Overview of the Self-Direction Hiring Process

The Participant/Designee is responsible for:	RCIL is responsible for:
• Recruiting • Setting Wages • Interviewing • Training • Supervising, Evaluating and Dismissing Workers	• Administering the hiring process, managing wages and benefits on behalf of the Participant. • Maintaining training and background checks on behalf of the Participant

Please complete the hiring packet in its entirety and return it to RCIL within five business days. **Please be sure that all forms are completed using blue or black ink, with all required signatures and dates**. All forms are accessible on our website at http://www.rcil.com/self-direction-packets.

Your Employer will submit the completed packet by one of the following methods:

By MAIL: ATTN: Self-Direction HR Liaisons
RCIL
P.O. Box 210
Utica, NY 13503-0210

By FAX: 315-272-2954
ATTN: Self-Direction HR Liaisons

By SCAN: hrselfdirected@rcil.com

Packet Drop Off Locations:
Corporate Office: 131 Genesee Street, Utica, NY
Herkimer Locations: 420 East German Street, Suite 107A, Herkimer, NY
Amsterdam Location: 131 Maple Avenue Extension, Amsterdam, NY

Please note that some forms are required to be mailed to RCIL to comply with certain rules and regulations, refer to the Self-Direction Hiring Process for further guidance.

Fingerprinting appointments will be arranged once a completed packet is received by RCIL's Human Resources department. You will be contacted by a member of Human Resources to schedule your appointment. Please bring all appropriate identification to the appointment. The receipt provided to you at the fingerprinting site should be forwarded to RCIL's Human Resources office.

You will be trained in RCIL's electronic timekeeping system prior to your start date. You will be provided login credentials for this site (do not share your login credentials with anyone).

After your paperwork, background checks, and training requirements are complete, the Participant/Designee will receive a call and email from RCIL notifying them that you may begin working.

Please feel free to contact RCIL's Human Resources Self-Direction Liaisons at 315-797-4642 extensions 1897, 1670, 2793, or 2958 should you have any questions or concerns.

Thank you,

RCIL's Human Resource Department

Resource Center for Independent Living as the Fiscal Intermediary (FI) for the Self-Direction Program

EMPLOYMENT FORM

Section 1: Worker's Information (Worker to Complete)

Worker's First Name:	MI:	Last Name:
Home Phone Number:		Cell Phone Number:
Email Address: (required)		
Mailing Address (PO Box):		Apartment #:
City:		State:
Zip Code:		County:
Emergency Contact: Relationship:		Home Phone Number: Cell Phone Number:

Section 2: Employer's Information (Participant/Designee to Complete)

Employer (Participant) First and Last Name:	
Designated Representative/Designee (If applicable):	Is individual receiving services 18 years or older: YES NO
Home Phone Number:	Cell Phone Number:
Email Address:	
Will the worker be a back-up Support Worker? YES NO Back-up workers must remain up to date with annual training requirements and adhere to the Back-up Workers Guidelines.	Will the worker provide transportation or run errands? YES NO

Support Worker's Schedule: (choose one)

☐ Set Schedule:	☐ Variable Hours / No Set Schedule. *
Monday _____ Tuesday _____ Wednesday_____ Thursday_____ Friday_____ Saturday_____ Sunday_____	*Please be advised, a six-month look back measurement period will determine benefits eligibility. *Vacation PTO nor NYS Paid Sick Leave will not be paid out upon separation from employment.

EMPLOYMENT FORM

Section 3: Attestation Statements (Worker to Complete, Participant/Designee to sign)

Worker's Full Name:

Have you ever been convicted of a motor vehicle moving violation, including, but not limited to, alcohol and drug-related offenses?

_____ YES _____ NO

If yes, please describe. You must indicate any suspension, revocation, or occurrence involving harm to human beings or property while driving.

Are you currently working with another participant in Self-Direction?

_____ YES _____ NO

Under the Self-Direction Program, the following relationships to the Participant cannot be hired as staff:

- Parents,
- Legal Guardians,
- Spouses,
- Adult Children,
- Son-in-laws and Daughter-in-laws; and/or
- Any family member/relative that resides in the Participant's home.

I certify that I am 18 years or older as required by OPWDD to be hired in the Self-Direction program _____ (initial or check here)

Choose one:

I certify that I am not related to the Participant for whom I will be working in any of the relationships listed above _____ (initial or check here)

OR

I certify that if I am a family member/relative not listed above, I do not reside in the Participant's home _____ (initial or check here)

By signing the below, I certify that the information provided in this document is true, accurate and complete, and I certify knowing that any falsification, misrepresentation or omission of this information may cause the withdrawal of any conditional offer or termination of employment, if hired, by my Employer (Participant), regardless of the timing or circumstances of discovery.

_____ _____
Worker Signature Date

_____ _____
Employer/Participant/Designee Signature Date

SELF-DIRECTION SUPPORT WORKER JOB DESCRIPTION

Job Title: Self-Direction Support Worker
Reports to: Participant/Designee
Status: Hourly, Non-Exempt
Purpose: To provide services to Participants as described within their Staff Action Plan and as directed by the Participant/Designee.
Duties and Responsibilities:
Implement the goals/safeguards outlined in the Staff Action Plan.
Follow all Electronic Visit Verification (EVV) requirements including but not limited to entering notes daily and during shift.
Report all reportable incidents timely to the Designee, Compliance, and Self-Direction Coordinator.
Maintain confidentiality of all work-related information and follow all Health Insurance and Portability Accountability Act (HIPAA) regulations.
Work, Education, Knowledge, and Skill Requirements:
The Participant/Designee recruits and supervises the Support Worker. The requirements are based on the Participant's needs and set by the Participant/Designee in accordance with the Staff Action Plan.
Other:
Lifting may be required and will depend on Participant needs. Support Workers must be 18 years of age or older.

The above statements are intended to describe the essential functions of the position. They are not intended to encompass all duties.

Support Worker's Printed Name: _____

Support Worker's Signature: _____ Date: _____

Participant/Designee's Printed Name: _____

Participant/Designee's Signature: _____ Date: _____

Directions to Complete the Employment Eligibility Verification (Form I-9)

Please use Blue or Black ink only. No other colors will be accepted. **White Out is not allowed.**

Any corrections need to be made using a single line cross-out and it must be initialed and dated for the form to be valid. If you choose to complete the fillable form (suggested) all fields are typed for the exception of any signature and date fields. **(Date format must be mm/dd/yyyy) Example: 01/01/2018**

RCIL uses E-Verify, an Internet-based system that compares information from the Form I-9, to confirm that a worker is authorized to work in the United States. We must collect copies of the identification used to prove employment eligibility. **The copies of ID's may be scanned, faxed, or mailed to our office or simply added in with the application.**

Section one: Completed by Self-Direction Worker

Ensure you use your last name that's associated with your social security card to keep from any delay in processing.

1. Write your full legal name, address, middle initial (if applicable), other last names used and date of birth. Ensure all writing is complete and legible.
    - Date format on date of birth must be 8 digits (**mm/dd/yyyy**).
    - Please write "N/A" in any boxes that are not applicable to you.
2. The SD Worker must add Not Applicable (N/A) in any boxes that are not filled in (such as other names used *if any*, apt #, email address).
3. Write your full Social Security number.
4. Identify your citizenship/immigration status.
5. Check and verify that you signed and dated the bottom of this form. The date is the current date you signed the form. (Date format must be 8 digits **mm/dd/yyyy**).

**If someone other than yourself assisted with completing Section One, the preparer/translator needs to complete, page 3, Supplement A, Preparer and/or Translator Certification for Section

We are here to help:

We encourage you to contact our office for assistance with completing the Form I-9.

HR Self-Direction Liaisons: 315-797-4642 extension 1897, 1670, 2793, or 2958.

You can also email the team at hrselfdirected@rcil.com.

Section Two Completed by Participant and/or Designated Rep

1. You must physically examine one document from list A **or** a combination of one document from List B **AND** one document from List C as listed on the "Lists of Acceptable Documents" (Page 2). ID's must be valid and unexpired. (Copies of the documentation must be sent in).
2. Check to ensure each document has been entered in the proper list. For example, the List B item is, in fact, listed under list B and not List C or List A.
3. Under **CERTIFICATION,** you as the participant/designated rep must complete this section with your information. (Date format must be 8 digits **mm/dd/yyyy**).
4. The company name should be RCIL.
5. Your title should be Employer/Supervisor
6. Any corrections need to be made using a single line cross-out and it must be initialed and dated for the form to be valid. **(Date format: mm/dd/yyyy) Example:01/01/2018**
7. **Copies of the I-9 form will not be accepted** and it will cause a delay in your SD Worker's approval to start working. The original I-9 form must be sent in. No Exceptions.
8. If there are too many corrections where the form is now illegible, then you must redo the I-9 form.

Please do not complete document on page 4, Supplement B, Reverification and Rehire.

We are here to help:

We encourage you to contact our office for assistance with completing Section Two of the Form I-9. We have the capability to FaceTime/Skype and provide assistance virtually.

Please contact any HR Self-Direction Liaison and they can assist you with completing this form.

HR Self-Direction Liaisons: 315-797-4642 extension 1897, 1670, 2793, or 2958.

You can also email the team at hrselfdirected@rcil.com.

The Form I-9 can be mailed to:

RCIL
P.O. Box 210
Utica, NY 13503-0210
Attn: HR Self direction Liaison

Employment Eligibility Verification

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

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

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

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

Section 1. Employee Information and Attestation: Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)

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

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

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

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

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

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

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

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

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

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

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)			**Additional Information**		
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)			☐ Check here if you used an alternative procedure authorized by DHS to examine documents.		

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.	First Day of Employment (mm/dd/yyyy):

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

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
Resource Center for Independent Living	**131 Genesee St, PO Box 210, Utica, NY 13503**

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

LISTS OF ACCEPTABLE DOCUMENTS

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Acceptable Receipts

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Supplement B, Reverification and Rehire (formerly Section 3)

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

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

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

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

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

Medication Administration Acknowledgement

I, _____ (Worker) understand that under Justice Center regulations for the Self-Direction Program, I am not allowed to administer medication of any kind in my role as a Self-Direction Support Worker. This includes setting up medication, dosing medication or administering in any way.

_____

Worker's Name (please print clearly)

_____ _____

Worker's Signature Date

_____

Employer's Name (please print clearly)

_____ _____

Employer's Signature* Date

_____

*If you are signing as Designated Representative, list Participant's Name

Resource Center for Independent Living (RCIL) as the Fiscal Intermediary (FI) for the Self Direction (SD) Program

Program/Medicaid Billing Guidelines

SD Program Worker agrees to the following:

- I am at least 18 years old and am not the parent, legal guardian, Designee, legal spouse, or adult child (including sons and daughters-in-law) of the Participant I work for.
- I have disclosed my familial relationship with the Participant to RCIL.
- I have disclosed my residence and will inform RCIL of any changes immediately.
- I will log in at the beginning of each shift and log out at the end of each shift using the timekeeping and Electronic Visit Verification (EVV) system provided by RCIL. GPS will be turned on at the beginning and end of each shift.
- I will complete an accurate daily service note for each shift that I work using the timekeeping system provided by RCIL.
- If I am unable to login or out for any reason or am unable to accurately report all the times I worked, I will immediately inform RCIL's Self Direction Time and Attendance Staff. I will immediately contact RCIL via email at sdta@rcil.com or phone at (315) 738-2761. I will also inform the Participant or their Designee immediately.
- I am aware of the goals/safeguards on the Participant's Staff Action Plan, and that I must complete only tasks related to the Participant receiving services during the hours I work.
- I will not provide or engage in any other activity for which I receive compensation or other recognition (such as volunteer work) while I am providing paid services to the Participant.
- I acknowledge that under Medicaid Billing Guidelines, it is illegal to receive payment for services performed when a Participant is hospitalized or in rehabilitation or a nursing home placement, when a Participant is participating in another Medicaid program or service, when a Participant attends school, or if the Participant passes away. If the Participant I work for is hospitalized or passes away while on shift, I will log out and notify RCIL immediately. I will contact RCIL via email at sdta@rcil.com or phone at (315) 738-2761.
- I acknowledge that sleeping is not allowed during my shift while providing direct care to the Participant.
- I acknowledge that my username and password for RCIL's timekeeping system must not be shared with anyone including the Participant I work for or their Designee.

Created 9/2023

Resource Center for Independent Living (RCIL) as the Fiscal Intermediary (FI) for the Self Direction (SD) Program

- I will respect the privacy of Participants and follow the Health Insurance Portability and Accountability Act (HIPAA) Federal and State Confidentiality Laws by keeping all health-related information confidential.

- I will inform RCIL's Human Resources Department of any changes in my information or status, including any changes to my name, address, or phone number. To report a disability leave, please call 315-272-2943. To report any changes with name, address, or phone number, please call 315-272-2958 or 315-738-2793 and or email: hrselfdirected@rcil.com.

- I am aware that signing and submitting false information may lead to a charge of Medicaid Fraud.

I have read and understand this agreement and accept these terms and responsibilities. I agree that I will return all payments received from RCIL for any hours worked in violation of these terms and responsibilities, and the Medicaid Billing Guidelines.

Signature of Worker:

Please Print Name	**Signature**	**Date**

Self-Direction Service Location Acknowledgement

Please check all that apply:

_____ I am a current resident of New York State and intend to deliver in person services only in New York State.

_____ I am a current resident of New York State and intend to deliver telehealth services.

_____ I reside outside of New York State but will be providing in person services in New York State.

_____ I reside outside of New York State and intend to deliver telehealth services only.

_____ I reside outside of New York State and will provide in person and telehealth services.

_____ None of the above apply to me. Explain below.

Describe your current out of state situation, including, but not limited to: (1) the reason you reside out of New York State, but are working in New York State, (2) whether your out of state residence is temporary or permanent, and (3) any other relevant information regarding your arrangement to work in, but live outside of, New York State:

_____

_____

NYS work location address:

_____

You must inform RCIL if you move out of state and any time your address, email, or phone number change. Changes should be sent to hrselfdirected@rcil.com.

Support Worker's Printed Name: _____

Support Worker's Signature: _____ Date: _____

Participant/Designee's Printed Name: _____

Participant/Designee's Signature: _____ Date: _____

Self-Direction Support Worker Application for Employment

Applicant Information			
Full Legal Name:			
Last	First		M.I.
Preferred Name (if different):			
Last	First		M.I.
Address:			
Street		Apartment #	
City	State	Zip Code	
Contact:			
Phone	Email		
Date available to begin work?			
Are you 18 years or older?		YES ☐ NO ☐	
Are you a citizen of the United States?		YES ☐ NO ☐	
If not a U.S. Citizen, are you authorized to work in the U.S.?		YES ☐ NO ☐	
Have you ever worked for RCIL?		YES ☐ NO ☐	
If yes, when?			
Are you related to the person receiving services or to any other workers/ relatives in the household?		YES ☐ NO ☐	
If yes, what is your relationship?			

Education
Highest level of education completed:

Employment History		
List most recent employment first		
1. Name of Employer:		Phone:
Address:		Supervisor Name:
Job Title:		
Responsibilities:		
From:	To:	Reason for leaving:
May your supervisor be contacted for a reference? YES ☐ NO ☐		
2. Name of Employer:		Phone:
Address:		Supervisor Name:
Job Title:		
Responsibilities:		
From:	To:	Reason for leaving:
May your supervisor be contacted for a reference? YES ☐ NO ☐		

3. Name of Employer:		Phone:
Address:		Supervisor Name:
Job Title:		
Responsibilities:		
From:	To:	Reason for leaving:
May your supervisor be contacted for a reference? YES ☐ NO ☐		
Please address any gaps in employment:		

Additional References

Please list below additional references if not provided in the employment history above. References can include teachers, coaches, clergy, volunteer work, etc. References should not include family members.

1. Full Name:	Phone:
Address:	Relationship:
2. Full Name:	Phone:
Address:	Relationship:
3. Full Name:	Phone:
Address:	Relationship:

Disclaimer and Signature

All applicants must obtain background check clearance in accordance with New York State Justice Center requirements. Please be advised that individuals who are listed on a Medicaid Exclusionary List are prohibited from employment in this position.

I certify that my answers are true and complete to the best of my knowledge, and I understand that false or misleading information in my application or job interview may result in termination of employment.

Signature of Full Legal Name	Date
Print Full Legal Name	

Resource Center for Independent Living as the Fiscal Intermediary (FI) for the Self-Direction Program

REQUEST FOR APPLICANT DATA

Completion of this form is voluntary

Since RCIL is the Fiscal Intermediary for your Employer and an Affirmative Action agency; RCIL is required to collect, maintain and report on certain information. Such information is stored in a secure and confidential manner separate from personnel records, and is only used for purposes of complying with the requirements and objectives pertaining to Affirmative Action. Reporting is statistical in nature and normally does not contain individually identifiable information, except when requested for audit purposes by the government agency responsible for Affirmative Action compliance.

You are not required to provide this information, and failure to do so will not in any way affect your prospects for employment by a Participant.

Worker's Name: _____ **Date:** _____

1) Check one of the following:

☐ Female ☐ Male

2) Check one of the following:

My ethnicity is Hispanic or Latino.

☐ Yes ☐ No

3) If your answer to Item 2) is "No," Check one of the following races:

☐ White
☐ Black or African-American
☐ Native Hawaiian or Other Pacific Islander
☐ Asian
☐ American Indian or Alaska Native
☐ Two or more races

4) Check one from each of the following:

Vietnam Era Veteran	☐ Yes	☐ No
Special Disabled Veteran	☐ Yes	☐ No
Other Protected Veteran	☐ Yes	☐ No
Armed Forces Service Medal Veteran	☐ Yes	☐ No
Discharge Date:	_____	

Voluntary Self-Identification of Disability

Form CC-305
OMB Control Number 1250-0005
Expires 1/31/2020

Why are you being asked to complete this form?

Because we do business with the government, we must reach out to, hire, and provide equal opportunity to qualified people with disabilities.[i] To help us measure how well we are doing, we are asking you to tell us if you have a disability or if you ever had a disability. Completing this form is voluntary, but we hope that you will choose to fill it out. If you are applying for a job, any answer you give will be kept private and will not be used against you in any way.

If you already work for us, your answer will not be used against you in any way. Because a person may become disabled at any time, we are required to ask all of our employees to update their information every five years. You may voluntarily self-identify as having a disability on this form without fear of any punishment because you did not identify as having a disability earlier.

How do I know if I have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition.

Disabilities include, but are not limited to:

- Blindness
- Deafness
- Cancer
- Diabetes
- Epilepsy
- Autism
- Cerebral palsy
- HIV/AIDS
- Schizophrenia
- Muscular dystrophy
- Bipolar disorder
- Major depression
- Multiple sclerosis (MS)
- Missing limbs or partially missing limbs
- Post-traumatic stress disorder (PTSD)
- Obsessive compulsive disorder
- Impairments requiring the use of a wheelchair
- Intellectual disability (previously called mental retardation)

Please check one of the boxes below:

☐ YES, I HAVE A DISABILITY (or previously had a disability)
☐ NO, I DON'T HAVE A DISABILITY
☐ I DON'T WISH TO ANSWER

Your Name _____ Today's Date _____

Voluntary Self-Identification of Disability

Reasonable Accommodation Notice

Federal law requires employers to provide reasonable accommodation to qualified individuals with disabilities. Please tell us if you require a reasonable accommodation to apply for a job or to perform your job. Examples of reasonable accommodation include making a change to the application process or work procedures, providing documents in an alternate format, using a sign language interpreter, or using specialized equipment.

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[i] Section 503 of the Rehabilitation Act of 1973, as amended. For more information about this form or the equal employment obligations of Federal contractors, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

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

Step 3: Claim Dependent and Other Credits

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

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

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

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

Step 4 (optional): Other Adjustments

(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)
Resource Center for Independent Living, PO Box 210 Utica, NY 13503-0210		**222518284**

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

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

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

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

1. Expect to work only part of the year;

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

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

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

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

Specific Instructions

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

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

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

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

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

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

Step 4 (optional).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

. . . . . 2 $

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

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

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

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

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

Single or Married Filing Separately

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

Head of Household

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

NEW YORK STATE 2024

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 (this includes the Bronx, Brooklyn, Manhattan, Queens, and Staten Island)? ..... Yes ☐ No ☐

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

Before making any entries, see the *Note* below, and if applicable, complete the worksheet in the instructions.

1	Total number of allowances you are claiming for New York State and Yonkers, if applicable *(from line 19, if using worksheet)*	1
2	Total number of allowances for New York City *(from line 31, if using worksheet)*	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.

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's signature	Date

Employee: Give this form to your employer and keep a copy for your records. Remember to review this form once a year and update it if needed.

Note: Single taxpayers with one job and zero dependents, enter ***1*** on lines 1 and 2 (if applicable). Married taxpayers with or without dependents, heads of household or taxpayers that expect to itemize deductions or claim tax credits, or both, complete the worksheet in the instructions. Visit *www.tax.ny.gov* (search: *IT-2104-I)* or scan the QR code below.

Employer: Keep this certificate with your records.

If any of the following apply, mark an ***X*** in each corresponding box, complete the additional information requested, and send an additional copy of this form to New York State. See ***Employer*** in the instructions. Visit *www.tax.ny.gov* (search: *IT-2104-I)* or scan the QR code below.

A Employee claimed more than 14 exemption allowances for New York State ..... A ☐

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

You may report new hire information online instead of mailing the form to New York State. Visit *www.nynewhire.com*.

Note: Employers **must** report individuals under an **independent contractor arrangement** with contracts in excess of $2,500 using the online reporting website above, **not** Form IT-2104.

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 New York State Tax Department.)*	Employer identification number
Resource Center for Independent Living, PO Box 210 Utica, NY 13503-0210	222518284

Scan here

https://www.tax.ny.gov/r/it2104i-2024

Self-Direction Metro Tax Information

FOR RESIDENTS OF AND SUPPORT WORKERS IN NEW YORK CITY AND YONKERS TO COMPLETE

If you reside or will be working in New York City or Yonkers, please answer the questions below to assist RCIL in ensuring all applicable taxes are withheld. For future changes, please inform RCIL's Human Resources Department immediately to update your address and applicable tax withholdings at hrselfdirected@rcil.com.

1. **Do you reside in New York City?**

   YES OR NO

2. **Do you reside in Yonkers?**

   YES OR NO

3. **Does the Participant reside in Yonkers?**

   YES OR NO

4. **Which county does the Participant reside in?**

   _____

Resource Center for Independent Living (RCIL) Payroll & Reimbursement Authorization Form

Support Worker's Information *(print and complete all fields)*			
First Name:	Middle Name:	Last Name:	
Date of Birth:	Department/Program: **Self-Direction**		Last Four Digits of Social Security #:
Mailing Address:			Apt # (if applicable):
City:		State:	Zip Code:
Home Phone:	Mobile Phone:	Email Address:	
Physical Address (Required if PO Box listed above):		Apt # (if applicable):	
City:	State:	Zip Code:	
Payment Election: *I hereby authorize RCIL to distribute my paycheck and reimbursements as follows:*			

☐ **Direct deposit into my bank account** ☐ **Direct deposit onto my preferred Debit Card**

***You may receive your first paycheck in the mail as your bank account information for direct deposit is being verified.**

You must attach the following documents (depending on the type of account you elect):
Checking: Voided Check or a statement from your bank, on bank letterhead, containing your name and account information.
Savings: Savings Deposit Slip or a statement from your bank, on bank letterhead, containing your name and account information.
Debit Card: Electronic information regarding your account, including name and account information.

Routing Number:			
Account Number:			
Type of Account:	☐ Checking	☐ Savings	☐ Debit Card

If you do not elect deposit to your personal account, one of the below will be selected for you.

☐ **Direct deposit onto the Wisely Pay by ADP card**

The Wisely Pay card will be issued by RCIL's payroll service provider ADP. This card will be mailed to your mailing address listed above. **You will be required to activate your card immediately upon receipt.**

☐ **Direct deposit onto the Wisely Check by ADP** *(ADP will mail you a card and checks)*

I understand that although I will be enrolled in the Wisely Program, I am not required to activate or use a Wisely Pay card to use the Wisely Check to receive my full net pay. Wisely Check will be the default payment method if no other wage payment method is selected above.

If I elect to use the Wisely Check, I understand that each payday I will need to make the check payable to myself for my full net pay, date the check, call to authenticate the check and write the authentication code on the check prior to being able to cash the Wisely Check.

Consent to Deposit Payment:	
Signature:	**Date:**

Updated: 12/2019; 03/2022; 9/2023; 11/2023

Code of Conduct for Custodians of People with Special Needs

Introduction

The Code of Conduct, as set forth in the Code of Conduct itself, sets forth a framework intended to assist impacted employees to help people with special needs "live self-directed, meaningful lives in their communities, free from abuse and neglect, and protected from harm," in addition to the specific guidance provided by the agency's policies and training.

Similarly, the Notice to Mandated Reporters contains guidance designed to assist mandated reporters and is intended to provide a summary of reporting obligations for mandated reporters. It is not intended to supplement or in any way add to the reporting obligations provided by law, rule, or regulation.

As provided by law, rule, or regulation, only custodians who have or will have regular and direct contact with vulnerable persons receiving services or support from facilities or providers covered by the Justice Center Act must sign that they have read and understand the Code of Conduct.

The framework provides:

1. Person-Centered Approach

My primary duty is to the people who receive supports and services from this organization. I acknowledge that each person of suitable age must have the opportunity to direct his or her own life, honoring, where consistent with agency policy, their right to assume risk in a safe manner, and recognizing each person's potential for lifelong learning and growth. I understand that my job will require flexibility, creativity and commitment. Whenever consistent with agency policy, I will work to support the individual's preferences and interests.

2. Physical, Emotional and Personal Well-being

I will promote the physical, emotional and personal well-being of any person who receives services and supports from this organization, including their protection from abuse and neglect and reducing their risk of harm to others and themselves.

3. Respect, Dignity and Choice

I will respect the dignity and individuality of any person who receives services and supports from this organization and honor their choices and preferences whenever possible and consistent with agency policy. I will help people receiving supports and services use the opportunities and resources available to all in the community, whenever possible and consistent with agency policy.

4. Self-Determination

I will help people receiving supports and services realize their rights and responsibilities, and, as consistent with agency policy, make informed decisions and understand their options related to their physical health and emotional well-being.

5. Relationships

I will help people who receive services and supports from this organization maintain or develop healthy relationships with family and friends. I will support them in making informed choices about safely expressing their sexuality and other preferences, whenever possible and consistent with agency policy.

6. Advocacy

I will advocate for justice, inclusion and community participation with, or on behalf of, any person who receives services and supports from this organization, as consistent with agency policy. I will promote justice, fairness and equality, and respect their human, civil and legal rights.

7. Personal Health Information and Confidentiality

I understand that persons served by my organization have the right to privacy and confidentiality with respect to their personal health information and I will protect this information from unauthorized use or disclosure, except as required or permitted by law, rule, or regulation.

8. Non-Discrimination

I will not discriminate against people receiving services and supports or colleagues based on race, religion, national origin, sex, age, sexual orientation, gender identity, economic condition, disability, or any other protected class under the law.

9. Integrity, Responsibility and Professional Competency

I will reinforce the values of this organization when it does not compromise the well-being of any person who receives services and supports. I will maintain my skills and competency through continued learning, including all training provided by this organization. I will actively seek advice and guidance of others whenever I am uncertain about an appropriate course of action. I will not misrepresent my professional qualifications or affiliations. I will demonstrate model behavior to all, including persons receiving services and supports.

10. Reporting Requirement

As a mandated reporter, I acknowledge my legal obligation under Social Services Law § 491, as may be amended from time to time or superseded, to report all allegations of reportable incidents immediately upon discovery to the Justice Center's Vulnerable Persons' Central Register by calling 1-855-373-2122.

Code of Conduct[1] Acknowledgement for Custodians of People with Special Needs

I pledge to prevent abuse, neglect, or harm toward any person with special needs, consistent with agency policy. In addition, to the extent I am required to report abuse, neglect, or harm of any person with special needs by law, rule, or regulation, I agree to abide by the law, rule, or regulation. If I learn of, or witness, any incident of abuse, neglect or harm toward any person with special needs, I will offer immediate assistance, notify emergency personnel, including 9-1-1, and inform the management of this organization, consistent with agency policy.

I acknowledge that I have read and that I understand the Code of Conduct.

Signature	Print Name	Date

Program: _____

Department: _____

Facility/Provider Organization: _____

[1]No aspect of this Code of Conduct is in any way intended to interfere, abridge, or infringe upon the rights provided by the Taylor Law.

Self-Direction Transportation Requirements

The purpose of the Self-Direction Transportation Requirements is to establish guidelines to protect the health and safety of the Support Workers, Participants, and the public, and to minimize the risk of damages and claims against RCIL in connection with Support Worker's operation of personal vehicles while on Agency business.

Under the Self-Direction Program, through the Resource Center for Independent Living (RCIL), the Support Worker will operate their own personal vehicle to transport Participants or to perform other services while on Agency business. The following are general rules to follow:

1. All Support Workers driving during work hours are required to comply with all motor vehicle and traffic laws and regulations, including but not limited to speed limits, seatbelt, cell phone, parking and child car seat laws and regulations.
2. All vehicles must have up to date inspections and registrations.
3. Support Workers operating any vehicle during work hours shall only do so when the vehicle is in safe operating conditions.
4. Should Support Workers commit traffic violations or other violations during their work hours, all fines and penalties incurred are the Support Worker's responsibility and will not be paid by RCIL or the Participant/Designee.
5. When a motor vehicle accident occurs on the job, Support Workers should take the appropriate steps to obtain medical treatment, if needed, for themselves and any passengers in the vehicle and, if physically able, contact appropriate law enforcement authorities. Support Workers must obtain the other vehicle's insurance information, vehicle make and model, and vehicle color and plate number. Support Workers must contact RCIL and notify their Participant/Designee within 24 hours and submit both an accident and police report promptly to a Human Resources representative.
6. Support Workers approved to drive during their work hours are required to promptly inform their Participant/Designee and a Human Resources representative if their license, insurance or registration has expired, or has been suspended or revoked, if they incur any serious accidents, infractions, charges, convictions or any other changes in their driving record that may affect either their legal or physical ability to drive or which may impact their continued insurability. Failure to report such information to their Participant/Designee and RCIL may result in disciplinary action, up to and including termination of employment.
7. Although Support Workers authorized to provide transportation to Participants may, on occasion, need to transport the Participant's children, friends, and/or parents along with the Participant to meet the Participant's service needs, Support Workers should do so only when necessary. Support Workers may transport their own family members or friends while transporting Participants only when expressly authorized in the Participant's care plan and by the Participant.
8. To ensure a clean and safe environment, Support Workers authorized to transport Participants are responsible for cleaning the interior of the vehicle after each use.
9. Smoking is not permitted while transporting Participants using their own person vehicle. Support Workers are forbidden to use, sell or possess alcohol, or illegal drugs at any time during work hours, including operating their own personal vehicle to transport Participants or conduct Agency business.
10. Support workers are forbidden to operate motorcycles during work hours for Agency business including commuting from their designated work site, traveling between Participants' homes, and the transportation of Participants.

When an employee uses his/her/their own personal vehicle for authorized purposes, the Support Worker's own personal insurance will be primary and available Agency insurance will be secondary. The Agency requires that primary insurance coverage is the responsibility of the vehicle owner and not that of the Agency. Support Workers who operate their personal vehicles during work hours must pay for and maintain valid personal auto liability insurance coverage for bodily injury and property damage that meets the state minimum insurance requirements. Support Workers who are regularly required to drive as part of their position and who fail to maintain sufficient insurance coverage will be restricted from driving.

The New York State minimum requirements are:

- Bodily Injury: $25,000 per person/$50,000 per accident
- Property Damage: $10,000

All Support Workers who have been extended a conditional offer of employment with the Agency are subject to a driver's license check and must sign a release form giving the Agency permission to conduct such a check of their driver's license. The release will be kept in the Support Worker's file.

All New York State driver's licenses are entered into the NYS Department of Motor Vehicle License Event Notification (LENS) system. This system will validate the status of the Support Worker's license and acceptable driving history. The Support Worker will remain under the LENS roster for the duration of their employment and LENS will send notifications regarding any change in status to the Support Worker's driving record. This will include, but not limited to, suspensions, revocations, tickets, insurance lapses, accidents, fines, safety courses, etc. Any information received by RCIL that should require the Participant/Designee's review will be shared accordingly. To avoid disciplinary action, changes to the Support Worker's driving status must be reported withing 24 hours to the Participant/Designee and a Human Resources representative. Support Workers should be aware that traffic or other violations incurred during non-work hours may result in disqualification or restriction of their job-related driving privileges. A Support Worker charged with a violation, such as DWI or DWAI will not be permitted to transport participants or conduct Agency business while operating under a conditional license.

Support Workers who demonstrate unacceptable driving standards will not be allowed to drive a Participant in their personal vehicle at any time. Unacceptable driving standards include the following:

- Suspended or revoked license;
- Four or more moving violations in the past three years;
- One or more DUI/DWI/DWAI within the past twelve months;
- At fault in a fatal accident within the past five years;
- A reckless driving conviction within the past twelve months;
- A hit and run conviction within the past five years;
- Other unacceptable activity related to driving, in the sole discretion of RCIL.

Support Workers are requested to notify RCIL, if a driver's license is obtained after the initial hire date. Falsification of information about driving records may be a cause for termination of employment.

Support Workers whose position requires them to drive as an essential job function may be subject to a fitness for duty test when RCIL has a reasonable belief that the Support Worker may not be able to perform the essential functions of the position without posing a risk of harm to himself/herself/their self or others.

In light of the Agency's interest in protecting the health and well-being of Participants, the Agency reserves the right, in its sole discretion, to deny and/or revoke a Support Worker's job-related driving privileges at any time and for any reason.

Self-Direction Transportation Requirements Acknowledgement

I have received a copy of the Self-Direction Transportation Requirements, I acknowledge that I have the responsibility to maintain a valid driver's license, registration, and vehicle insurance at all times. I have read the contents and agree to abide by the requirements set forth.

Support Worker's Printed Name: _____

Support Worker's Signature: _____ Date: _____

Participant's Printed Name: _____

Participant/Designee's Signature: _____ Date: _____

Designee's Printed Name (if applicable): _____

RCIL
RESOURCE CENTER FOR INDEPENDENT LIVING

Overtime Guidelines

As a Self-Direction Support Worker, you cannot work overtime without preapproval from RCIL's Vice President of Self-Direction. If you work in multiple programs such as CDPAP, Waiver, or Many Hearts, you cannot work in excess of 40 hours a week collectively.

The definition of overtime is all hours worked in excess of 40 hours in one week. RCIL's work week is from Sunday to Saturday.

Do you work for multiple programs or multiple participants within the same program?

☐ **YES** ☐ **NO**

If yes, how many hours do you currently work in one week? _____

If yes, which program(s) do you work in?

☐ **CDPAP** ☐ **Waiver** ☐ **Self-Direction** ☐ **Many Hearts**

Attestation Statement:

I acknowledge that I have received, reviewed and understand the Overtime Guidelines.

_____
Self-Direction Support Worker Print Name

_____ _____
Self-Direction Support Worker Signature Date

Revised 3/24/2021 RS 11/3/2023

BACKGROUND CHECK
Notice, Authorization and Release

In compliance with the Fair Credit Reporting Act, 15 U.S.C.A. §§ 1681, *et seq.*, the New York Fair Credit Reporting Act, and any other applicable statutes, you are notified that in connection with, and in order to better evaluate, your application for employment as a Support Worker under the Self-Direction Program, a report which will provide applicable information concerning your criminal background, personal references and past employment history will be requested by the Resource Center for Independent Living (RCIL).

By my signature below,

- **I acknowledge** that any offer of employment I may have received from the Employer (Participant) is a ***conditional*** offer, contingent upon, among other things, completion by Resource Center for Independent Living (RCIL), of a Background Check regarding me with results satisfactory to OPWDD. **I understand** that unsatisfactory results from, refusal to cooperate with, or any attempt to affect the results of this Background Check may, at RCIL/Participant/Designee's discretion, result in withdrawal of any conditional employment offer or termination of employment if already employed.
- Pursuant to the Fair Credit Reporting Act, 15 U.S.C.A. §§ 1681, *et. seq.*, the New York Fair Credit Reporting Act, and any other applicable statutes, **I knowingly and voluntarily authorize** RCIL and/or its representatives, to conduct a search and review of my background and/or obtain written reports as requested by the Participant/Designee bearing on my background, in order for RCIL/Participant/Designee to evaluate my opportunities for prospective employment, including, but not limited to, reports detailing my criminal history and other reports which verify the information provided by me on the application form.
- **I release and forever discharge** the Participant/Designee and RCIL, its officers, directors, agents and employees, and any individual, corporation, agency, other organization or entity that may disclose or release information concerning me to RCIL pursuant to this authorization, their officers, directors, agents and employees and the heirs, successors and assigns all of them, from any and all claims, complaints, charges and liabilities whatsoever that may arise from the seeking, furnishing, reviewing and use of information for the purposes herein described.
- **I understand** that RCIL's role is limited to acquiring the criminal history record report and that RCIL will have no responsibility for evaluating the results of any such report or for making any decisions regarding my employment.
- **I understand** that all information collected by RCIL will remain confidential and will be utilized by the Participant/Designee and RCIL for employment purposes only.
- **I understand** that under New York Law, a criminal conviction will not necessarily disqualify me from employment with the Participant/Designee, but that the Participant/Designee will consider the circumstances surrounding the conviction in determining my qualifications for employment.
- In the event that an individual, corporation, agency, or other record source requires an alternative release form or additional identifying characteristics in order to release the requested information, **I agree** to provide the additional information and sign any additional release authorizations.
- **I acknowledge** my obligation during the course of my employment, in the event I become employed, to report promptly to RCIL and the Participant/Designee any arrests/convictions for misdemeanors or felonies, and, should my employment require operation of a motor vehicle, any suspension or revocation of my driver license for any reason whatsoever, and any other legally imposed restriction on my employment-related operation of a motor vehicle, **and I further acknowledge** that my employment may be terminated without notice in the event I fail to make any such report.

I acknowledge that by signing below, I have also received a copy of Article 23-A of the New York Correction Law, in compliance with Article 25 Section 380-g of the New York General Business Law.

Support Worker's Signature _____ **Date** _____

Print Support Worker's Name _____

TO BE COMPLETED BY THE SUPPORT WORKER:

The following information will be used to complete required background checks:

Last Name:	**First Name:**	**Middle Initial:**
All other names you have ever used, including, without limitation, maiden, aliases, aka's ("also known as") and nicknames that may appear on any record applicable to this Background Check. (You may omit only names protected from disclosure by court order, such as in connection with a witness protection program.)		
Mailing Address:		
City:	**State:**	**Zip Code:**
Email Address:	**Phone number:**	
Social Security Number:		**Date of Birth:**
Driver's License Number:		**State Driver's License was issued:**
Driver's License Expiration Date:		**Driver's License Class:**

Please note: You will be contacted by RCIL's Human Resources Department to schedule a fingerprinting appointment.

I certify that all information provided in this document is true, accurate and complete, and I so certify knowing that any falsification, misrepresentation, or omission of information will cause the withdrawal of any conditional offer I have been made and may cause the immediate termination of my employment by my Participant/Designee, if hired, regardless of the timing or circumstances of discovery.

Signature _____ **Date** _____

HUMAN RESOURCES USE ONLY:

DRIVER'S LICENSE CHECK	**X**		**JUSTICE CENTER STAFF EXCLUSION CHECK (SEL)**	**X**	
SEX OFFENDER CHECK	**X**		**OPWDD MHL 16.34 CHECK**	**X**	
MEDICAID EXCLUSION CHECK	**X**		**JUSTICE CENTER FINGERPRINTING RESULTS**	**X**	

NYS Justice Center For the Protection of People with Special Needs	**Applicant Consent Form for Fingerprinting for Justice Center Criminal Background Check (CBC)**	**NYS Justice Center for the Protection of People with Special Needs (Justice Center) Criminal Background Check Unit**

Part 1. Applicant Information (Please Print)

Last Name:	First Name:	MI:
Date of Birth:	Applicant type: Employee X Volunteer___ Family Care___ Operator_____	
Applicant address, city state:	Social Security Number:	
Facility/Provider Name: Resource Center for Independent Living, Inc. (RCIL)		

Part 2. Attestation

1. I have been advised that as part of the application process, the facility or provider agency listed above must request a background check with the NYS Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI) and the Justice Center must review and evaluate the results received from DCJS and the FBI. A conviction for certain crimes may affect my suitability for employment in this position.
2. I consent to having my fingerprints taken and submitted to DCJS and the FBI and consent to the Justice Center sharing with the facility or provider agency listed above a summary of the NYS criminal history information, if any, returned by DCJS, as part of its background investigation of my suitability for employment or volunteer service, or for certification as a natural person operator.
3. I have been advised that procedures exist for me to obtain, review and, if necessary, seek correction of my criminal history information pursuant to regulations established by DCJS in 9 NYCRR Part 6050, and the FBI, as applicable.
4. I have been advised that I have the right to withdraw my application for employment or volunteer service, or certification as a natural person operator, without prejudice, any time before employment, volunteer service, or certification as a natural person operator is offered or declined, regardless of whether the authorized person of the facility or provider agency has reviewed the summary of any criminal history information.
5. I have been advised that the results of the criminal background check forwarded to the Justice Center shall be confidential pursuant to the applicable federal and state laws, rules and regulations, and shall only be disclosed to persons authorized by law. Criminal history information will be considered pursuant to Article 23-A of the NYS Correction Law in making hiring determinations.
6. I affirm that the fingerprints submitted will be my own and that the information I have provided is true, complete and accurate.
7. I certify to the best of my knowledge that I: (check as appropriate)
   (a) ____ have not been convicted of a crime.
   (b) ____ have been convicted of a crime in NY or other jurisdiction.
   (c) ____ have pending arrest charges.
   If (b) or (c) is checked, provide details:_____
   _____
   _____
   _____

You have not been convicted of a crime if:
a. Your conviction was sealed; dismissed; reversed; resulted in a youthful offender (YO) or juvenile delinquency (JD) adjudication; resulted in a conviction for a non-criminal violation offense; or if you were acquitted;
b. you received an Adjournment in Contemplation of Dismissal (ACD) and the adjournment period has elapsed; or
c. you withdrew your plea after completing a treatment program, and were not convicted of a felony or misdemeanor.

8. I have been advised that my social security number is being requested so that the Justice Center may check whether I am on the Staff Exclusion List as required by Social Services Law and will be performed prior to the criminal history information check.

Applicant Signature		Date:
Guardian signature if under 18	N/A	Date: N/A
Part 3	**Facility or Provider Agency Authorized Person Information**	
Authorized Person Name:	Marlene Muniz	Title: HR Generalist
Signature:	Marlene Muniz	Email: mmuniz@rcil.com

JC CBC 4 (3/17)

Justice Center Fingerprint Applicant Information Sheet

Last Name:	First Name:	MI:
Date of Birth (MM/DD/YYYY):		
Methods of Contact:		
Phone Number:		☐ specify preferred method
Email:		☐ specify preferred method
Personal Questions:		
Have you ever used a maiden and/or previous name? ☐ YES ☐ NO		
If YES, please list name(s):		
Have you ever used an alias? ☐ YES ☐ NO		
If YES, please list name(s):		
Is your mailing address the same as your residential address? ☐ YES ☐ NO		
Personal Information:		
Height (Feet/Inches):		
Weight:		
Eye Color: please select below		
☐ Black	☐ Blue	
☐ Brown	☐ Gray	
☐ Green	☐ Hazel	
☐ Maroon	☐ Pink	
☐ Multicolored	☐ Unknown	
Hair Color: please select below		
☐ Bald	☐ Black	
☐ Blonde or Strawberry	☐ Brown	
☐ Gray or Partially Gray	☐ Red or Auburn	
☐ Sandy	☐ White	
☐ Green	☐ Blue	
☐ Orange	☐ Pink	
☐ Purple	☐ Unknown	
Preferred Language:		
Gender: ☐ Male ☐ Female ☐ Unknown		
Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown		
Race: ☐ Native American ☐ Asian ☐ Black ☐ Caucasian/Latino ☐ Unknown		

Home Address:		
Number:	**Street:**	**Apt #:**
City:	**State:**	**Zip:**

Identification Document: *Please choose one of the below listed required documents to bring to your enrollment. Please ensure the name you are enrolling under matches the name on the document selected.*

- ☐ Commercial Driver's License issued by a State or outlying possession of the U.S.
- ☐ Department of Defense Common Access Card
- ☐ Driver's License PERMIT issued by a State or outlying possession of the U.S.
- ☐ Driver's License issued by a State or outlying possession of the U.S.
- ☐ Employment Authorization Card/Document (I-766) with Photo
- ☐ Enhanced Driver's License (EDL)
- ☐ Enhanced Tribal Identification Card (for federally recognized US tribes)
- ☐ Federal ID Card with seal or logo from a federal agency
- ☐ Merchant Mariner Document (MMD)
- ☐ Military Dependent's Card
- ☐ Military ID Card
- ☐ Military ID Card (retired)
- ☐ Passport Book or Card
- ☐ Permanent Resident Card/Green Card (I-551)
- ☐ Photo ID Waiver for Minors and US Social Security Card or Birth Certificate
- ☐ State ID Card (or outlying possession of the U.S.) with a seal or logo from State or State Agency
- ☐ Uniformed Services Identification Card (Form DD-1172-2)
- ☐ Canadian Driver's License (Non-Commercial)
- ☐ Enhanced Commercial Driver's License
- ☐ Foreign Passport
- ☐ Government ID with a seal or logo from a local government agency
- ☐ US VISA issued by the US Dept. of Consular Affairs for travel to or within or residence within the US

FORM OPWDD 152 (8/2013)

INSTRUCTIONS: This form is to be completed by a prospective employee or volunteer. Complete all fields. If exact dates are not known, give approximate dates. Submit the completed form to your potential employer or organization with which you are applying to volunteer.	**State of New York** **OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES** **APPLICANT INFORMATION**
1. NAME	
2. SOCIAL SECURITY NUMBER	3. DATE OF BIRTH
4. MAILING ADDRESS (include Street Address, Apt. #, City, State, Zip and County	
5. PROVIDER OF SERVICES NAME Resource Center for Independent Living (RCIL) as the Fiscal Intermediary	

6. List complete employment history for the past 7 years, including the start and end date. Begin with the most recent employment and list employers in chronological order. Use an additional sheet if needed.

Full Name of Employer	Location (e.g., city, state)	Start Date	End Date
List Full Agency, no abbreviations	City and State only	MM/YYYY	MM/YYYY

7. List all employment history serving people with developmental disabilities that occurred beyond 7 years. Write "none" if there is no history. Use an additional sheet if needed.

Full Name of Employer	Location (e.g., city, state)	Start Date	End Date

8. List all volunteer work for the past 7 years and volunteer work serving people with developmental disabilities at any time. Write "none" if there is no history. Use an additional sheet if needed.

Full Name of Agency/Organization	Location (e.g., city, state)	Start Date	End Date

I CERTIFY that the information provided in this form is true and correct to the best of my knowledge and belief, and authorize investigation of all information given.

The provision of false information is grounds for dismissal.

SIGNATURE: _____ DATE: _____

AGENCY CERTIFICATION: I certify that I have reviewed the employment/volunteer history provided by this applicant and that, to the best of my knowledge, the applicant has no employment/volunteer history in the OPWDD system. I also certify that I am an individual designated as an "authorized person" who is authorized to request and receive criminal history information pursuant to exec. L. 845-b.

SIGNATURE: _____ DATE: _____

If the Provider of Services agency has certified the applicant has no employment/volunteer history with OPWDD, the agency may hire the applicant and must retain this form as documentation.

Required OPWDD Pre-Employment Trainings

Training can be completed only once your background clearance has been received and you have been contacted by RCIL to proceed with the required trainings.

Please do not proceed unless advised by RCIL.