CC CODE: _____

# WORK AVAILABILITY

**NAME:** _____ **LANGUAGE**: _____

**TELEPHONE#:** _____, _____

**DAYS AND HOURS:** **COMMENTS:**

___Saturday ___AM ___PM _____

___Sunday ___AM ___PM _____

___Monday ___AM ___PM _____

___Tuesday ___AM ___PM _____

___Wednesday ___AM ___PM _____

___Thursday ___AM ___PM _____

___Friday ___AM ___PM _____

**DO YOU USE A SMART PHONE?** ___ Yes ___ No

Are pets OK? ___Yes ___No _____

Is smoking OK? ___Yes ___No _____

Kosher experience? ___Yes ___No _____

Is vehicle available for work? ___Yes ___No _____

Shift Preference: ☐ 4 hour ☐ 8 hour ☐12 hour ☐ Live-In

Location(s): ☐ Brooklyn ☐ Queens ☐ Bronx ☐ Manhattan ☐ Long Island

EDISON
HOME HEALTH CARE

# ORIENTATION CHECKLIST

**Name:** _____ **SS#:** _____

**Title:** _____HHA / PCA_____

| **Welcome to Edison Home Health Care** | **↓Your Initials↓** | **↓Date↓** |
|---|---|---|
| A. Tax Forms from TAXOA | | |
| B. I-9 Form, Wage form, W-4 | | |
| C. Employee Handbook | | |
| 1. Employment Requirements and Agency Policies | | |
| 2. Continuous Employment | | |
| 3. Job Description | | |
| 4. HHA Services Fact Sheet | | |
| 5. Required E V V, (clock in/out) | | |
| 6. Case Acceptance | | |
| 7. Absences and Lateness Policy | | |
| 8. Patient Abandonment Policy | | |
| 9. No Call No Show Policy | | |
| 10. Dress Code | | |
| 11. Cellular/Wireless Device Policy | | |
| 12. Employee Counseling | | |
| 13. Grievances/Complaints | | |
| 14. 47 Points of Discussion | | |
| 15. Equal Employment Opportunity Policy | | |
| 16. Pregnancy Accommodations | | |
| 17. Anti-Harassment Policy | | |
| 18. Sexual Harassment Policy | | |
| 19. Protection Against Retaliation | | |
| D. Code of Conduct | | |
| a. Fraud and Abuse | | |
| b. Professional Standards | | |
| c. Confidentiality | | |
| E. HHA/PCA Activity -- DUTY CODES/Timesheets | | |
| F. HHA Exchange App | | |
| G. Medflyt App | | |
| H. Picture IDs | | |
| I. Missing Documentation from Application Process | | |

I have read my job description and understand that I will be evaluated based on the performance criteria in my job description. I acknowledge having completed all of the orientation in service curriculum.

_____ _____

**EMPLOYEES SIGNATURE** **Date**

_____ _____

**INSTRUCTOR'S SIGNATURE** **Date**

EDISON
HOME HEALTH CARE

## Acknowledgement of Receipt of the

## Paid Safe and Sick Leave Notice of Employee Rights

I _____ have received the Notice of Employee Rights for the Paid Safe and Sick Leave Law. My questions regarding Paid Safe and Sick Leave have been answered.

I know I can contact Edison Home Health Care at the above address or telephone number if I have any other questions regarding this notice.

I understand the following about the Paid Safe and Sick Leave:

1- I must work 80 hours or more per calendar year (from January 1st to December 31st) in order to be covered by the Paid Sick Leave Law.

2- I accrue 1 hour for every 30 hours worked, up to a maximum of 40 hours per calendar year.

3- For new employees: I can use the accrued time after 120 days from my 1st work day.

4- I am allowed to carry over any unused sick leave to the following year but can only use up to 40 hours of Paid Sick Leave per calendar year.

5- I am required to provide Edison with a health care provider's note if I use my sick leave time for four or more consecutive days, no specifics regarding my health is necessary.

6- I may use Paid Sick Leave for sick leave ONLY and I must be scheduled in order to use sick leave. I must provide Edison with 7 days of advance notice whenever possible; if I am presented with an unforeseeable situation, then I will provide a notice as soon as possible.

7- I understand that if I call out or sick the day before or the day after a holiday I am scheduled to work, I will not get paid sick time even if I have it available.

_____ _____

**Employee's Signature** **Date**

***Acknowledgement Of***
***HHA Exchange Time and Attendance***
***And Duty Codes Training and Responsibilities***

I _____ certify that I have been trained on Edison Home Health Care's automatic time and attendance and duty codes. I understand that my paycheck is generated by the call in and out through HHA Exchange automated telephone system. If I do not clock in and out correctly I will not be paid. When I clock out, it is my responsibility to dial in the duty codes that represent the duties I have performed for my patient that day. I must specify at least five duties performed. The Plan of Care should match the duties I put in. I must immediately inform my supervisor if the client's telephone is not working or if the client refuses the use their telephone.

I understand that my work day must be verified. If I fail to clock in and out correctly (because of circumstances out of my control, ex: telephone is not working) the visit must be verified by the submission of a signed and verified time sheet. If the visit is not verified, then Edison Home Health Care will not be able to generate a pay check for that unverified work day.

I certify that I have been trained on Edison Home Health Care's "on-call" policy and procedure. I understand that when the office is closed and there is an emergency or if I am unable to make it to work, it is my responsibility to follow the proper procedure. I must reach the answering service. I may not leave a voicemail.

I may be subject to disciplinary actions/investigation and or termination for violation of the agency's policy and procedures, including but not limited to time and attendance.

_____ _____

**Employee's Signature** **Date**

_____ _____

**Instructor's Signature** **Date**

***Acknowledgement Of***
***HHA Mandatory Compliance Responsibilities***

I _____ Home Health Aide certify that I have been oriented and trained regarding mandatory compliance responsibilities of the agency with the Department of Health. Although Edison Home Health Care reminds me of annual compliance needs, it is my sole responsibility to:

1) Attend 7 hours of In Service every 6 months to complete 14 hours annually.
2) To have completed a pre-employment physical, PPD and toxicology drug screen.
3) To have obtained Rubella and Rubeola Titers prior to employment
4) To obtain an annual physical, drug screen and PPD
5) If I have a history of a Positive PPD, I will submit an annual TB Questionnaire and a copy of a Chest X-ray report to EHHC.
6) To have an Edison ID

I acknowledge that I am solely responsible to submit these required documentations in order to continue my employment with Edison Home Health Care. I acknowledge that for the safety of the patients whom I will service I will not be able to work with patients if I do not have these requirements completed. I have read, understand and agree with Edison Home Health Care Personnel Policy and will abide by it.

_____ _____

**Employee Signature** **Date**

# CORPORATE COMPLIANCE / CONFLICT OF INTEREST NON-SOLICITATION AND NONCIRCUMVENTION

As an employee of Edison Home Health Care (the agency), I, _____, understand that any attempt on my part to provide services to a patient without the knowledge of the agency would be harmful and damaging to the agency. I agree that during the term of my employment with the agency and for a period of ninety (90) days after the end of my employment:

1. I will not in any way, directly or indirectly, offer to provide services to any of the agency's patients without the agency's actual knowledge, authorization and consent.

2. I will not in any way, directly or indirectly, accept a patient's offer to hire me directly without the agency's actual knowledge, authorization and consent.

3. I will not in any way, directly or indirectly, actually provide services to any of the agency's patients without the agency's actual knowledge, authorization and consent.

I recognize that a breach of this agreement can result in harm to the agency and agree that in the event of such a breach, I will be liable to pay the agency a minimum of the full payment the agency would have earned had I not circumvented the agency, plus further damages to the extent allowed by law and that the agency shall be entitled to and may seek any and all additional remedies to the extent available by law.

**Employee Signature** **Date**

Form **8850**
(Rev. March 2016)
Department of the Treasury
Internal Revenue Service

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

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

OMB No. 1545-1500

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

Your name _____ Social security number ► _____

Street address where you live _____

City or town, state, and ZIP code _____

County _____ Telephone number _____

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

**1** ☐ Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.

**2** ☐ Check here if **any** of the following statements apply to you.

- I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
- I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
- I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
- I am at least age 18 but **not** age 40 or older and I am a member of a family that:
  **a.** Received SNAP benefits (food stamps) for the past 6 months; **or**
  **b.** Received SNAP benefits (food stamps) for at least 3 of the past 5 months, **but** is no longer eligible to receive them.
- During the past year, I was convicted of a felony or released from prison for a felony.
- I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
- I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.

**3** ☐ Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.

**4** ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.

**5** ☐ Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.

**6** ☐ Check here if you are a member of a family that:

- Received TANF payments for at least the past 18 months; **or**
- Received TANF payments for any 18 months beginning after August 5, 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years; **or**
- Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.

**7** ☐ Check here if you are in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation.

**Signature—All Applicants Must Sign**

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

**Job applicant's signature ►** **Date**

TAX OPPORTUNITIES AMERICA
"you work hard, we give you the credit"

**Please fill in these forms and legibly.** **Company Name:**_____
(NO script)

**Have you worked for this Employer before?** **Are you a Re-hire?** Yes☐ No☐
**If Yes**, enter last day of employment:_____

**Are you under age 40?** Yes☐ No☐

**Have you been unemployed for at least 27 weeks,** and collected Unemployment Insurance for part or all of that time period? Yes☐ No☐
If YES, what state did you receive unemployment compensation in? _____
(Enter state where UI compensation was received)

Have you or your family, received **SNAP benefits (Food Stamps)** in the **6 months** before you were hired? Yes☐ No☐
Or received **SNAP Benefits** for at least a **3 month period**, but you are no longer receiving it? Yes☐ No☐
If yes to either question, enter Name of Primary Recipient: _____
And City, State where benefits were received_____.

Are you a member of a family that received **Temporary Assistance for Needy Families (TANF)** assistance for at least 18 months before you were hired? Yes☐ No☐
Or, did your family stop being eligible for **Temporary Assistance for Needy Families (TANF)** assistance Within 2 years before being hired, because you reached the maximum time those benefits can be received? Yes☐ No☐
If yes to either question, enter Name of Primary Recipient:_____
And City, State where benefits were received_____

**Are you a Veteran of the US Armed Forces?** Yes☐ No☐
If *yes*:
Are you a member of a family that received SNAP (Food Stamps Benefits)? Yes☐ No☐
Are you entitled to compensation for a service-connected disability? Yes☐ No☐
Were you discharged from active duty within the last year? Yes☐ No☐
Were you unemployed for a combined total of 6 months before you were hired? Yes☐ No☐

Did you receive Supplemental Security Income **(SSI Benefits)** for any month, ending within the 60 days, before you were hired? Yes☐ No☐

Were you convicted of a **Felony** during the year before you were hired? Yes☐ No☐

Were you referred to an employer by:
- A Vocational Rehab Agency approved by the state? Yes☐ No☐
- An Employment Network under the Ticket to Work Program? Yes☐ No☐
- The Dept. of Veteran Affairs? Yes☐ No☐

| Print Name: | Social Security#: | Date of Birth: |
|---|---|---|
| _____ | _____ | _____ |

This company participates in various federal and state tax credit programs. This information in no way will negatively impact any hiring, retention decision. Your responses to the questions will only be shared with your employer's management and federal, state, or local govern mental agencies as needed in administration of these 5 programs. By completing this form, you knowingly and voluntarily waive any objection to providing your social security number. Any information provided will be used in a manner consistent with the American Disability Act. Under penalty of perjury, I certify that this information is true and correct to the best of my knowledge. I hereby authorize this company's management, and federal, state, and local government agencies to provide information I to Tax Opportunities America and/or SWA, to determine eligibility. I understand that the information above may be subject to verification.

**Employment Start Date**_____ **Starting Wage**_____ **Position**_____

**Signature**_____ **Today's Date**_____

For any questions, email info@taxoa.com, or call 718.705.9003

U.S. Department Labor
Employment and Training Administration

OMB Control No. 1205-0371
Expiration Date: January 31, 2020

# LONG-TERM UNEMPLOYMENT RECIPIENT SELF-ATTESTATION FORM
## Work Opportunity Tax Credit (WOTC) Program

Instructions: This Self-Attestation Form (SAF) is to be completed, signed, and dated by the new hire only. Employers or consultants submit this SAF to the State Workforce Agency with IRS Form 8850 or if filed separately, with ETA Form 9061 (or ETA Form 9062) for each certification request filed for the new target group.

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

New Hire's Signature: _____Date_____

New Hire Name: _____

Social Security Number: _____-☐☐☐☐
(Enter last four digits)

Employer Name: _____

**Please check the statements below if they apply to you.**

☐ I declare that I was in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period I received unemployment compensation.

☐ I declare that I have been in a period of unemployment since _____.
(Enter start date)

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

**Public Burden Statement:**
Persons are not required to respond to this collection of information unless it displays a currently valid OM B control number. Respondents' obligation to complete this form is required to obtain or retain benefits (P.L. 111-5). Public reporting burden is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of Information. Send comments regarding this burden estimate to the U.S. Department of Labor, Division of National Programs Tools Technical Assistance, Room C-4510, Washington, D.C. 20210 (Paperwork Reduction Project 1205-0371). Please do not submit completed forms to this address.

TAX OPPORTUNITIES AMERICA
"you work hard, we give you the credit"

# New York Urban Youth Jobs Program

First Name_____ Last Name_____

Date of Birth_____ SSN:_____ Phone Number:_____

Home Address:_____ City, State, Zip:_____

Email _____

**I am currently working.**

☐Yes ☐No (If yes, please give start date_____)

**I am 16 or 17 years old and have the permission of my parent of guardian to submit this application:**

☐Yes ☐No

**I am 18 to 24 years old:**

☐Yes ☐No

I have a high school diploma, a GED or HSE diploma, satisfactorily completed a TASC exam, or I am enrolled in a TASC program.

☐Yes ☐No

☐ **I confirm that I currently meet one or more of the youth categories listed below.**

- I am over 18 and do not have a high school diploma of GED/HSE diploma.
- I am a member of a family that is receiving assistance from Temporary Assistance for Needy Families (TANF).
- I am a member of a family that is receiving SNAP benefits (food stamps).
- I am a member of a family that is receiving SSI benefits.
- I am receiving a free of reduced-cost school lunch.
- I have served in jail or prison, or am on probation or parole.
- I am pregnant or a parent of a child.
- I am currently or was in foster care of the custody of the Office of Children and Family Services.
- I am a veteran.
- I am the daughter or son of a parent who is currently in jail or prison, or has been within in the past two years.
- I am the daughter or son of a parent who is collecting unemployment insurance.
- I live in public housing or receive housing assistance such as a Section 8 voucher, or is homeless.
- Another risk factor not identified above.

## Agreement

I have provided my private information on this application. While I need to disclose this information to qualify for the program, I understand that I do not need to explain the reasons I choose to anyone I ask for a job, who gives me a job, or who I work with. I agree to allow the New York State Department of Taxation and Finance to share my wage records with the New York State Department of Labor. I understand that the New York State Department of Labor will make sure the information submitted in this application is true and may ask me for details. I believe this information is correct and complete. I am aware that there are consequences for filling this false documents or other information with the government.

☐ **When I check this box and submit this form, I agree to the statement above.**

☐ **I allow Tax Opportunities America to submit this application on my behalf.**

For any questions, email info@taxoa.com, or call 718.705.9003

EDISON
HOME HEALTH CARE

# Acknowledgement of Mandatory Compliance Regarding Time Sheets and Clock In and Out

I _____ Home Health Aide / Personal Care Aide certify that I have been trained regarding mandatory compliance responsibilities of the agency with the Department of Health. I have been trained and understand the following:

- Timesheets must be filled out according to the time that I serviced the patient. I understand to write down the time that I was with the patient, **NOT** the scheduled time.
- I understand that I can not submit a timesheet if the patient is in care of a third party. Such as Hospital or Hospice or Dialysis Centers including any facilities that are considered 3rd Party.
- I have been trained and shown how to fill out a timesheet correctly.
- I understand that I must submit the time sheets by every week Monday the latest.
- I understand that I may not schedule myself to work for two patients at the same time.
- I understand that I must not give my clock-in ID # to anyone including the patient.
- I understand that the patient or anyone else cannot clock me in or out.
- I understand that I must not send anyone other than myself to work for me.
- I understand that if the patient has a working phone, **I MUST CLOCK IN AND OUT**.
- I understand that I will use the **patient's** telephone or cell phone, **NOT MY CELL PHONE,** to clock in and out.

I acknowledge that I am solely responsible for these requirements in order to continue my employment with Edison Home Health Care. Violations of these requirements are grounds for immediate termination. I acknowledge that for the safety of the patients whom I will service, I will abide by Edison Home Health Care policy.

_____ _____

Signature Date

_____

Print Name

Form **W-4**

Department of the Treasury
Internal Revenue Service

# Employee's Withholding Certificate

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

OMB No. 1545-0074

**2020**

## Step 1: Enter Personal Information

| **(a)** First name and middle initial | Last name | **(b) Social security number** |
|---|---|---|
| Address | | ► **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*. |
| City or town, state, and ZIP code | | |

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

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

## Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

**(a)** Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

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

**(c)** If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ► ☐

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

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

## Step 3: Claim Dependents

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

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

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

Add the amounts above and enter the total here . . . . . **3** $

## Step 4 (optional): Other Adjustments

**(a) Other income (not from jobs).** If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

**(b) Deductions.** If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

**(c) Extra withholding.** Enter any additional tax you want withheld each **pay period** . **4(c)** $

## Step 5: Sign Here

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

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

## Employers Only

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

# General Instructions

## Future Developments

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

## Purpose of Form

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

**Exemption from withholding.** You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 **and** you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), 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 2020 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 16, 2021.

**Your privacy.** If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

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

1. Expect to work only part of the year;

2. Have dividend or capital gain income, or are subject to additional taxes, such as the additional Medicare tax;

3. Have self-employment income (see below); or

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

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

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

# Specific Instructions

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

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

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

If you (and your spouse) have a total of only two jobs, you may instead 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 roughly 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.** Step 3 of Form W-4 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. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. 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 2020 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.

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

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

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

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

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

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

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

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

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

**1** Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $ _____

**2** Enter:
- $24,800 if you're married filing jointly or qualifying widow(er)
- $18,650 if you're head of household
- $12,400 if you're single or married filing separately

. . . . . **2** $ _____

**3** If line 1 is greater than line 2, subtract line 2 from line 1. If line 2 is greater than line 1, enter "-0-" . . **3** $ _____

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

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

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

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

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

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

## Married Filing Jointly or Qualifying Widow(er)

| 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 | $220 | $850 | $900 | $1,020 | $1,020 | $1,020 | $1,020 | $1,020 | $1,210 | $1,870 | $1,870 |
| $10,000 - 19,999 | 220 | 1,220 | 1,900 | 2,100 | 2,220 | 2,220 | 2,220 | 2,220 | 2,410 | 3,410 | 4,070 | 4,070 |
| $20,000 - 29,999 | 850 | 1,900 | 2,730 | 2,930 | 3,050 | 3,050 | 3,050 | 3,240 | 4,240 | 5,240 | 5,900 | 5,900 |
| $30,000 - 39,999 | 900 | 2,100 | 2,930 | 3,130 | 3,250 | 3,250 | 3,440 | 4,440 | 5,440 | 6,440 | 7,100 | 7,100 |
| $40,000 - 49,999 | 1,020 | 2,220 | 3,050 | 3,250 | 3,370 | 3,570 | 4,570 | 5,570 | 6,570 | 7,570 | 8,220 | 8,220 |
| $50,000 - 59,999 | 1,020 | 2,220 | 3,050 | 3,250 | 3,570 | 4,570 | 5,570 | 6,570 | 7,570 | 8,570 | 9,220 | 9,220 |
| $60,000 - 69,999 | 1,020 | 2,220 | 3,050 | 3,440 | 4,570 | 5,570 | 6,570 | 7,570 | 8,570 | 9,570 | 10,220 | 10,220 |
| $70,000 - 79,999 | 1,020 | 2,220 | 3,240 | 4,440 | 5,570 | 6,570 | 7,570 | 8,570 | 9,570 | 10,570 | 11,220 | 11,240 |
| $80,000 - 99,999 | 1,060 | 3,260 | 5,090 | 6,290 | 7,420 | 8,420 | 9,420 | 10,420 | 11,420 | 12,420 | 13,260 | 13,460 |
| $100,000 - 149,999 | 1,870 | 4,070 | 5,900 | 7,100 | 8,220 | 9,320 | 10,520 | 11,720 | 12,920 | 14,120 | 14,980 | 15,180 |
| $150,000 - 239,999 | 2,040 | 4,440 | 6,470 | 7,870 | 9,190 | 10,390 | 11,590 | 12,790 | 13,990 | 15,190 | 16,050 | 16,250 |
| $240,000 - 259,999 | 2,040 | 4,440 | 6,470 | 7,870 | 9,190 | 10,390 | 11,590 | 12,790 | 13,990 | 15,520 | 17,170 | 18,170 |
| $260,000 - 279,999 | 2,040 | 4,440 | 6,470 | 7,870 | 9,190 | 10,390 | 11,590 | 13,120 | 15,120 | 17,120 | 18,770 | 19,770 |
| $280,000 - 299,999 | 2,040 | 4,440 | 6,470 | 7,870 | 9,190 | 10,720 | 12,720 | 14,720 | 16,720 | 18,720 | 20,370 | 21,370 |
| $300,000 - 319,999 | 2,040 | 4,440 | 6,470 | 8,200 | 10,320 | 12,320 | 14,320 | 16,320 | 18,320 | 20,320 | 21,970 | 22,970 |
| $320,000 - 364,999 | 2,720 | 5,920 | 8,750 | 10,950 | 13,070 | 15,070 | 17,070 | 19,070 | 21,290 | 23,590 | 25,540 | 26,840 |
| $365,000 - 524,999 | 2,970 | 6,470 | 9,600 | 12,100 | 14,530 | 16,830 | 19,130 | 21,430 | 23,730 | 26,030 | 27,980 | 29,280 |
| $525,000 and over | 3,140 | 6,840 | 10,170 | 12,870 | 15,500 | 18,000 | 20,500 | 23,000 | 25,500 | 28,000 | 30,150 | 31,650 |

## 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 | $460 | $940 | $1,020 | $1,020 | $1,470 | $1,870 | $1,870 | $1,870 | $1,870 | $2,040 | $2,040 | $2,040 |
| $10,000 - 19,999 | 940 | 1,530 | 1,610 | 2,060 | 3,060 | 3,460 | 3,460 | 3,460 | 3,640 | 3,830 | 3,830 | 3,830 |
| $20,000 - 29,999 | 1,020 | 1,610 | 2,130 | 3,130 | 4,130 | 4,540 | 4,540 | 4,720 | 4,920 | 5,110 | 5,110 | 5,110 |
| $30,000 - 39,999 | 1,020 | 2,060 | 3,130 | 4,130 | 5,130 | 5,540 | 5,720 | 5,920 | 6,120 | 6,310 | 6,310 | 6,310 |
| $40,000 - 59,999 | 1,870 | 3,460 | 4,540 | 5,540 | 6,690 | 7,290 | 7,490 | 7,690 | 7,890 | 8,080 | 8,080 | 8,080 |
| $60,000 - 79,999 | 1,870 | 3,460 | 4,690 | 5,890 | 7,090 | 7,690 | 7,890 | 8,090 | 8,290 | 8,480 | 9,260 | 10,060 |
| $80,000 - 99,999 | 2,020 | 3,810 | 5,090 | 6,290 | 7,490 | 8,090 | 8,290 | 8,490 | 9,470 | 10,460 | 11,260 | 12,060 |
| $100,000 - 124,999 | 2,040 | 3,830 | 5,110 | 6,310 | 7,510 | 8,430 | 9,430 | 10,430 | 11,430 | 12,420 | 13,520 | 14,620 |
| $125,000 - 149,999 | 2,040 | 3,830 | 5,110 | 7,030 | 9,030 | 10,430 | 11,430 | 12,580 | 13,880 | 15,170 | 16,270 | 17,370 |
| $150,000 - 174,999 | 2,360 | 4,950 | 7,030 | 9,030 | 11,030 | 12,730 | 14,030 | 15,330 | 16,630 | 17,920 | 19,020 | 20,120 |
| $175,000 - 199,999 | 2,720 | 5,310 | 7,540 | 9,840 | 12,140 | 13,840 | 15,140 | 16,440 | 17,740 | 19,030 | 20,130 | 21,230 |
| $200,000 - 249,999 | 2,970 | 5,860 | 8,240 | 10,540 | 12,840 | 14,540 | 15,840 | 17,140 | 18,440 | 19,730 | 20,830 | 21,930 |
| $250,000 - 399,999 | 2,970 | 5,860 | 8,240 | 10,540 | 12,840 | 14,540 | 15,840 | 17,140 | 18,440 | 19,730 | 20,830 | 21,930 |
| $400,000 - 449,999 | 2,970 | 5,860 | 8,240 | 10,540 | 12,840 | 14,540 | 15,840 | 17,140 | 18,450 | 19,940 | 21,240 | 22,540 |
| $450,000 and over | 3,140 | 6,230 | 8,810 | 11,310 | 13,810 | 15,710 | 17,210 | 18,710 | 20,210 | 21,700 | 23,000 | 24,300 |

## 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 | $830 | $930 | $1,020 | $1,020 | $1,020 | $1,480 | $1,870 | $1,870 | $1,930 | $2,040 | $2,040 |
| $10,000 - 19,999 | 830 | 1,920 | 2,130 | 2,220 | 2,220 | 2,680 | 3,680 | 4,070 | 4,130 | 4,330 | 4,440 | 4,440 |
| $20,000 - 29,999 | 930 | 2,130 | 2,350 | 2,430 | 2,900 | 3,900 | 4,900 | 5,340 | 5,540 | 5,740 | 5,850 | 5,850 |
| $30,000 - 39,999 | 1,020 | 2,220 | 2,430 | 2,980 | 3,980 | 4,980 | 6,040 | 6,630 | 6,830 | 7,030 | 7,140 | 7,140 |
| $40,000 - 59,999 | 1,020 | 2,530 | 3,750 | 4,830 | 5,860 | 7,060 | 8,260 | 8,850 | 9,050 | 9,250 | 9,360 | 9,360 |
| $60,000 - 79,999 | 1,870 | 4,070 | 5,310 | 6,600 | 7,800 | 9,000 | 10,200 | 10,780 | 10,980 | 11,180 | 11,580 | 12,380 |
| $80,000 - 99,999 | 1,900 | 4,300 | 5,710 | 7,000 | 8,200 | 9,400 | 10,600 | 11,180 | 11,670 | 12,670 | 13,580 | 14,380 |
| $100,000 - 124,999 | 2,040 | 4,440 | 5,850 | 7,140 | 8,340 | 9,540 | 11,360 | 12,750 | 13,750 | 14,750 | 15,770 | 16,870 |
| $125,000 - 149,999 | 2,040 | 4,440 | 5,850 | 7,360 | 9,360 | 11,360 | 13,360 | 14,750 | 16,010 | 17,310 | 18,520 | 19,620 |
| $150,000 - 174,999 | 2,040 | 5,060 | 7,280 | 9,360 | 11,360 | 13,480 | 15,780 | 17,460 | 18,760 | 20,060 | 21,270 | 22,370 |
| $175,000 - 199,999 | 2,720 | 5,920 | 8,130 | 10,480 | 12,780 | 15,080 | 17,380 | 19,070 | 20,370 | 21,670 | 22,880 | 23,980 |
| $200,000 - 249,999 | 2,970 | 6,470 | 8,990 | 11,370 | 13,670 | 15,970 | 18,270 | 19,960 | 21,260 | 22,560 | 23,770 | 24,870 |
| $250,000 - 349,999 | 2,970 | 6,470 | 8,990 | 11,370 | 13,670 | 15,970 | 18,270 | 19,960 | 21,260 | 22,560 | 23,770 | 24,870 |
| $350,000 - 449,999 | 2,970 | 6,470 | 8,990 | 11,370 | 13,670 | 15,970 | 18,270 | 19,960 | 21,260 | 22,560 | 23,900 | 25,200 |
| $450,000 and over | 3,140 | 6,840 | 9,560 | 12,140 | 14,640 | 17,140 | 19,640 | 21,530 | 23,030 | 24,530 | 25,940 | 27,240 |

EDISON
HOME HEALTH CARE

# Acknowledgement of Receipt of the

# Personnel Policy and Privacy Notice

I _____ have received Edison Home Health Care Personnel Policy and Privacy Notice. My questions regarding the Personnel Policy and Privacy Notice have been answered.

I know I can contact Edison Home Health Care at the above address or telephone number if I have any other questions regarding this form.

I further understand that my employment is at will, and neither Edison Home Health Care nor I have entered a contract regarding the duration of my employment. Except as otherwise provided in a valid and enforceable collective bargaining agreement, I am free to terminate my employment with the Edison Home Health Care at any time, with or without reason and Edison Home Health Care has the right to terminate my employment, or otherwise discipline, transfer, or demote me at any time, with or without reason at the discretion of the Facility. No employee of Edison Home Health Care can enter into an employment contract for a specified period of time or make any agreement contrary to this policy without the written approval of the Administrator.

_____ _____

**Employee's Signature** **Date**

Department of Taxation and Finance

# Employee's Withholding Allowance Certificate

**New York State • New York City • Yonkers**

# IT-2104

| First name and middle initial | Last name | Your Social Security number |
|---|---|---|
| | | |
| Permanent home address *(number and street or rural route)* | Apartment number | Single or Head of household ☐ Married ☐ |
| | | Married, but withhold at higher single rate ☐ |
| City, village, or post office | State / ZIP code | **Note:** If married but legally separated, mark an ***X*** in the *Single or Head of household* box. |

Are you a resident of New York City? ..... Yes ☐ No ☐

Are you a resident of Yonkers? ..... Yes ☐ No ☐

**Complete the worksheet on page 4 before making any entries.**

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

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

| | | |
|---|---|---|
| **3** New York State amount ..... | **3** | |
| **4** New York City amount ..... | **4** | |
| **5** Yonkers amount ..... | **5** | |

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

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

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

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

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**Employer: Keep this certificate with your records.**

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

A Employee claimed more than 14 exemption allowances for NYS ..... A ☐

B Employee is a new hire or a rehire ... B ☐ First date employee performed services for pay *(mm-dd-yyyy) (see instr.)*:

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

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

| Employer's name and address *(Employer: complete this section only if you are sending a copy of this form to the NYS Tax Department.)* | Employer identification number |
|---|---|
| | |

## Instructions

### Changes effective for 2020

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

### Who should file this form

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

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

For tax years 2020 or later, withholding allowances are no longer reported on federal Form W-4. Therefore, if you submit a federal Form W-4 to your employer for tax year 2020 or later, and you do not file Form IT-2104, your employer may use zero as your number of allowances. This may result in the wrong amount of tax withheld for New York State, New York City, and Yonkers.

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

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

- The total income of you and your spouse has increased to $107,650 or more for the tax year.
- You have significantly more or less income from other sources or from another job.
- You no longer qualify for exemption from withholding.
- You have been advised by the Internal Revenue Service that you are entitled to fewer allowances than claimed on your original federal Form W-4 (submitted to your employer for tax year 2019 or earlier), and the disallowed allowances were claimed on your original Form IT-2104.
- You are a covered employee of an employer that has elected to participate in the Employer Compensation Expense Program.
- You made contributions to a New York Charitable Gifts Trust Fund (the Health Charitable Account or the Elementary and Secondary Education Account).

## Exemption from withholding

You cannot use Form IT-2104 to claim exemption from withholding. To claim exemption from income tax withholding, you **must** file Form IT-2104-E, *Certificate of Exemption from Withholding*, with your employer. You must file a new certificate each year that you qualify for exemption. This exemption from withholding is allowable only if you had no New York income tax liability in the prior year, you expect none in the current year, **and** you are over 65 years of age, under 18, or a full-time student under 25. You may also claim exemption from withholding if you are a military spouse and meet the conditions set forth under the Servicemembers Civil Relief Act as amended by the Military Spouses Residency Relief Act and the Veterans Benefits and Transition Act. If you are a dependent who is under 18 or a full-time student, you may owe tax if your income is more than $3,100.

## Withholding allowances

You may **not** claim a withholding allowance for yourself or, if married, your spouse. Claim the number of withholding allowances you compute in Part 1 and Part 5 of the worksheet on page 4. If you want more tax withheld, you may claim fewer allowances. **If you claim more than 14 allowances,** your employer **must send** a copy of your **Form IT-2104** to the New York State Tax Department. You may then be asked to verify your allowances. If you arrive at negative allowances (less than zero) on lines 1 or 2 and your employer cannot accommodate negative allowances, **enter *0*** and see *Additional dollar amount(s)* below.

**Income from sources other than wages –** If you have more than $1,000 of income from sources other than wages (such as interest, dividends, or alimony received), reduce the number of allowances claimed on line 1 and line 2 (if applicable) of the IT-2104 certificate by one for each $1,000 of nonwage income. If you arrive at negative allowances (less than zero), see *Withholding allowances* above. You may also consider making estimated tax payments, especially if you have significant amounts of nonwage income. Estimated tax requires that payments be made by the employee directly to the Tax Department on a quarterly basis. For more information, see the instructions for Form IT-2105, *Estimated Tax Payment Voucher for Individuals*, or see *Need help?* on page 7.

**Other credits** (Worksheet line 14) **–** If you will be eligible to claim any credits other than the credits listed in the worksheet, such as an investment tax credit, you may claim additional allowances.

Find your filing status and your New York adjusted gross income (NYAGI) in the chart below, and divide the amount of the expected credit by the number indicated. Enter the result (rounded to the nearest whole number) on line 14.

| Single and NYAGI is: | Head of household and NYAGI is: | Married and NYAGI is: | Divide amount of expected credit by: |
|---|---|---|---|
| Less than $215,400 | Less than $269,300 | Less than $323,200 | 65 |
| Between $215,400 and $1,077,550 | Between $269,300 and $1,616,450 | Between $323,200 and $2,155,350 | 68 |
| Over $1,077,550 | Over $1,616,450 | Over $2,155,350 | 88 |

**Example:** *You are married and expect your New York adjusted gross income to be less than $323,200. In addition, you expect to receive a flow-through of an investment tax credit from the S corporation of which you are a shareholder. The investment tax credit will be $160. Divide the expected credit by 65. 160/65 = 2.4615. The additional withholding allowance(s) would be 2. Enter **2** on line 14.*

**Married couples with both spouses working –** If you and your spouse both work, you should each file a separate IT-2104 certificate with your respective employers. Your withholding will better match your total tax if the higher wage-earning spouse claims all of the couple's allowances and the lower wage-earning spouse claims zero allowances. **Do not** claim more total allowances than you are entitled to. If your combined wages are:

- less than $107,650, you should each mark an ***X*** in the box *Married, but withhold at higher single rate* on the certificate front, and divide the total number of allowances that you compute on line 20 and line 35 (if applicable) between you and your working spouse.
- $107,650 or more, use the chart(s) in Part 6 and enter the additional withholding dollar amount on line 3.

**Taxpayers with more than one job –** If you have more than one job, file a separate IT-2104 certificate with each of your employers. Be sure to claim only the total number of allowances that you are entitled to. Your withholding will better match your total tax if you claim all of your allowances at your higher-paying job and zero allowances at the lower-paying job. In addition, to make sure that you have enough tax withheld, if you are a single taxpayer or head of household with two or more jobs, and your combined wages from all jobs are under $107,650, reduce the number of allowances by seven on line 1 and line 2 (if applicable) on the certificate you file with your higher-paying job employer. If you arrive at negative allowances (less than zero), see *Withholding allowances* above.

If you are a single or a head of household taxpayer, and your combined wages from all of your jobs are between $107,650 and $2,263,265, use the chart(s) in Part 7 and enter the additional withholding dollar amount from the chart on line 3.

If you are a married taxpayer, and your combined wages from all of your jobs are $107,650 or more, use the chart(s) in Part 6 and enter the additional withholding dollar amount from the chart on line 3 (Substitute the words *Higher-paying job* for *Higher earner's wages* within the chart).

**Dependents –** If you are a dependent of another taxpayer and expect your income to exceed $3,100, you should reduce your withholding allowances by one for each $1,000 of income over $2,500. This will ensure that your employer withholds enough tax.

Following the above instructions will help to ensure that you will not owe additional tax when you file your return.

**Heads of households with only one job –** If you will use the head-of-household filing status on your state income tax return, mark the *Single or Head of household* box on the front of the certificate. If you have only one job, you may also wish to claim two additional withholding allowances on line 15.

## Additional dollar amount(s)

You may ask your employer to withhold an additional dollar amount each pay period by completing lines 3, 4, and 5 on Form IT-2104. In most instances, if you compute a negative number of allowances and your employer cannot accommodate a negative number, for each negative allowance claimed you should have an additional $1.85 of tax withheld per week for New York State withholding on line 3, and an additional $0.80 of tax withheld per week for New York City withholding on line 4. Yonkers residents should use 16.75% (.1675) of the New York State amount for additional withholding for Yonkers on line 5.

**Note:** If you are requesting your employer to withhold an additional dollar amount on lines 3, 4, or 5 of this allowance certificate, the additional dollar amount, as determined by these instructions or by using the chart(s) in Part 6 or Part 7, is accurate for a weekly payroll. Therefore, if you are not paid on a weekly basis, you will need to adjust the dollar amount(s) that you compute. For example, if you are paid biweekly, you must double the dollar amount(s) computed.

## Avoid underwithholding

Form IT-2104, together with your employer's withholding tables, is designed to ensure that the correct amount of tax is withheld from your pay. If you fail to have enough tax withheld during the entire year, you may owe a large tax liability when you file your return. The Tax Department must assess interest and may impose penalties in certain situations in addition to the tax liability. Even if you do not file a return, we may determine

that you owe personal income tax, and we may assess interest and penalties on the amount of tax that you should have paid during the year.

## Employers

**Box A –** If you are required to submit a copy of an employee's Form IT-2104 to the Tax Department because the employee claimed more than 14 allowances, mark an ***X*** in box A and send a copy of Form IT-2104 to: **NYS Tax Department, Income Tax Audit Administrator, Withholding Certificate Coordinator, W A Harriman Campus, Albany NY 12227-0865.** If the employee is also a new hire or rehire, see *Box B* instructions. See Publication 55, *Designated Private Delivery Services*, if not using U.S. Mail.

Due dates for sending certificates received from employees claiming more than 14 allowances are:

| Quarter | Due date | Quarter | Due date |
|---|---|---|---|
| January – March | April 30 | July – September | October 31 |
| April – June | July 31 | October – December | January 31 |

**Box B –** If you are submitting a copy of this form to comply with New York State's New Hire Reporting Program, mark an ***X*** in box B. Enter the first day any services are performed for which the employee will be paid wages, commissions, tips and any other type of compensation. For services based solely on commissions, this is the first day an employee working for commissions is eligible to earn commissions. Also, mark an ***X*** in the *Yes* or *No* box indicating if dependent health insurance benefits are available to this employee. If *Yes*, enter the date the employee qualifies for coverage. Mail the completed form, within 20 days of hiring, to: **NYS Tax Department, New Hire Notification, PO Box 15119, Albany NY 12212-5119.** To report newly-hired or rehired employees online instead of submitting this form, go to *https://www.nynewhire.com.*

*(continued)*

# Worksheet

**See the instructions before completing this worksheet.**

## Part 1 – Complete this part to compute your withholding allowances for New York State and Yonkers (line 1).

| | | | |
|---|---|---|---|
| **6** | Enter the number of dependents that you will claim on your state return *(do not include yourself or, if married, your spouse)* | **6** | |
| **For lines 7, 8, and 9, enter *1* for each credit you expect to claim on your state return.** | | | |
| **7** | College tuition credit | **7** | |
| **8** | New York State household credit | **8** | |
| **9** | Real property tax credit | **9** | |
| **For lines 10, 11, and 12, enter *3* for each credit you expect to claim on your state return.** | | | |
| **10** | Child and dependent care credit | **10** | |
| **11** | Earned income credit | **11** | |
| **12** | Empire State child credit | **12** | |
| **13** | New York City school tax credit: If you expect to be a resident of New York City for any part of the tax year, enter ***2*** | **13** | |
| **14** | Other credits *(see instructions)* | **14** | |
| **15** | Head of household status **and** only one job *(enter **2** if the situation applies)* | **15** | |
| **16** | Enter an estimate of your federal adjustments to income, such as deductible IRA contributions you will make for the tax year. Total estimate $ _____. Divide this estimate by $1,000. Drop any fraction and enter the number | **16** | |
| **17** | If you expect to be a covered employee of an employer who elected to pay the employer compensation expense tax in 2020, complete Part 3 below and enter the number from line 29 | **17** | |
| **18** | If you made contributions in 2019 to a New York Charitable Gifts Trust Fund (the Health Charitable Account or the Elementary and Secondary Education Account), complete Part 4 below and enter the amount from line 32 | **18** | |
| **19** | If you expect to itemize deductions on your state tax return, complete Part 2 below and enter the number from line 24. All others enter ***0*** | **19** | |
| **20** | Add lines 6 through 19. Enter the result here and on line 1. If you have more than one job, or if you and your spouse both work, see instructions for *Taxpayers with more than one job* or *Married couples with both spouses working*. | **20** | |

## Part 2 – Complete this part only if you expect to itemize deductions on your state return.

| | | | |
|---|---|---|---|
| **21** | Enter your estimated NY itemized deductions for the tax year *(see Form IT-196 and its instructions; enter the amount from line 49)* | **21** | |
| **22** | Based on your federal filing status, enter the applicable amount from the table below | **22** | |

**Standard deduction table**

| | | | |
|---|---|---|---|
| Single (cannot be claimed as a dependent) | $ 8,000 | Qualifying widow(er) | $16,050 |
| Single (can be claimed as a dependent) | $ 3,100 | Married filing jointly | $16,050 |
| Head of household | $11,200 | Married filing separate returns | $ 8,000 |

| | | | |
|---|---|---|---|
| **23** | Subtract line 22 from line 21 *(if line 22 is larger than line 21, enter **0** here and on line 19 above)* | **23** | |
| **24** | Divide line 23 by $1,000. Drop any fraction and enter the result here and on line 19 above | **24** | |

## Part 3 – Complete this part if you expect to be a covered employee of an employer that has elected to participate in the Employer Compensation Expense Program (line 17).

| | | | |
|---|---|---|---|
| **25** | Expected annual wages and compensation from electing employer in 2020 | **25** | |
| **26** | Line 25 minus $40,000 (if zero or less, **stop**) | **26** | |
| **27** | Line 26 multiplied by .03 | **27** | |
| **28** | Line 27 multiplied by .935 | **28** | |
| **29** | Divide line 28 by 65. Drop any fraction and enter the result here and on line 17 above | **29** | |

## Part 4 – Complete this part if you made contributions in 2019 to the Health Charitable Account or the Elementary and Secondary Education Account (line 18).

| | | | |
|---|---|---|---|
| **30** | Contributions to these funds in 2019 | **30** | |
| **31** | Multiply line 30 by 85% (.85) | **31** | |
| **32** | Divide line 31 by 60. Drop any fraction and enter the result here and on line 18 above | **32** | |

## Part 5 – Complete this part to compute your withholding allowances for New York City (line 2).

| | | | |
|---|---|---|---|
| **33** | Enter the amount from line 6 above | **33** | |
| **34** | Add lines 15 through 19 above and enter total here | **34** | |
| **35** | Add lines 33 and 34. Enter the result here and on line 2 | **35** | |

**Part 6 –** These charts are only for married couples with both spouses working or married couples with one spouse working more than one job, and whose combined wages are between $107,650 and $2,263,265.

Enter the additional withholding dollar amount on line 3.

The additional dollar amount, as shown below, is accurate for a weekly payroll. If you are not paid on a weekly basis, you will need to adjust these dollar amount(s). For example, if you are paid biweekly, you must double the dollar amount(s) computed.

| | | Combined wages between $107,650 and $538,749 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Higher earner's wages | | $107,650 $129,249 | $129,250 $150,749 | $150,750 $172,299 | $172,300 $193,849 | $193,850 $236,949 | $236,950 $280,099 | $280,100 $323,199 | $323,200 $377,099 | $377,100 $430,949 | $430,950 $484,899 | $484,900 $538,749 |
| $53,800 | $75,299 | $13 | $19 | | | | | | | | | |
| $75,300 | $96,799 | $12 | $20 | $28 | $32 | | | | | | | |
| $96,800 | $118,399 | $8 | $17 | $24 | $32 | $39 | | | | | | |
| $118,400 | $129,249 | $2 | $11 | $19 | $26 | $36 | $33 | | | | | |
| $129,250 | $139,999 | | $4 | $15 | $22 | $33 | $30 | | | | | |
| $140,000 | $150,749 | | $2 | $11 | $18 | $29 | $30 | $25 | | | | |
| $150,750 | $161,549 | | | $4 | $15 | $25 | $30 | $22 | | | | |
| $161,550 | $172,499 | | | $2 | $11 | $22 | $28 | $22 | $19 | | | |
| $172,500 | $193,849 | | | | $4 | $16 | $23 | $22 | $29 | $30 | | |
| $193,850 | $236,949 | | | | | $6 | $12 | $18 | $30 | $36 | $31 | |
| $236,950 | $280,099 | | | | | | $6 | $12 | $36 | $45 | $39 | $41 |
| $280,100 | $323,199 | | | | | | | $6 | $30 | $53 | $47 | $41 |
| $323,200 | $377,099 | | | | | | | | $15 | $31 | $40 | $34 |
| $377,100 | $430,949 | | | | | | | | | $8 | $18 | $27 |
| $430,950 | $484,899 | | | | | | | | | | $8 | $18 |
| $484,900 | $538,749 | | | | | | | | | | | $8 |

| | | Combined wages between $538,750 and $1,185,399 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Higher earner's wages | | $538,750 $592,649 | $592,650 $646,499 | $646,500 $700,399 | $700,400 $754,299 | $754,300 $808,199 | $808,200 $862,049 | $862,050 $915,949 | $915,950 $969,899 | $969,900 $1,023,749 | $1,023,750 $1,077,549 | $1,077,550 $1,131,499 | $1,131,500 $1,185,399 |
| $236,950 | $280,099 | $28 | | | | | | | | | | | |
| $280,100 | $323,199 | $45 | $22 | | | | | | | | | | |
| $323,200 | $377,099 | $28 | $33 | $37 | $22 | | | | | | | | |
| $377,100 | $430,949 | $21 | $16 | $20 | $25 | $5 | $5 | | | | | | |
| $430,950 | $484,899 | $27 | $21 | $16 | $20 | $25 | $5 | $5 | $5 | | | | |
| $484,900 | $538,749 | $18 | $27 | $21 | $16 | $20 | $25 | $5 | $5 | $5 | $5 | | |
| $538,750 | $592,649 | $8 | $18 | $27 | $21 | $16 | $20 | $25 | $5 | $5 | $5 | $3 | $2 |
| $592,650 | $646,499 | | $8 | $18 | $27 | $21 | $16 | $20 | $25 | $5 | $5 | $3 | $2 |
| $646,500 | $700,399 | | | $8 | $18 | $27 | $21 | $16 | $20 | $25 | $5 | $3 | $2 |
| $700,400 | $754,299 | | | | $8 | $18 | $27 | $21 | $16 | $20 | $25 | $3 | $2 |
| $754,300 | $808,199 | | | | | $8 | $18 | $27 | $21 | $16 | $20 | $26 | $2 |
| $808,200 | $862,049 | | | | | | $8 | $18 | $27 | $21 | $16 | $22 | $29 |
| $862,050 | $915,949 | | | | | | | $8 | $18 | $27 | $21 | $17 | $25 |
| $915,950 | $969,899 | | | | | | | | $8 | $18 | $27 | $22 | $20 |
| $969,900 | $1,023,749 | | | | | | | | | $8 | $18 | $29 | $26 |
| $1,023,750 | $1,077,549 | | | | | | | | | | $8 | $20 | $32 |
| $1,077,550 | $1,131,499 | | | | | | | | | | | $9 | $21 |
| $1,131,500 | $1,185,399 | | | | | | | | | | | | $9 |

| Higher earner's wages | | Combined wages between $1,185,400 and $1,724,299 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | $1,185,400 $1,239,249 | $1,239,250 $1,293,199 | $1,293,200 $1,347,049 | $1,347,050 $1,400,949 | $1,400,950 $1,454,849 | $1,454,850 $1,508,699 | $1,508,700 $1,562,549 | $1,562,550 $1,616,449 | $1,616,450 $1,670,399 | $1,670,400 $1,724,299 |
| $592,650 | $646,499 | $5 | $8 | | | | | | | | |
| $646,500 | $700,399 | $5 | $8 | $11 | $14 | | | | | | |
| $700,400 | $754,299 | $5 | $8 | $11 | $14 | $18 | $21 | | | | |
| $754,300 | $808,199 | $5 | $8 | $11 | $14 | $18 | $21 | $24 | $27 | | |
| $808,200 | $862,049 | $5 | $8 | $11 | $14 | $18 | $21 | $24 | $27 | $30 | $33 |
| $862,050 | $915,949 | $32 | $8 | $11 | $14 | $18 | $21 | $24 | $27 | $30 | $33 |
| $915,950 | $969,899 | $28 | $36 | $11 | $14 | $18 | $21 | $24 | $27 | $30 | $33 |
| $969,900 | $1,023,749 | $23 | $31 | $39 | $14 | $18 | $21 | $24 | $27 | $30 | $33 |
| $1,023,750 | $1,077,549 | $29 | $26 | $34 | $42 | $18 | $21 | $24 | $27 | $30 | $33 |
| $1,077,550 | $1,131,499 | $33 | $30 | $28 | $36 | $43 | $19 | $22 | $25 | $28 | $32 |
| $1,131,500 | $1,185,399 | $21 | $33 | $30 | $28 | $36 | $43 | $19 | $22 | $25 | $28 |
| $1,185,400 | $1,239,249 | $9 | $21 | $33 | $30 | $28 | $36 | $43 | $19 | $22 | $25 |
| $1,239,250 | $1,293,199 | | $9 | $21 | $33 | $30 | $28 | $36 | $43 | $19 | $22 |
| $1,293,200 | $1,347,049 | | | $9 | $21 | $33 | $30 | $28 | $36 | $43 | $19 |
| $1,347,050 | $1,400,949 | | | | $9 | $21 | $33 | $30 | $28 | $36 | $43 |
| $1,400,950 | $1,454,849 | | | | | $9 | $21 | $33 | $30 | $28 | $36 |
| $1,454,850 | $1,508,699 | | | | | | $9 | $21 | $33 | $30 | $28 |
| $1,508,700 | $1,562,549 | | | | | | | $9 | $21 | $33 | $30 |
| $1,562,550 | $1,616,449 | | | | | | | | $9 | $21 | $33 |
| $1,616,450 | $1,670,399 | | | | | | | | | $9 | $21 |
| $1,670,400 | $1,724,299 | | | | | | | | | | $9 |

| Higher earner's wages | | Combined wages between $1,724,300 and $2,263,265 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | $1,724,300 $1,778,149 | $1,778,150 $1,832,049 | $1,832,050 $1,885,949 | $1,885,950 $1,939,799 | $1,939,800 $1,993,699 | $1,993,700 $2,047,599 | $2,047,600 $2,101,499 | $2,101,500 $2,155,349 | $2,155,350 $2,209,299 | $2,209,300 $2,263,265 |
| $862,050 | $915,949 | $36 | $39 | | | | | | | | |
| $915,950 | $969,899 | $36 | $39 | $42 | $46 | | | | | | |
| $969,900 | $1,023,749 | $36 | $39 | $42 | $46 | $49 | $52 | | | | |
| $1,023,750 | $1,077,549 | $36 | $39 | $42 | $46 | $49 | $52 | $55 | $58 | | |
| $1,077,550 | $1,131,499 | $35 | $38 | $41 | $44 | $47 | $50 | $53 | $56 | $490 | $906 |
| $1,131,500 | $1,185,399 | $32 | $35 | $38 | $41 | $44 | $47 | $50 | $53 | $487 | $906 |
| $1,185,400 | $1,239,249 | $28 | $32 | $35 | $38 | $41 | $44 | $47 | $50 | $484 | $903 |
| $1,239,250 | $1,293,199 | $25 | $28 | $32 | $35 | $38 | $41 | $44 | $47 | $481 | $900 |
| $1,293,200 | $1,347,049 | $22 | $25 | $28 | $32 | $35 | $38 | $41 | $44 | $477 | $897 |
| $1,347,050 | $1,400,949 | $19 | $22 | $25 | $28 | $32 | $35 | $38 | $41 | $474 | $894 |
| $1,400,950 | $1,454,849 | $43 | $19 | $22 | $25 | $28 | $32 | $35 | $38 | $471 | $891 |
| $1,454,850 | $1,508,699 | $36 | $43 | $19 | $22 | $25 | $28 | $32 | $35 | $468 | $888 |
| $1,508,700 | $1,562,549 | $28 | $36 | $43 | $19 | $22 | $25 | $28 | $32 | $465 | $885 |
| $1,562,550 | $1,616,449 | $30 | $28 | $36 | $43 | $19 | $22 | $25 | $28 | $462 | $881 |
| $1,616,450 | $1,670,399 | $33 | $30 | $28 | $36 | $43 | $19 | $22 | $25 | $459 | $878 |
| $1,670,400 | $1,724,299 | $21 | $33 | $30 | $28 | $36 | $43 | $19 | $22 | $456 | $875 |
| $1,724,300 | $1,778,149 | $9 | $21 | $33 | $30 | $28 | $36 | $43 | $19 | $453 | $872 |
| $1,778,150 | $1,832,049 | | $9 | $21 | $33 | $30 | $28 | $36 | $43 | $449 | $869 |
| $1,832,050 | $1,885,949 | | | $9 | $21 | $33 | $30 | $28 | $36 | $474 | $866 |
| $1,885,950 | $1,939,799 | | | | $9 | $21 | $33 | $30 | $28 | $466 | $890 |
| $1,939,800 | $1,993,699 | | | | | $9 | $21 | $33 | $30 | $458 | $882 |
| $1,993,700 | $2,047,599 | | | | | | $9 | $21 | $33 | $461 | $875 |
| $2,047,600 | $2,101,499 | | | | | | | $9 | $21 | $464 | $877 |
| $2,101,500 | $2,155,349 | | | | | | | | $9 | $451 | $880 |
| $2,155,350 | $2,209,299 | | | | | | | | | $235 | $438 |
| $2,209,300 | $2,263,265 | | | | | | | | | | $14 |

**Note:** These charts do not account for additional withholding in the following instances:

- a married couple with both spouses working, where one spouse's wages are more than $1,131,632 but less than $2,263,265, and the other spouse's wages are also more than $1,131,632 but less than $2,263,265;
- married taxpayers with only one spouse working, and that spouse works more than one job, with wages from each job under $2,263,265, but combined wages from all jobs is over $2,263,265.

If you are in one of these situations and you would like to request an additional dollar amount of withholding from your wages, please contact the Tax Department for assistance (see *Need help?* on page 7).

**Part 7 –** These charts are only for single taxpayers and head of household taxpayers with more than one job, and whose combined wages are between $107,650 and $2,263,265.

Enter the additional withholding dollar amount on line 3.

The additional dollar amount, as shown below, is accurate for a weekly payroll. If you are not paid on a weekly basis, you will need to adjust these dollar amount(s). For example, if you are paid biweekly, you must double the dollar amount(s) computed.

| | | Combined wages between $107,650 and $538,749 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Higher wage | | $107,650 $129,249 | $129,250 $150,749 | $150,750 $172,299 | $172,300 $193,849 | $193,850 $236,949 | $236,950 $280,099 | $280,100 $323,199 | $323,200 $377,099 | $377,100 $430,949 | $430,950 $484,899 | $484,900 $538,749 |
| $53,800 | $75,299 | $13 | $18 | | | | | | | | | |
| $75,300 | $96,799 | $12 | $20 | $27 | $26 | | | | | | | |
| $96,800 | $118,399 | $8 | $17 | $24 | $27 | $28 | | | | | | |
| $118,400 | $129,249 | $2 | $11 | $18 | $21 | $26 | $35 | | | | | |
| $129,250 | $139,999 | | $4 | $14 | $17 | $22 | $39 | | | | | |
| $140,000 | $150,749 | | $2 | $10 | $13 | $19 | $39 | $38 | | | | |
| $150,750 | $161,549 | | | $3 | $10 | $15 | $38 | $36 | | | | |
| $161,550 | $172,499 | | | $1 | $7 | $13 | $38 | $38 | $36 | | | |
| $172,500 | $193,849 | | | | $3 | $10 | $36 | $42 | $38 | $37 | | |
| $193,850 | $236,949 | | | | | $11 | $31 | $44 | $42 | $42 | $25 | |
| $236,950 | $280,099 | | | | | | $9 | $18 | $29 | $25 | $28 | $15 |
| $280,100 | $323,199 | | | | | | | $7 | $17 | $27 | $22 | $26 |
| $323,200 | $377,099 | | | | | | | | $8 | $18 | $27 | $22 |
| $377,100 | $430,949 | | | | | | | | | $8 | $18 | $27 |
| $430,950 | $484,899 | | | | | | | | | | $8 | $18 |
| $484,900 | $538,749 | | | | | | | | | | | $8 |

| | | Combined wages between $538,750 and $1,185,399 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Higher wage | | $538,750 $592,649 | $592,650 $646,499 | $646,500 $700,399 | $700,400 $754,299 | $754,300 $808,199 | $808,200 $862,049 | $862,050 $915,949 | $915,950 $969,899 | $969,900 $1,023,749 | $1,023,750 $1,077,549 | $1,077,550 $1,131,499 | $1,131,500 $1,185,399 |
| $236,950 | $280,099 | $9 | | | | | | | | | | | |
| $280,100 | $323,199 | $9 | $8 | | | | | | | | | | |
| $323,200 | $377,099 | $26 | $8 | $8 | $8 | | | | | | | | |
| $377,100 | $430,949 | $22 | $26 | $8 | $8 | $8 | $8 | | | | | | |
| $430,950 | $484,899 | $27 | $22 | $26 | $8 | $8 | $8 | $8 | $8 | | | | |
| $484,900 | $538,749 | $18 | $27 | $22 | $26 | $8 | $8 | $8 | $8 | $8 | $8 | | |
| $538,750 | $592,649 | $8 | $18 | $27 | $22 | $26 | $8 | $8 | $8 | $8 | $8 | $236 | $451 |
| $592,650 | $646,499 | | $8 | $18 | $27 | $22 | $26 | $8 | $8 | $8 | $8 | $236 | $451 |
| $646,500 | $700,399 | | | $8 | $18 | $27 | $22 | $26 | $8 | $8 | $8 | $236 | $451 |
| $700,400 | $754,299 | | | | $8 | $18 | $27 | $22 | $26 | $8 | $8 | $236 | $451 |
| $754,300 | $808,199 | | | | | $8 | $18 | $27 | $22 | $26 | $8 | $236 | $451 |
| $808,200 | $862,049 | | | | | | $8 | $18 | $27 | $22 | $26 | $236 | $451 |
| $862,050 | $915,949 | | | | | | | $8 | $18 | $27 | $22 | $254 | $451 |
| $915,950 | $969,899 | | | | | | | | $8 | $18 | $27 | $250 | $470 |
| $969,900 | $1,023,749 | | | | | | | | | $8 | $18 | $255 | $465 |
| $1,023,750 | $1,077,549 | | | | | | | | | | $8 | $246 | $471 |
| $1,077,550 | $1,131,499 | | | | | | | | | | | $123 | $233 |
| $1,131,500 | $1,185,399 | | | | | | | | | | | | $14 |

*(Part 7 continued on page 8)*

**Privacy notification**

See our website or Publication 54, *Privacy Notification*.

## Need help?


Visit our website at ***www.tax.ny.gov***

- get information and manage your taxes online
- check for new online services and features

**Telephone assistance**

| | |
|---|---|
| Automated income tax refund status: | 518-457-5149 |
| Personal Income Tax Information Center: | 518-457-5181 |
| To order forms and publications: | 518-457-5431 |
| Text Telephone (TTY) or TDD equipment users | Dial 7-1-1 for the New York Relay Service |

| | | Combined wages between $1,185,400 and $1,724,299 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Higher wage | | $1,185,400 $1,239,249 | $1,239,250 $1,293,199 | $1,293,200 $1,347,049 | $1,347,050 $1,400,949 | $1,400,950 $1,454,849 | $1,454,850 $1,508,699 | $1,508,700 $1,562,549 | $1,562,550 $1,616,449 | $1,616,450 $1,670,399 | $1,670,400 $1,724,299 |
| $592,650 | $646,499 | $475 | $498 | | | | | | | | |
| $646,500 | $700,399 | $475 | $498 | $522 | $546 | | | | | | |
| $700,400 | $754,299 | $475 | $498 | $522 | $546 | $569 | $593 | | | | |
| $754,300 | $808,199 | $475 | $498 | $522 | $546 | $569 | $593 | $616 | $640 | | |
| $808,200 | $862,049 | $475 | $498 | $522 | $546 | $569 | $593 | $616 | $640 | $663 | $687 |
| $862,050 | $915,949 | $475 | $498 | $522 | $546 | $569 | $593 | $616 | $640 | $663 | $687 |
| $915,950 | $969,899 | $475 | $498 | $522 | $546 | $569 | $593 | $616 | $640 | $663 | $687 |
| $969,900 | $1,023,749 | $493 | $498 | $522 | $546 | $569 | $593 | $616 | $640 | $663 | $687 |
| $1,023,750 | $1,077,549 | $489 | $517 | $522 | $546 | $569 | $593 | $616 | $640 | $663 | $687 |
| $1,077,550 | $1,131,499 | $266 | $284 | $312 | $318 | $341 | $365 | $388 | $412 | $435 | $459 |
| $1,131,500 | $1,185,399 | $42 | $74 | $92 | $120 | $126 | $149 | $173 | $196 | $220 | $243 |
| $1,185,400 | $1,239,249 | $14 | $42 | $74 | $92 | $120 | $126 | $149 | $173 | $196 | $220 |
| $1,239,250 | $1,293,199 | | $14 | $42 | $74 | $92 | $120 | $126 | $149 | $173 | $196 |
| $1,293,200 | $1,347,049 | | | $14 | $42 | $74 | $92 | $120 | $126 | $149 | $173 |
| $1,347,050 | $1,400,949 | | | | $14 | $42 | $74 | $92 | $120 | $126 | $149 |
| $1,400,950 | $1,454,849 | | | | | $14 | $42 | $74 | $92 | $120 | $126 |
| $1,454,850 | $1,508,699 | | | | | | $14 | $42 | $74 | $92 | $120 |
| $1,508,700 | $1,562,549 | | | | | | | $14 | $42 | $74 | $92 |
| $1,562,550 | $1,616,449 | | | | | | | | $14 | $42 | $74 |
| $1,616,450 | $1,670,399 | | | | | | | | | $14 | $42 |
| $1,670,400 | $1,724,299 | | | | | | | | | | $14 |

| | | Combined wages between $1,724,300 and $2,263,265 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Higher wage | | $1,724,300 $1,778,149 | $1,778,150 $1,832,049 | $1,832,050 $1,885,949 | $1,885,950 $1,939,799 | $1,939,800 $1,993,699 | $1,993,700 $2,047,599 | $2,047,600 $2,101,499 | $2,101,500 $2,155,349 | $2,155,350 $2,209,299 | $2,209,300 $2,263,265 |
| $862,050 | $915,949 | $710 | $734 | | | | | | | | |
| $915,950 | $969,899 | $710 | $734 | $757 | $781 | | | | | | |
| $969,900 | $1,023,749 | $710 | $734 | $757 | $781 | $804 | $828 | | | | |
| $1,023,750 | $1,077,549 | $710 | $734 | $757 | $781 | $804 | $828 | $851 | $875 | | |
| $1,077,550 | $1,131,499 | $482 | $506 | $529 | $553 | $576 | $600 | $623 | $647 | $670 | $262 |
| $1,131,500 | $1,185,399 | $267 | $290 | $314 | $337 | $361 | $384 | $408 | $431 | $455 | $478 |
| $1,185,400 | $1,239,249 | $243 | $267 | $290 | $314 | $337 | $361 | $384 | $408 | $431 | $455 |
| $1,239,250 | $1,293,199 | $220 | $243 | $267 | $290 | $314 | $337 | $361 | $384 | $408 | $431 |
| $1,293,200 | $1,347,049 | $196 | $220 | $243 | $267 | $290 | $314 | $337 | $361 | $384 | $408 |
| $1,347,050 | $1,400,949 | $173 | $196 | $220 | $243 | $267 | $290 | $314 | $337 | $361 | $384 |
| $1,400,950 | $1,454,849 | $149 | $173 | $196 | $220 | $243 | $267 | $290 | $314 | $337 | $361 |
| $1,454,850 | $1,508,699 | $126 | $149 | $173 | $196 | $220 | $243 | $267 | $290 | $314 | $337 |
| $1,508,700 | $1,562,549 | $120 | $126 | $149 | $173 | $196 | $220 | $243 | $267 | $290 | $314 |
| $1,562,550 | $1,616,449 | $92 | $120 | $126 | $149 | $173 | $196 | $220 | $243 | $267 | $290 |
| $1,616,450 | $1,670,399 | $74 | $92 | $120 | $126 | $149 | $173 | $196 | $220 | $243 | $267 |
| $1,670,400 | $1,724,299 | $42 | $74 | $92 | $120 | $126 | $149 | $173 | $196 | $220 | $243 |
| $1,724,300 | $1,778,149 | $14 | $42 | $74 | $92 | $120 | $126 | $149 | $173 | $196 | $220 |
| $1,778,150 | $1,832,049 | | $14 | $42 | $74 | $92 | $120 | $126 | $149 | $173 | $196 |
| $1,832,050 | $1,885,949 | | | $14 | $42 | $74 | $92 | $120 | $126 | $149 | $173 |
| $1,885,950 | $1,939,799 | | | | $14 | $42 | $74 | $92 | $120 | $126 | $149 |
| $1,939,800 | $1,993,699 | | | | | $14 | $42 | $74 | $92 | $120 | $126 |
| $1,993,700 | $2,047,599 | | | | | | $14 | $42 | $74 | $92 | $120 |
| $2,047,600 | $2,101,499 | | | | | | | $14 | $42 | $74 | $92 |
| $2,101,500 | $2,155,349 | | | | | | | | $14 | $42 | $74 |
| $2,155,350 | $2,209,299 | | | | | | | | | $14 | $42 |
| $2,209,300 | $2,263,265 | | | | | | | | | | $14 |

EDISON
HOME HEALTH CARE

**Sleep & Meal Period Agreement – Employees On Duty**
**For Twenty-Four (24) Hours Or More**

You will be paid for all hours worked. During each full 24-hour period during which you are required to be on duty, you agree that Bona Fide Meal Periods of up to three (3) hours and a Bona Fide Sleep Period of up to eight (8) hours will not count as hours worked. All other hours during the course of such period will be considered hours worked.

- "Bona Fide Meal Periods" are meal periods (e.g. for breakfast, lunch, and dinner) that are duty free and at least thirty (30) minutes in duration.

- "Bona Fide Sleep Periods" are regularly scheduled sleep periods, which include at least five (5) consecutive hours that are uninterrupted by a call to duty, in adequate sleeping facilities.

It is expected that you will enjoy at least:
-Three (3) hours of Bona Fide Meal Periods AND
-Eight (8) hours Bona Fide Sleep Period for each full twenty-four (24) hour shift.

Where you receive at least:
-Three (3) hours of Bona Fide Meal Period AND
-Eight (8) hours Bona Fide Sleep Period
you will be credited with thirteen (13) hours of work for the twenty-four (24) hour shift.

To ensure that you are paid for all hours you work, if you do not receive at least three (3) hours of Bond Fide Meal Periods and/or at least an eight (8) hour Bona Fide Sleep Period for each full twenty-four (24) hour shift, you must: (a) contact your coordinator within twenty-four (24) hours of the conclusion of the shift; and (b) complete a "Sleep and Meal Period Exception Certification Form" and return the form to your coordinator within seventy-two (72) hours. A blank Sleep and Meal Period Execution Certification Form is attached, and additional forms are available from any coordinator. If you believe that you were not paid for all hours worked that you identified on a Sleep and Meal Period Exception Certification Form, you must contact the Corporate Human Resources Department immediately.

Any employee who submits a false Sleep and Meal Period Exception Certification Form will be subject to immediate disciplinary action, up to and including termination of employment

**ACKNOWLDGEMENT**

I acknowledge receipt of the Sleep and Meal Period Agreement – Employees on Duty for twenty-four (24) hours or More, and by signing below, I hereby agree to be bound by its terms.

_____ _____
Print Name Date

_____
Signature

## EDISON HOME HEALTH CARE'S SERVICES

# CORPORATE COMPLIANCE
# CERTIFICATION OF RECEIPT OF CODE OF CONDUCT AND FEDERAL FALSE CLAIMS ACT SUMMARY PURSUANT TO DRA SECTION 6032

**Questions?**

Edison HHC encourages employees, contractors, and agents to raise questions or concerns, and seek clarification regarding these laws or related policy issues with the Compliance Officer or other designated party.

**Acknowledgement:**

**I HAVE RECEIVED THE FEDERAL FALSE CLAIMS ACT SUMMARY OF LAWS AND EDISON HHC'S CODE OF CONDUCT AND I UNDERSTAND AND AGREE TO CONDUCT MYSELF IN ACCORDANCE WITH AND IN COMPLIANCE WITH THE FEDERAL FALSE CLAIMS ACT, THE NEW YORK FALSE CLAIMS ACT, AND NEW YORK HEALTH CARE FRAUD LAWS AND THE FACILITY'S CURRENT CODE OF CONDUCT PURSUANT TO DRA SECTION 6032**

_____

**Print Name**

_____ _____

**Employee's Signature** **Date**

# Employee Acknowledgement of Outside Employment

## Attestation Form

All Edison Home Health Care personnel are required to follow the Rule of Conduct and avoid actions that result in a conflict of interest.

☐ I am *not* currently employed by another Home Care Agency or any other organizations.

☐ I am currently employed by another:

- ☐ Home Care Agency
- ☐ Other Organization

I work from _____ to _____.
(Day of the Week) (Day of the Week)

My hours are from _____ to _____.

I am aware that I cannot and will not work for another Home Care Agency or any other organization while I am assigned to provide services to a patient of Edison Home Health Care.

_____ _____

Signature Date

Print Name: _____

EDISON
HOME HEALTH CARE

## Acknowledgement of Receipt
## Photo Identification

As an employee of Edison Home Health Care, I, _____, acknowledge receipt of the agency issued photo identification badge. As required by regulation and agency policy, I agree to wear the ID when working where it is visible to the eye immediately by the patient, all the patient's family members and Supervising Nurse.

The identification badge is the property of Edison Home Health Care and will be returned to the agency upon termination of employment.

I know I can contact Edison Home Health Care at the above address or telephone number if I have any other questions regarding this form

**_____ / HHA/PCA** **_____**

**Employee's Signature / Title** **Date**

EDISON
HOME HEALTH CARE

***Notice of Payment Options and Consent to Form of Payment***

New York State Department of Labor regulations that will become effective on March 17, 2017 require that the following notice be given to all employees except employees employed in a bona fide executive, administrative, or professional capacity whose earnings exceed $900 per week.

Edison HHC offers to all employees two ways of payment for their wages:

1. Check
2. Direct Deposit (Bank information needed)

The Employer cannot compel you to accept wages by Direct Deposit. It is your choice to receive your wages by check or Direct Deposit to your own bank account.

Edison Home Health Care does not charge any fees to its employees for access to their wages in full.

If an employee has previously consented to Direct Deposit, his or her consent may be withdrawn at any time by filling out the Acknowledgment and Consent form below and returning it to 946 McDonald Avenue, Brooklyn NY 11218 or fax it to 718-972-2323.

The NYDOL has represented that it will prepare sample notices and consents in Spanish, Chinese, Haitian Creole, Korean, Polish, Russian, French, Arabic, Bengali, Tagalog, and Urdu. If you wish to be provided with a notice and consent in any of those languages when published, please inform Human Resources at 718-972-2929 ext. 700.

***Acknowledgment and Consent***

On this day, I have been informed of my options of payment methods. I give consent to Edison Home Health Care to facilitate my payment for employment as follows:

☐ **Check:** I prefer to receive a check for my wages, mailed to my residence.

☐ **Direct Deposit:** I prefer for my employer to pay my wages through Direct Deposit to a financial institution that I have selected. I will provide the necessary bank information for this process to start. I understand that I will be able to withdraw or change this consent at any time.

1.Bank Name: _____

City, State: _____

Routing Transit #: _____ Account Number: _____

□ Checking □ Savings □ Other I wish to deposit $_____ □ Entire Net Amount_____

2.Bank Name: _____

City, State: _____

Routing Transit #: _____ Account Number: _____

□ Checking □ Savings □ Other I wish to deposit $_____ □ Entire Net Amount_____

_____ _____

**Print your Name** **LAST 4 DIGITS OF YOUR SOCIAL**

_____ _____

**Employee Signature** **Date**

# Receipt of Edison Home Health Care's Cellular and Wireless Device in the Workplace

Please read the policy carefully to ensure that you understand the policy before signing this document.

I certify that I have received a copy of Edison Home Health Care's Cellular and Wireless Devices in the Workplace policies. I understand that it is my responsibility to read and comprehend the policy. I have read and understand the content, requirements and expectations of the policy and I agree to abide by the policy's guidelines. I understand that if at any time, I have questions regarding this policy, I will consult with my immediate supervisor or the Corporate Compliance Officer.

I agree to observe and follow this policy. I understand that failure to abide by the policy could result in disciplinary actions and possible termination.

_____

**Employee's Name (Please print)**

_____

**Employee's Signature**

_____

**Date**

EDISON
HOME HEALTH CARE

# HHA / PCA NO CONFLICT ATTESTATION

In order to accept any case as an HHA or PCA for any Patient, I attest to ALL of the following:

- I CANNOT BE the Patient's son or daughter
- I CANNOT BE the Patient's spouse
- I CANNOT BE the Patient's son-in-law
- I CANNOT BE the Patient's daughter-in-law

If I am ever assigned to a case in which the patient is any of the relatives above, I understand that I CANNOT act as the HHA or PCA for this patient.
I understand that if the patient assigned to me is any other relative, I must notify the agency and they will determine if I am eligible to work on this case.

HHA/PCA Name: _____ Date: _____

Signature _____

EDISON
HOME HEALTH CARE

# Acknowledgement of Receipt of Paid Family Leave (PFL) Instructions

Under a new New York state law, working New Yorkers will be able to take time off to care for a loved one while still receiving a portion of their salary. The eligible employees will now be able to take up to 8 weeks of benefits and job-protected leave in any 52-week period at up to 50 percent of their salary.

## Employee Eligibility

*Full-Time employees (individuals working 30 or more hours a week):* must work 20 or more hours per week for 26 or more consecutive weeks of employment.

*Part Time employees (individuals working less than 30 hours a week):* must work fewer than 20 hours per week for 175 days in a 52-consecutive week period.

The employee must provide advance notice of 30 days. If providing notice of less than 30 days an explanation must be given.

## Types of Leave

1. Care for a close relative with a serious health condition. A close relative could be yopu spouse, domestic partner, children, parents, parents' in-law, grandparents, and grandchildren.

2. Maternity and paternity leave. Employees can take time to bond with their newborn, newly adopted, or a newly placed child, within the first 12 months after the child's birth, adoption, or placement of an adopted or foster child.

3. Qualifying Exigency Leave: when an employee's spouse, child, domestic partner, or parent is on covered active duty or has been notified of an impending call or order to covered active duty; or to care for a servicemember with a serious injury or illness, if the employee is the servicemember's spouse, child, domestic partner, or parents.

## Payroll Deductions to Fund Paid Family Leave Benefits

The maximum employee contribution is 0.126 percent of their weekly wage, not to exceed $1,305.92 as per NY DOL.

New York State has more information about the Paid Family Leave program at www.ny.gov/paidfamilyleave

All requests for Paid Family Leave must be made through the Human Resources Department. Please call Tiffany Nichols at 718-972-2929 ext. 340

I acknowledge that I have received the necessary information and instructions regarding Paid Family Leave benefits.

Print Employee's Name _____ Date: _____

Employee's signature: _____

EDISON
HOME HEALTH CARE

**NYC Temporary Changes To Work Schedule Law**
**Acknowledgement Of Receipt**

The NYC Temporary Schedule Change Law, allows employees to temporarily change their schedule. A Temporary Change means an adjustment on the employees' usual calendar.

## Employee Eligibility

Any employee, who have been employed for 120 days or more and have worked 80+ hours per calendar year, is qualified.

## The aides could make changes to up to:

-Two separate occasions of 1 business day each

Or

-One occasion for up to Two business days

You may use PTO or Sick and Safe Leave, if they have it available, you can also take leave without pay.
You must submit your request in writing before your leave or on the 2nd day of your return.

## Employees can take the Temporary Schedule Change for:

*Personal event*, which could be to care for a child under age of 18, to care for a person with disability who is a family or household member and relies on the employee for medical care or to meet the needs of daily living, the need to attend a legal proceeding, any other reason for the employee to use Paid Safe and Sick Leave.

*Family member*, any individual whose close association with the employee is the equivalent of family: child (biological, adopted, or foster, legal ward, or loco parentis), grandchild, spouse, domestic partner, parent, grandparent, child or parent of an employee's spouse or domestic partner, sibling, any other individual related by blood to the employee.

All requests for Temporary Schedule Change must be made through the Coodination Department.

I acknowledge that I have received the necessary information and instructions regarding the Temporary Schedule Change Law

Print Employee's Name_____ Date: _____

Employee's signature: _____

EDISON
HOME HEALTH CARE

**SEXUAL HARASSMENT POLICY ACKNOWLEDGMENT**

I _____ certify that I have been trained on the NYS Sexual Harassment Policy. I understand that Sexual harassment is a form of workplace discrimination. Edison HHC has a zero-tolerance policy for any form of sexual harassment, and all employees are required to work in a manner that prevents sexual harassment in the workplace. I also understand that Sexual harassment is against the law and that I have the legal right to a workplace free from sexual harassment, and I can file a complaint internally with Edison HHC, or with a government agency or in court under federal, state or local anti-discrimination laws. This policy applies to all employees, paid or unpaid interns, and non-employees and all must follow and uphold this policy.

I have given the Complaint form and contact information if I ever must file a complaint for sexual harassment.

Employee's Signature_____ Date: _____

**MUTUAL ARBITRATION AGREEMENT**

**This Mutual Arbitration Agreement is a contract and covers important issues relating to your rights. It is your sole responsibility to read it and understand it. You are free to seek assistance from independent advisors of your choice outside the Company or to refrain from doing so if that is your choice.**

**El Acuerdo Mutuo de Arbitraje es un contrato y cubre aspectos importantes de tus derechos. Es tu absoluta responsabilidad leerlo y entenderlo. Tienes la libertad de buscar asistencia de asesores independientes de tu elección fuera de la Empresa o de abstenerte de buscar asistencia si esa es tu elección.**

**1.** This Mutual Arbitration Agreement ("Agreement") is between Employee and NAE Edison, LLC d/b/a Edison Home Health Care ("COMPANY"). The Federal Arbitration Act (9 U.S.C. §§ 1 *et seq.*) governs this Agreement, which evidences a transaction involving commerce. **EXCEPT AS THIS AGREEMENT OTHERWISE PROVIDES, ALL DISPUTES COVERED BY THIS AGREEMENT WILL BE DECIDED BY AN ARBITRATOR THROUGH FINAL AND BINDING ARBITRATION AND NOT BY WAY OF COURT OR JURY TRIAL.**

**2.** **COVERED CLAIMS/DISPUTES**. Except as otherwise provided in this Agreement, this Agreement applies to any and all disputes, past, present or future, that may arise between Employee (sometimes "you" or "your") and COMPANY, including without limitation any dispute arising out of or related to Employee's application, employment and/or separation of employment with COMPANY. This Agreement applies to a covered dispute that COMPANY may have against Employee or that Employee may have against COMPANY, its parent companies, subsidiaries, related companies and affiliates, franchisors, or their officers, directors, principals, shareholders, members, owners, employees, and managers or agents, any of which may enforce this Agreement as direct or third-party beneficiaries.

The claims subject to arbitration are those that absent this Agreement could be brought under applicable law. Except as it otherwise provides, this Agreement applies, without limitation, to claims based upon or related to the application for employment, background checks, privacy, the employment relationship, discrimination, harassment, retaliation, defamation (including post-employment defamation or retaliation), breach of a contract or covenant, fraud, negligence, emotional distress, breach of fiduciary duty, trade secrets, unfair competition, wages, minimum wage and overtime or other compensation claimed to be owed, breaks and rest periods, termination, tort claims, equitable claims, and all statutory and common law claims unless specifically excluded below. Except as it otherwise provides, the Agreement covers, without limitation, claims arising under the Fair Credit Reporting Act, Defend Trade Secrets Act, Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 1981, the Americans With Disabilities Act, the Age Discrimination in Employment Act, the Family Medical Leave Act, the Fair Labor Standards Act, Rehabilitation Act, Civil Rights Acts of 1866 and 1871, the Civil Rights Act of 1991, the Pregnancy Discrimination Act, the Equal Pay Act, the Genetic Information Non-Discrimination Act, Employee Retirement Income Security Act of 1974 (except for claims for employee benefits under any benefit plan sponsored by the COMPANY and (a) covered by the Employee Retirement Income Security Act of 1974 or (b) funded by insurance), Affordable Care Act, Uniform Services Employment and Reemployment Rights Act, Worker Adjustment and Retraining Notification Act, state statutes or regulations addressing the same or similar subject matters, including but not limited to New York Home Care Worker Wage Parity Law and New York Labor Law, and all other federal or state legal claims arising out of or relating to Employee's employment or the termination of employment.

Additionally, except as otherwise provided in this Section 3 of this Agreement, Employee and the COMPANY agree that any legal dispute or controversy arising out of, relating to, or concerning the arbitrability of any dispute or controversy or the validity, enforceability or breach of this Agreement shall be subject to final and binding arbitration.

**EXCLUDED CLAIMS/DISPUTES**. This Agreement does not apply to litigation pending in a state or federal court as of the date of your receipt of this Agreement. The Agreement also does not apply to claims for worker's compensation benefits, state disability insurance benefits and unemployment insurance benefits; however, this Agreement applies to retaliation claims based upon seeking such benefits, such as claims for worker's compensation retaliation.

Nothing contained in this Agreement shall be construed to prevent or excuse you (individually or in concert with others) or the COMPANY from utilizing the COMPANY's existing internal procedures for resolution of complaints, and this Agreement is not intended to be a substitute for the utilization of such procedures. In addition, either party may apply to a court of competent jurisdiction for temporary or preliminary injunctive relief in connection with an arbitrable controversy, but only upon the ground that the award to which that party may be entitled may be rendered ineffectual without such relief or to prevent irreparable

harm. Such relief may include for example, an order to prevent the unauthorized use of patient or referral source information or confidential proprietary business information, subject to final relief in arbitration.

Nothing in this Agreement prevents you from making a report to or filing a claim or charge with a government agency, including without limitation the Equal Employment Opportunity Commission, U.S. Department of Labor, U.S. Securities and Exchange Commission, National Labor Relations Board, or Office of Federal Contract Compliance Programs. Nothing in this Agreement prevents the investigation by a government agency of any report, claim or charge otherwise covered by this Agreement. This Agreement also does not prevent federal administrative agencies from adjudicating claims and awarding remedies based on those claims, even if the claims would otherwise be covered by this Agreement. Nothing in this Agreement prevents or excuses a party from satisfying any conditions precedent and/or exhausting administrative remedies under applicable law before bringing a claim in arbitration. The COMPANY will not retaliate against you for filing a claim with an administrative agency or for exercising rights (individually or in concert with others) under Section 7 of the National Labor Relations Act.

3. **CLASS AND COLLECTIVE ACTION WAIVER.** Both you and COMPANY agree to bring any dispute in arbitration on an individual basis only, and not on a class or collective action basis on behalf of others. There will be no right or authority for any dispute to be brought, heard or arbitrated as a class or collective action and the arbitrator will have no authority to hear or preside over any such claim ("Class Action Waiver"). Regardless of anything else in this Agreement and/or the American Arbitration Association ("AAA") rules or procedures, a dispute or controversy over the validity, enforceability or breach of the Class Action Waiver may only be determined by a court and not an arbitrator. In any case in which (1) the dispute is filed as a class or collective action and (2) there is a final judicial determination that all or part of the Class Action Waiver is unenforceable, the class or collective action to that extent must be litigated in a civil court of competent jurisdiction, but the portion of the Class Action Waiver that is enforceable shall be enforced in arbitration. You will not be retaliated against, disciplined or threatened with discipline by the filing of or participation in a class or collective action in any forum. However, COMPANY may lawfully seek enforcement of this Agreement and the Class Action Waiver under the Federal Arbitration Act and seek dismissal of such class or collective actions or claims.

4. **ARBITRATOR SELECTION**. The parties will proceed to arbitration before a single arbitrator and in accordance with the then current American Arbitration Association ("AAA") Employment Arbitration Rules ("AAA Rules") (the AAA Rules may be found at www.adr.org or by searching for "AAA Employment Arbitration Rules" using a service such as www.Google.com), provided, however, that if there is a conflict between the AAA Rules and this Agreement, this Agreement will govern. Unless the parties mutually agree otherwise, the Arbitrator will be either an attorney experienced in employment law and licensed to practice law in the state in which the arbitration is convened or a former judge from any jurisdiction. The AAA will give each party a list of eleven (11) arbitrators drawn from its panel of arbitrators. Ten days after AAA's transmission of the list of neutrals, AAA will convene a telephone conference and the parties will strike names alternately from the list of common names until only one remains. The party who strikes first will be determined by a coin toss. The person that remains will be designated as the Arbitrator. If for any reason, the individual selected cannot serve, AAA will issue another list of eleven (11) arbitrators and repeat the alternate striking selection process. If for any reason the AAA will not administer the arbitration, either party may apply to a court of competent jurisdiction with authority over the location where the arbitration will be conducted to appoint a neutral Arbitrator.

5. **INITIATING ARBITRATION**. A party who wishes to arbitrate a claim covered by this Agreement must make a written Request for Arbitration and deliver it to the other party by hand or mail no later than the expiration of the statute of limitations (deadline for filing) that applicable law prescribes for the claim. The Request for Arbitration shall identify the claims asserted, the factual basis for the claim(s), and the relief and/or remedy sought. The Arbitrator will resolve all disputes regarding the timeliness or propriety of the Request for Arbitration and apply the statute of limitations that would have applied if the claim(s) had been brought in court.

6. **RULES/STANDARDS GOVERNING PROCEEDING**. The Arbitrator may award any remedy to which a party is entitled under applicable law, but remedies are limited to those that would be available to a party in his or her individual capacity in a court of law for the claims presented to the Arbitrator, and no remedies that otherwise would be available to an individual under applicable law will be forfeited by this Agreement. Each party can take the deposition of one individual witness and any expert witness designated by another party. Each party also has the right to make requests for production of documents to any party. The parties can jointly agree to more discovery, and either party can ask the Arbitrator to order more discovery. Each party will also have the right to subpoena witnesses and documents for the arbitration, including documents relevant to the case from third parties. At least thirty (30) days before the final hearing, the parties must exchange a list of witnesses, excerpts of depositions to be introduced, and copies of all exhibits to be used.

Unless the parties jointly agree otherwise, the arbitration will take place in or near the city and in the same state in which Employee is or was last employed by the COMPANY. The Arbitrator has the authority to hear and rule on pre-hearing disputes. The Arbitrator will have the authority to hear and decide a motion to dismiss and/or a motion for summary judgment by any party, consistent with Rule 12 or Rule 56 of the Federal Rules of Civil Procedure. The Arbitrator will issue a written decision or award, stating the essential findings of fact and conclusions of law. A court of competent jurisdiction will have the authority to enter judgment upon the Arbitrator's decision/award.

7. **PAYMENT OF FEES**. The COMPANY will pay the Arbitrator's and arbitration fees and costs, except for the filing fee as required by the AAA. If you are financially unable to pay a filing fee, the COMPANY will pay the filing fee, and you will be relieved of the obligation to pay the filing fee. Disputes regarding the apportionment of fees will be decided by the Arbitrator. Each party will pay for its own costs and attorneys' fees, if any, but if any party prevails on a claim which affords the prevailing party costs or attorneys' fees, the Arbitrator may award costs and fees to the prevailing party as provided by law.

8. **CONDITION OF EMPLOYMENT**. **Arbitration is a mandatory condition of your employment at the COMPANY.** You have the right to consult with counsel of your choice concerning this Agreement.

9. **ENTIRE AGREEMENT/SEVERABILITY**. This Agreement replaces all prior agreements regarding the arbitration of disputes and is the full and complete agreement relating to the resolution of disputes covered by this Agreement. If any portion of this Agreement is deemed unenforceable, the unenforceable provision will be severed from the Agreement and the remainder of the Agreement will be enforceable. This Agreement will survive the termination of Employee's employment and the expiration of any benefit. This Agreement will also continue to apply notwithstanding any change in Employee's duties, responsibilities, position, or title, or if Employee transfers to any affiliate of the COMPANY. This Agreement does not alter the "at-will" status of Employee's employment. Notwithstanding any contrary language in any COMPANY policy or employee handbook, this Agreement may not be modified or terminated absent consent by both parties.

**CONSIDERATION.** The COMPANY and Employee agree that the mutual obligations by the COMPANY and Employee to arbitrate disputes provide adequate consideration for this Agreement.

**AGREED:**

*NAE EDISON, LLC d/b/a EDISON HOME HEALTH CARE*

**RECEIVED AND AGREED:**

_____ _____

APPLICANT/EMPLOYEE SIGNATURE DATE

_____

APPLICANT/EMPLOYEE NAME PRINTED

Firmwide:155602881.1 097690.1000

EDISON
HOME HEALTH CARE

# DRIVING POLICY ACKNOWLEDGMENT

I _____ certify that I have been trained on the Edison HHC Driving Policy. I understand driving a patient's vehicle or being a passenger in a patient's vehicle is strictly forbidden and is not allowed under any circumstance.

Transporting a patient in their vehicle or any vehicle is also strictly forbidden and is not allowed under any circumstance. Public or private for hire transportation must be utilized to transport patients.

Any violation of this policy is grounds for immediate termination. This policy is meant for the patient's protection, your protection and the company's protection. The duties of your employment in no way include driving a patient's vehicle, being a passenger in a patient's vehicle or transporting a patient. Any such activity is a prohibited deviation from the scope and duties of your employment with the Company.

Employee's Signature_____ Date: _____

# Compliance Program

Dear Staff Member:

Edison Home Health Care is dedicated to conducting its business honestly and ethically wherever Edison HHC operates. In order to meet this commitment, Edison HHC has set forth in this Code of Conduct the principles and rules to be followed by all personnel who work with Edison HHC.

The purpose of this Code of Conduct is to inform all personnel and interested third parties that Edison HHC is fully dedicated to approaching all of its activities, including compliance with laws and regulations, in an ethical manner. This Code of Conduct will familiarize new personnel with the ethical standards that guide our business and patient relationships in our highly regulated environment. For existing personnel, it will reaffirm our commitment to ethical behavior in all circumstances. Since everyone at Edison HHC has a personal stake in this important program, we strongly urge each of you to review this information thoroughly and refer to it whenever situations arise requiring you to exercise your judgment.

Compliance with laws, regulations and out policies require the full commitment of all Edison HHC personnel. Each of us is personally and professionally responsible for understanding and adhering to this Code of Conduct and the supporting policies and procedures, including those areas covering your specific job responsibilities. The purpose of this Code of Conduct is to provide you with guidance on ethical and compliance issues. However, this Code of Conduct cannot cover every issue you may encounter. If you have a question or encounter a situation which concerns you, you should ask for Edison HHC through your department supervisor, the Administrator and/or the Compliance Officer.

Compliance Hotline is 718-475-1910 or the email is compliance@edisonhhc.com .

_____ _____

Print Name Employee's Signature

EDISON
HOME HEALTH CARE

# 120 DAYS HHA PERFORMANCE REVIEW

**BY: Staffing Coordinator ONLY**

**Employee** _____ **CC #**_____
**Last Name** **First**

**JOB TITLE:** _____**HHA / PCA**_____

**Rating:** **NI=Needs Improvement** **S = Satisfactory** **VG=Very Good** **E=Excellent**

| | | | | |
|---|---|---|---|---|
| **1. Longevity on assignments** | ☐ NI | ☐ S | ☐ VG | ☐ E |
| **2. Informs Staffing Coordinator of changes in schedule in a timely manner, including client appointments or overtime.** | ☐ NI | ☐ S | ☐ VG | ☐ E |
| **3. Accepts assignments to meet the needs of the program.** | ☐ NI | ☐ S | ☐ VG | ☐ E |
| **4. Uses HHA EXCHANGE for recording time appropriately.** | ☐ NI | ☐ S | ☐ VG | ☐ E |
| **5. Inputs tasks as required.** | ☐ NI | ☐ S | ☐ VG | ☐ E |
| **6. Reports incidents in a timely manner.** | ☐ NI | ☐ S | ☐ VG | ☐ E |
| **7. Calls for replacements in a timely manner.** | ☐ NI | ☐ S | ☐ VG | ☐ E |
| **8. Appearance is appropriate.** | ☐ NI | ☐ S | ☐ VG | ☐ E |
| **9. Demonstrates concern for assigned clients' well being.** | ☐ NI | ☐ S | ☐ VG | ☐ E |
| **10. Attends scheduled appointments including medical, in-service and competency.** | ☐ NI | ☐ S | ☐ VG | ☐ E |
| **11. Works alternate weekend.** | ☐ NI | ☐ S | ☐ VG | ☐ E |
| **12. Overall attendance (call outs/cancellations)** | ☐ NI | ☐ S | ☐ VG | ☐ E |
| **13. Punctuality** | ☐ NI | ☐ S | ☐ VG | ☐ E |
| **14. Works well with other staffing coordinators** | ☐ NI | ☐ S | ☐ VG | ☐ E |

**Additional Comments**_____
_____
_____
_____

**Employee Comments:** _____
_____
_____

**Employee Signature:** _____ **Date**_____

**Supervisor's Signature:** _____**Date**_____

CC CODE: _____

# WORK AVAILABILITY

**NAME:** _____ **LANGUAGE**: _____

**TELEPHONE#:** _____, _____

**DAYS AND HOURS:** **COMMENTS:**

___Saturday ___AM ___PM _____

___Sunday ___AM ___PM _____

___Monday ___AM ___PM _____

___Tuesday ___AM ___PM _____

___Wednesday ___AM ___PM _____

___Thursday ___AM ___PM _____

___Friday ___AM ___PM _____

**DO YOU USE A SMART PHONE?** ___ Yes ___ No

Are pets OK? ___Yes ___No _____

Is smoking OK? ___Yes ___No _____

Kosher experience? ___Yes ___No _____

Is vehicle available for work? ___Yes ___No _____

Shift Preference: ☐ 4 hour ☐ 8 hour ☐12 hour ☐ Live-In

Location(s): ☐ Brooklyn ☐ Queens ☐ Bronx ☐ Manhattan ☐ Long Island

# Receipt and Acknowledgement of Employee Handbook

Please read the following statements, sign below and return to [insert title of correct person(s)].

Acknowledgement and Receipt of Employee Handbook:

I have this day received a copy of the Edison Office Staff Handbook and I understand that I am responsible for becoming familiar with its contents.

This handbook/manual is for informational purposes only. I understand that any of the provisions of this applicant/employee manual/handbook may be changed, modified or deleted at any time and that the Company has the right to administer, interpret, modify, discontinue or enhance any policy, benefit, plan or program. I understand that neither this manual/handbook nor any other written or oral communications by a management representative constitutes, or in any way, creates a contract or guarantee of employment.

I have read and I understand the Company's policies regarding confidentiality. I pledge to respect the confidentiality of all information pertaining to the clients and Company. I have received a copy of the Company's confidentiality statement.

Acknowledgement of At-Will Employment:

I further understand that my employment is at will, and neither Edison nor I have entered into a contract regarding the duration of my employment. Except as otherwise provided in a valid and enforceable collective bargaining agreement, I am free to terminate my employment with Edison at any time, with or without reason and Edison has the right to terminate my employment, or otherwise discipline, transfer, or demote me at any time, with or without reason at the discretion of Edison. No employee of Edison can enter into an employment contract for a specified period of time or make any agreement contrary to this policy without the written approval of the Administrator and/or Owner of Edison Home Health Care.

I understand that, if I am a member of a union, this paragraph will be superseded by a valid and enforceable collective bargaining agreement.

As an employment condition, I understand that Edison may periodically monitor, survey, or review my work performance by using mechanical, electronic, or other methods. To this work performance surveillance, I expressly consent.

_____ _____

Employee's Printed Name Position

_____ _____

Employee's Signature Date

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

**1. Employer Information**

Name:

NAE Edison LLC

Doing Business As (DBA) Name(s):

Edison Home Health Care

FEIN (optional):

26-4463070

Physical Address:

946 McDonald Avenue
Brooklyn NY 11218

Mailing Address:

946 McDonald Avenue
Brooklyn NY 11218

Phone:

718-972-2929

**2. Notice given:**

☒ At hiring

☐ Before a change in pay rate(s), allowances claimed or payday

**3. Employee's rate of pay:**

$ 15.00 per hour

**4. Allowances taken:**

☒ None

☐ Tips _____ per hour

☐ Meals _____ per meal

☐ Lodging _____

☐ Other _____

**5. Regular payday**: Friday

**6. Pay is:**

☒ Weekly

☐ Bi-weekly

☐ Other

**7. Overtime Pay Rate:**

$ 22.50 per hour (This must be at least 1½ times the worker's regular rate with few exceptions.)

**8. Employee Acknowledgement:**

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

**Check one:**

☐ I have been given this pay notice in English because it is my primary language.

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

_____
Print Employee Name

_____
Employee Signature

_____
Date

Dita Kodraj / Director Of HR
Preparer's Name and Title

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

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