,440	6,840	8,390	9,790	11,100	12,470	14,470	16,470	18,470	20,470	22,470
\$365,000 - 524,999	2,790	6,290	9,790	12,440	14,940	17,350	19,650	21,950	24,250	26,550	28,850	31,150
\$525,000 and over	3,140	6,840	10,540	13,390	16,090	18,700	21,200	23,700	26,200	28,700	31,200	33,700

**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	\$200	\$850	\$1,020	\$1,020	\$1,020	\$1,370	\$1,870	\$1,870	\$1,870	\$1,870	\$1,870	\$2,040
\$10,000 - 19,999	850	1,700	1,870	1,870	2,220	3,220	3,720	3,720	3,720	3,720	3,890	4,090
\$20,000 - 29,999	1,020	1,870	2,040	2,390	3,390	4,390	4,890	4,890	4,890	5,060	5,260	5,460
\$30,000 - 39,999	1,020	1,870	2,390	3,390	4,390	5,390	5,890	5,890	6,060	6,260	6,460	6,660
\$40,000 - 59,999	1,220	3,070	4,240	5,240	6,240	7,240	7,880	8,080	8,280	8,480	8,680	8,880
\$60,000 - 79,999	1,870	3,720	4,890	5,890	7,030	8,230	8,930	9,130	9,330	9,530	9,730	9,930
\$80,000 - 99,999	1,870	3,720	5,030	6,230	7,430	8,630	9,330	9,530	9,730	9,930	10,130	10,580
\$100,000 - 124,999	2,040	4,090	5,460	6,660	7,860	9,060	9,760	9,960	10,160	10,950	11,950	12,950
\$125,000 - 149,999	2,040	4,090	5,460	6,660	7,860	9,060	9,950	10,950	11,950	12,950	13,950	14,950
\$150,000 - 174,999	2,040	4,090	5,460	6,660	8,450	10,450	11,950	12,950	13,950	15,080	16,380	17,680
\$175,000 - 199,999	2,040	4,290	6,450	8,450	10,450	12,450	13,950	15,230	16,530	17,830	19,130	20,430
\$200,000 - 249,999	2,720	5,570	7,900	10,200	12,500	14,800	16,600	17,900	19,200	20,500	21,800	23,100
\$250,000 - 399,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
\$400,000 - 449,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
\$450,000 and over	3,140	6,490	9,160	11,660	14,160	16,660	18,660	20,160	21,660	23,160	24,660	26,160

**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	\$450	\$850	\$1,000	\$1,020	\$1,020	\$1,020	\$1,020	\$1,870	\$1,870	\$1,870	\$1,890
\$10,000 - 19,999	450	1,450	2,000	2,200	2,220	2,220	2,220	3,180	4,070	4,070	4,090	4,290
\$20,000 - 29,999	850	2,000	2,600	2,800	2,820	2,820	3,780	4,780	5,670	5,690	5,890	6,090
\$30,000 - 39,999	1,000	2,200	2,800	3,000	3,020	3,980	4,980	5,980	6,890	7,090	7,290	7,490
\$40,000 - 59,999	1,020	2,220	2,820	3,830	4,850	5,850	6,850	8,050	9,130	9,330	9,530	9,730
\$60,000 - 79,999	1,020	3,030	4,630	5,830	6,850	8,050	9,250	10,450	11,530	11,730	11,930	12,130
\$80,000 - 99,999	1,870	4,070	5,670	7,060	8,280	9,480	10,680	11,880	12,970	13,170	13,370	13,570
\$100,000 - 124,999	1,950	4,350	6,150	7,550	8,770	9,970	11,170	12,370	13,450	13,650	14,650	15,650
\$125,000 - 149,999	2,040	4,440	6,240	7,640	8,860	10,060	11,260	12,860	14,740	15,740	16,740	17,740
\$150,000 - 174,999	2,040	4,440	6,240	7,640	8,860	10,860	12,860	14,860	16,740	17,740	18,940	20,240
\$175,000 - 199,999	2,040	4,440	6,640	8,840	10,860	12,860	14,860	16,910	19,090	20,390	21,690	22,990
\$200,000 - 249,999	2,720	5,920	8,520	10,960	13,280	15,580	17,880	20,180	22,360	23,660	24,960	26,260
\$250,000 - 449,999	2,970	6,470	9,370	11,870	14,190	16,490	18,790	21,090	23,280	24,580	25,880	27,180
\$450,000 and over	3,140	6,840	9,940	12,640	15,160	17,660	20,160	22,660	25,050	26,550	28,050	29,550



# 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	
<p><b>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.</b></p>		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):				
		<input type="checkbox"/> 1. A citizen of the United States				
		<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)				
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)				
<input type="checkbox"/> 4. A noncitizen (other than <b>Item Numbers 2.</b> and <b>3.</b> above) authorized to work until (exp. date, if any)						
If you check <b>Item Number 4.</b> , 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)	<p><b>Additional Information</b></p>				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)	<p><input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.</p>				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

**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.

Last Name, First Name and Title of Employer or Authorized Representative		Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)
<b>OLARTE, JOANNA   ADMINISTRATOR</b>				
Employer's Business or Organization Name		Employer's Business or Organization Address, City or Town, State, ZIP Code		
<b>NORTH LIGHT CARE SERVICES</b>		<b>1328 MAINT ST., CRETE, IL 60417</b>		

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
<ol style="list-style-type: none"> <li>1. U.S. Passport or U.S. Passport Card</li> <li>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</li> <li>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</li> <li>4. Employment Authorization Document that contains a photograph (Form I-766)</li> <li>5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole:               <ol style="list-style-type: none"> <li>a. Foreign passport; and</li> <li>b. Form I-94 or Form I-94A that has the following:                   <ol style="list-style-type: none"> <li>(1) The same name as the passport; and</li> <li>(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.</li> </ol> </li> </ol> </li> <li>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</li> </ol>	OR	<ol style="list-style-type: none"> <li>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</li> <li>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</li> <li>3. School ID card with a photograph</li> <li>4. Voter's registration card</li> <li>5. U.S. Military card or draft record</li> <li>6. Military dependent's ID card</li> <li>7. U.S. Coast Guard Merchant Mariner Card</li> <li>8. Native American tribal document</li> <li>9. Driver's license issued by a Canadian government authority</li> <li style="text-align: center;"><b>For persons under age 18 who are unable to present a document listed above:</b></li> <li>10. School record or report card</li> <li>11. Clinic, doctor, or hospital record</li> <li>12. Day-care or nursery school record</li> </ol>	AND	<ol style="list-style-type: none"> <li>1. A Social Security Account Number card, unless the card includes one of the following restrictions:               <ol style="list-style-type: none"> <li>(1) NOT VALID FOR EMPLOYMENT</li> <li>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</li> <li>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</li> </ol> </li> <li>2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)</li> <li>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</li> <li>4. Native American tribal document</li> <li>5. U.S. Citizen ID Card (Form I-197)</li> <li>6. Identification Card for Use of Resident Citizen in the United States (Form I-179)</li> <li>7. Employment authorization document issued by the Department of Homeland Security               <p style="margin-left: 20px;">For examples, see <a href="#">Section 7</a> and <a href="#">Section 13</a> of the M-274 on <a href="https://uscis.gov/i-9-central">uscis.gov/i-9-central</a>.</p> <p style="margin-left: 20px;">The Form I-766, Employment Authorization Document, is a List A, <b>Item Number 4</b>, document, not a List C document.</p> </li> </ol>
<p><b>Acceptable Receipts</b></p> <p>May be presented in lieu of a document listed above for a temporary period.</p> <p>For receipt validity dates, see the M-274.</p>				
<ul style="list-style-type: none"> <li>• Receipt for a replacement of a lost, stolen, or damaged List A document.</li> <li>• Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual.</li> <li>• Form I-94 with "RE" notation or refugee stamp issued to a refugee.</li> </ul>	OR	<p>Receipt for a replacement of a lost, stolen, or damaged List B document.</p>	AND	<p>Receipt for a replacement of a lost, stolen, or damaged List C document.</p>

\*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 ( <i>Family Name</i> ) from <b>Section 1</b> .	First Name ( <i>Given Name</i> ) from <b>Section 1</b> .	Middle initial (if any) from <b>Section 1</b> .
--	--	---

**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 ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )		First Name ( <i>Given Name</i> )		Middle Initial ( <i>if any</i> )
Address ( <i>Street Number and Name</i> )		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 ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )		First Name ( <i>Given Name</i> )		Middle Initial ( <i>if any</i> )
Address ( <i>Street Number and Name</i> )		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 ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )		First Name ( <i>Given Name</i> )		Middle Initial ( <i>if any</i> )
Address ( <i>Street Number and Name</i> )		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 ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )		First Name ( <i>Given Name</i> )		Middle Initial ( <i>if any</i> )
Address ( <i>Street Number and Name</i> )		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 ( <i>Family Name</i> ) from Section 1.	First Name ( <i>Given Name</i> ) 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 ( <i>if applicable</i> )	New Name ( <i>if applicable</i> )		
Date ( <i>mm/dd/yyyy</i> )	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) ( <i>mm/dd/yyyy</i> )
----------------	--------------------------	--

**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 ( <i>mm/dd/yyyy</i> )
---	--	------------------------------------

Additional Information (Initial and date each notation.)

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

Date of Rehire ( <i>if applicable</i> )	New Name ( <i>if applicable</i> )		
Date ( <i>mm/dd/yyyy</i> )	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) ( <i>mm/dd/yyyy</i> )
----------------	--------------------------	--

**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 ( <i>mm/dd/yyyy</i> )
---	--	------------------------------------

Additional Information (Initial and date each notation.)

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

Date of Rehire ( <i>if applicable</i> )	New Name ( <i>if applicable</i> )		
Date ( <i>mm/dd/yyyy</i> )	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) ( <i>mm/dd/yyyy</i> )
----------------	--------------------------	--

**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 <b>JOANNA OLARTE</b>	Signature of Employer or Authorized Representative	Today's Date ( <i>mm/dd/yyyy</i> )
---	--	------------------------------------

Additional Information (Initial and date each notation.)

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