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

Overview of the Self-Direction Pre-Employment Process

Under the Self-Direction Program, the ***Employer*** *is the* ***Participant, Participant's Representative or Legal Guardian.***

RCIL is the ***Fiscal Intermediary (FI)*** *for the Self-Direction Program.*

The Employer (Participant) is responsible for:	***The Fiscal Intermediary is responsible for:***
• Recruiting • Interviewing • Training • Supervising, Evaluating and Dismissing Workers	• Administering the hiring process and wages on behalf of the Employer • Maintaining training and background records on behalf of the Employer

1. After interviewing with your Employer and accepting the position, please complete the attached application packet and return to your Employer within five (5) business days. **Please be sure that all forms are complete, with all required signatures and dates.** Application must be complete within a 90-day timeframe. If over 90-days, it will no longer be valid. A new packet will need to be submitted. 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

The original packet should be mailed to RCIL if your Employer is scanning or faxing the initial application. Failure to submit original forms will delay your hiring.

After your paperwork, background checks, and pre-employment training requirements are complete, your Employer will receive a call and email from RCIL notifying them that you may begin working. Your Employer will also receive a letter to formally notify both of you of your approval.

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

Thank you,

Resource Center for Independent Living's Human Resources Department

YOU CANNOT START WORKING UNTIL YOUR EMPLOYER IS CONTACTED BY HUMAN RESOURCES THAT YOUR PACKET IS COMPLETE. NO EXCEPTIONS.

New York Labor Law Section 740 Notice

Pursuant to Section 740 of the New York Labor Law ("Section 740"), an employer shall not take any retaliatory action against an employee, whether or not within the scope of the employee's job duties, because such employee does any of the following: (a) discloses, or threatens to disclose to a supervisor or to a public body an activity, policy or practice of the employer that the employee reasonably believes is in violation of law, rule or regulation or that the employee reasonably believes poses a substantial and specific danger to the public health or safety; (b) provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any such activity, policy or practice by such employer; or (c) objects to, or refuses to participate in any such activity, policy or practice.

The protection against retaliatory action in "(a)" above pertaining to disclosure to a public body shall not apply to an employee who makes such disclosure to a public body unless the employee has made a good faith effort to notify his or her employer by bringing the activity, policy or practice to the attention of a supervisor of the employer and has afforded such employer a reasonable opportunity to correct such activity, policy or practice. Such employer notification shall not be required where: (a) there is an imminent and serious danger to the public health or safety; (b) the employee reasonably believes that reporting to the supervisor would result in a destruction of evidence or other concealment of the activity, policy or practice; (c) such activity, policy or practice could reasonably be expected to lead to endangering the welfare of a minor; (d) the employee reasonably believes that reporting to the supervisor would result in physical harm to the employee or any other person; or (e) the employee reasonably believes that the supervisor is already aware of the activity, policy or practice and will not correct such activity, policy or practice.

An employee who has been the subject of a retaliatory action in violation of Section 740 may institute a civil action in a court of competent jurisdiction for relief within two years after the alleged retaliatory action was taken. Any such action may be brought in the county in which the alleged retaliatory action occurred, in the county in which the complainant resides, or in the county in which the employer has its principal place of business. In any such action, the parties shall be entitled to a jury trial. It shall be a defense to any action brought under Section 740 that the retaliatory action was predicated upon grounds other than the employee's exercise of any rights protected by Section 740.

In any action brought under Section 740, the court may order relief as follows: (a) an injunction to restrain continued violation of this section; (b) the reinstatement of the employee to the same position held before the retaliatory action, or to an equivalent position, or front pay in lieu thereof; (c) the reinstatement of full fringe benefits and seniority rights; (d) the compensation for lost wages, benefits and other remuneration; (e) the payment by the employer of reasonable costs, disbursements, and attorney's fees; (f) a civil penalty of an amount not to exceed ten thousand dollars; and/or (g) the payment by the employer of punitive damages, if the violation was willful, malicious or wanton. A court, in its discretion, may also order that reasonable attorneys' fees and court costs and disbursements be awarded to an employer if the court determines that an action brought by an employee was without basis in law or in fact.

Nothing in Section 740 shall be deemed to diminish the rights, privileges, or remedies of any employee under any other law or regulation or under any collective bargaining agreement or employment contract.

RCIL
RESOURCE CENTER FOR INDEPENDENT LIVING

At Home
INDEPENDENT CARE INC.
In Partnership with RCIL

LIFE at RCIL
LIVING INDEPENDENTLY IS FOR EVERYONE

PO Box 210, Utica, NY 13503 www.rcil.com Phone: 315-797-4642

Preliminary Offer Letter

On behalf of RCIL (Resource Center for Independent Living), I am pleased to offer you the position of Self-Direction Support Worker, through our Self-Direction Program. In this capacity, you will be hired in a position that is hourly, non-exempt. As a reminder, this is a Fiscal Intermediary Program.

This offer is contingent upon the satisfactory completion of background checks, required trainings, and a completed hiring packet. Upon completion, you will be notified of a start date.

Sincerely,

Marlene Muniz

Marlene Muniz
Human Resources Generalist

By accepting employment at RCIL, you acknowledge that no oral or written representations, inducements, promises or agreements have been made by RCIL, or anyone acting on behalf of RCIL, which are not embodied herein.

_____
Support Worker Printed Name

_____ _____
Support Worker Signature Date

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:	**Fax Number:**
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:** **Monday** _____ **Tuesday** _____ **Wednesday**_____ **Thursday**_____ **Friday**_____ **Saturday**_____ **Sunday**_____	☐ **Variable Hours / No Set Schedule. *** ***Please be advised, a three-month look back measurement period will determine benefits eligibility.**

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

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, 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)

<u>Choose one:</u>

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**

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

EMPLOYMENT FORM

Worker's Full Name:	
TO BE COMPLETED BY: BUDGET LIAISON ONLY	
Hourly Rate:	**Overtime Rate:**
Date Budget Approved:	
Budget Liaison Name (Please print):	
Date:	

TO BE COMPLETED BY: HR ONLY	**Charge to: 053**
ADP #:	**Start Date:**
HR Liaison:	**Consumer ID:**

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

OPWDD SELF-DIRECTION SUPPORT WORKER REQUIREMENTS

Job Title: Self-Direction Support Worker
Reports to: Employer (Participant)
Status: Hourly
Purpose: To provide services to Participants as described within the written Service Plan that allows the Participant the ability to remain in the least restrictive environment and to maintain more control and freedom over his or her lifestyle.
Duties and Responsibilities
Implement the goals outlined in the Service Plan.
Complete and submit reports as required.
Observe Participant for any unusual physical or behavioral changes and report to Self-Direction Coordinator.
Provide own transportation to and from the Participant's home.
Submit time worked daily: must be completed and approved by the Employer weekly on Saturdays following Agency requirements.
Reimbursement requests must be sent to your Employer and forwarded to the Agency within 45 days of service.
Other duties as assigned.
Maintain confidentiality of all work-related information.
Work, Education, Knowledge and Skill Requirements: The Participant recruits and supervises the worker. RCIL is the Fiscal Intermediary. The requirements are based on the Participant's needs and set by the Participant in accordance with his or her Service Plan. **Per OPWDD Regulations, all workers must be at least 18 years of age.**

The above statements are intended to describe the principal functions of the position as required by OPWDD. They are not intended to encompass all duties. Your Employer will review your job duties and expectations on or before your first day of employment.

Worker Signature: _____ Date: _____

Employer Signature: _____ Date: _____

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

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 1 (Page 1) Completed by Self-Direction Worker

- Name, address, other last names used and date of birth are completed and legible.
- 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).
- If listing the Social Security number, it must be complete and accurate.
- SD Worker must identify his or her citizenship/immigration status.
- Check to verify that the SD Worker signed/dated the bottom of this form with a current date instead of their date of birth. (Date format must be: mm/dd/yyyy)
- Preparer or translator section is checked if someone other than the employee assisted with completing Section 1 on behalf of the employee. The Preparer/Translator needs to **sign, date and complete the bottom portion.**
- If not applicable, the SD Worker **must** check "I did not use a preparer or translator". (Date format: mm/dd/yyyy)
- Make sure your SD Worker uses their last name that is associated with the Social Security Office to keep from any delay in processing.
- **DO NOT WRITE IN SECTION 2 OR SECTION 3.**

Section 2 (Page 2) Completed by Participant and/or Designated Rep

- Write Worker's Last Name, First Name, M.I. and the number that is associated with the Citizenship Status on Section 1 (1st page) and apply it to Citizenship/Immigration Status on the top of Section 2.
- 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 3). ID's must be valid and unexpired. (Copies of the documentations must be sent in).
- Check to make sure each document has been entered in the proper list. List B item is, in fact, listed under list B and not List C or List A.
- Under **CERTIFICATION**, you as the participant/designated rep must complete this section with your information.
- The company name should be RCIL.
- Your title should be Employer/Supervisor
- 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
- **DO NOT WRITE IN SECTION 1 OR SECTION 3.**
- **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.
- If there are too many corrections making the form illegible, then you must redo the I-9 form.

If you have any questions, please contact an SD Liaison at (315) 797-4642 ext. 2984 or 1670 and they can assist you with completing this form.

I-9 forms must be mailed to: Attn: Self-Direction Liaisons RCIL; P.O. Box 210; Utica, NY 13503-0210

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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

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

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

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Section 2
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

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

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
		RCIL

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	ZIP Code
PO Box 210	Utica	NY	13503

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

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 a nonimmigrant alien authorized to work for a specific employer because of his or her status: **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 alien's nonimmigrant status 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
		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:		
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		**10.** School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

MEDICATION ADMINISTRATION ACKNOWLEDGMENT

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

RCIL
RESOURCE CENTER FOR INDEPENDENT LIVING

At Home
INDEPENDENT CARE INC.
In Partnership with RCIL

LIFE at RCIL
LIVING INDEPENDENTLY IS FOR EVERYONE

PO Box 210, Utica, NY 13503 www.rcil.com Phone: 315-797-4642

Service Location Acknowledgement

Please check one:

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

_____ I have an address outside of New York State, but intend to deliver services only in New York State.

_____ Neither 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 information that you think RCIL should know 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 changes. Changes should be sent to hr@rcil.com.

Certification:
I certify that all information requested in this document is provided herein is true, accurate and complete, and I so certify knowing that any falsification, misrepresentation, or omission of same will cause the withdrawal of any conditional offer I have been made and will cause the immediate termination of my employment regardless of the timing or circumstances of discovery.

Worker's Name:	
Signature:	Date:
Consumer/Participant/Designated Rep Name:	
Signature:	Date:

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

Application for Employment

Applicant Information		
Full Name:		
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 we contact your supervisor for a reference? YES ☐ NO ☐		
2. Name of Employer:		Phone:
Address:		Supervisor Name:
Job Title:		
Responsibilities:		
From:	To:	Reason for leaving:
May we contact your supervisor for a reference? YES ☐ NO ☐		

3. Name of Employer:		Phone:
Address:		Supervisor Name:
Job Title:		
Responsibilities:		
From:	To:	Reason for leaving:
May we contact your supervisor 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.

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	Date
Print Name	

Voluntary Self-Identification of Disability

Form CC-305
Page 1 of 1

OMB Control Number 1250-0005
Expires 05/31/2023

Name: _____ Date: _____

Employee ID: _____
(if applicable)

Why are you being asked to complete this form?

We are a federal contractor or subcontractor required by law to provide equal employment opportunity to qualified people with disabilities. We are also required to measure our progress toward having at least 7% of our workforce be individuals with disabilities. To do this, we must ask applicants and employees if they have a disability or have ever had a disability. Because a person may become disabled at any time, we ask all of our employees to update their information at least every five years.

Identifying yourself as an individual with a disability is voluntary, and we hope that you will choose to do so. Your answer will be maintained confidentially and not be seen by selecting officials or anyone else involved in making personnel decisions. Completing the form will not negatively impact you in any way, regardless of whether you have self-identified in the past. For more information about this form or the equal employment obligations of federal contractors under Section 503 of the Rehabilitation Act, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

How do you know if you 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:*

- Autism
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, or HIV/AIDS
- Blind or low vision
- Cancer
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or hard of hearing
- Depression or anxiety
- Diabetes
- Epilepsy
- Gastrointestinal disorders, for example, Crohn's Disease, or irritable bowel syndrome
- Intellectual disability
- Missing limbs or partially missing limbs
- Nervous system condition for example, migraine headaches, Parkinson's disease, or Multiple sclerosis (MS)
- Psychiatric condition, for example, bipolar disorder, schizophrenia, PTSD, or major depression

Please check one of the boxes below:

☐ Yes, I Have A Disability, Or Have A History/Record Of Having A Disability

☐ No, I Don't Have A Disability, Or A History/Record Of Having A Disability

☐ I Don't Wish To Answer

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.

For Employer Use Only

Employers may modify this section of the form as needed for recordkeeping purposes.

For example:

Job Title: _____ Date of Hire: _____

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:		

NEW YORK STATE 2023

Department of Taxation and Finance

Employee's Withholding Allowance Certificate

New York State • New York City • Yonkers

IT-2104

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

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

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

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.nys.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

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

2023

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, other details, and privacy.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Reserved for future use.

(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 . . . . . ☐

TIP: If you have self-employment income, see page 2.

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**

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

City Tax Information

FOR RESIDENTS OF AND WORKERS IN NEW YORK CITY AND YONKERS ONLY

IF YOU RESIDE IN NEW YORK CITY OR YONKERS…

IF YOU WILL BE WORKING IN NEW YORK CITY OR YONKERS…

PLEASE ANSWER THE QUESTIONS BELOW TO ASSIST RCIL IN ENSURING ALL APPLICABLE TAXES ARE WITTHELD.

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

   YES OR NO

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

   YES OR NO

3. **Does your employer reside in Yonkers?**

   YES OR NO

4. **Which county does your employer reside?**

   _____

For HR Use Only:
****Metro Tax applies to the following counties: Manhattan, Bronx, Kings (Brooklyn), Queens, Richmond (Staten Island), Rockland, Nassau, Suffolk, Orange, Putnam, Dutchess and Westchester.***

Tax Lookup:
Yonkers: *http://www8.tax.ny.gov/JRLA/jrlaStart*

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

WORKER INFORMATION *(print and complete all fields)*			
First Name	Middle Name	Last Name	
Date of Birth (mm/dd/yyyy)	Department/Program **Self-Direction**		Last Four Social Security #
Mailing Address		New Address? ☐ YES ☐ NO	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 weekly paycheck and reimbursements as follows (check your selection):

☐ **Direct deposit into my bank account**

☐ **Direct deposit onto my preferred Debit Card**

For each account you must attach the following documents:

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

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

This 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 immediately activate your card 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.

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

CONSENT TO DEPOSIT PAYMENT
Worker Signature:
Date:

WORKER SELF SERVICE
Through our ADP Workforce Now Self Service, your pay statements and W2's will be available to you day and night without paper statements. You will be able to view, and if desired, print your own statements, update your address, phone number, email, change your direct deposit, and change Federal or State tax information as needed. http://workforcenow.adp.com **GO GREEN TODAY!** 

Return this completed authorization form via email to hrselfdirected@rcil.com, fax: 315-272-2954, or mail to RCIL Attn: HR Self-Direction, PO Box 210, Utica, NY 13503.

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.

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

TRANSPORTATION REQUIREMENTS

Under the Self-Direction Program requirements, the Support Worker will operate their own personal vehicle to transport participants or to perform other services. The purpose of these requirements is to establish an understanding that shall maximize the safe operation of vehicles when transporting participants to protect the health and safety of participants and the public.

1. 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.
2. All Support Workers driving during work hours, are required to comply with all NY State 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.
3. Support Workers operating any vehicle during work hours shall only do so when the vehicle is in safe operating conditions. Support Workers operating a vehicle during work hours shall inspect the vehicle to assure that the vehicle is in sound operating condition.
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 the FI. The Support Worker may be subject to disciplinary action including termination by their participant for any traffic and other safety violations.
5. When accidents occur Support Workers should take 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 shall refrain from making statements regarding the accident to anyone other than the investigating police officer, an FI management representative or to representatives of the Support Worker's personal insurance provider. Employee should immediately contact FI and an accident report must be filed promptly with the FI's Human Resources Representative. Accident reports will be maintained in the Support Worker's file.
6. Support Workers approved to drive during their work hours are required to promptly inform their Employer and FI if their license has expired, suspended or revoked or 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. Support Workers approved to drive must also promptly notify their Employer and FI if their driver's registration, inspection or insurance has expired, suspended or revoked. Failure to report such information to their Employer and FI may result in disciplinary action, up to and including termination of employment by their Employer (participant).
7. 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.
8. Smoking is not permitted in vehicles or when an employee is using their own personal vehicle to transport participants. Support Workers are forbidden to use, sell or possess alcohol or illegal drugs at any time during work hours, as well as while operating a vehicle.

Primary Insurance Coverage:
When an employee uses his/her own personal vehicle for authorized purposes, the Support Worker's own personal insurance will be primary. 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 New York State's 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. When using a personal vehicle, Support Workers shall ensure that their vehicle's insurance, inspection and registration information is up-to-date and is in the vehicle's glove compartment.

Procedures:
1. When a participant hires a Support Worker and the Support Worker is required to transport the participant, the Support Worker must provide the FI with their NYS Driver's License information.
2. The NYS Driver's License is entered into the LENS system. This will validate the status of the Support Worker's license and acceptable driving history. As long as the Support Worker is affiliated with the FI, the staff will remain under the LENS roster and LENS will send notifications in regards to any change in status to the staff's driving record. This will include but not limited to: suspensions, revocations, tickets, insurance lapse, accidents, fines, safety courses, etc. Any information received by the FI that should require the Employer's review will be forwarded. To avoid disciplinary action by your Employer, please ensure to inform your Employer and FI of any changes to your driving status immediately.
3. Support Workers whose position requires them to drive as an essential job function will be subject to and must be capable of passing a physical examination when a question of fitness to drive arises because of illness, injury or unusual behavior that gives the FI a reason to believe that the worker poses a risk of harm to himself/herself or others. Any such medical examinations will be conducted in compliance with applicable state and federal law.

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

TRANSPORTATION REQUIREMENTS

All applicants who drive participant's will be subject to a driver's license background check, and must sign a release form giving the FI permission to conduct such a check of their driver's license. Any Support Worker without a valid state driver's license or whose driving record, at any time, reflects any unacceptable standards will not be allowed to drive a participant in their personal vehicle at any time. A Support Worker charged with a violation such as a DWI will not be permitted to transport participants while operating under a conditional license.

You are required to notify the FI (RCIL), if you obtain a driver's license after your initial hire date. Falsification of information about driving records may be a cause for the Employer (participant) to immediately terminate the Support Worker.

Transportation Requirements Acknowledgment

I have received a copy of the Transportation Requirements, I acknowledge that I have the responsibility to have 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.

_____ _____

Signature **Date**

_____

Printed Name

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, At Home Independent Care (AHIC), and/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** ☐ **AHIC** ☐ **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

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

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 Fiscal Intermediary on behalf of your Employer.

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 the Fiscal Intermediary, Resource Center for Independent Living (RCIL), of a Background Check regarding me with results satisfactory to the Employer (Participant). **I understand** that unsatisfactory results from, refusal to cooperate with, or any attempt to affect the results of this Background Check may, at the Employer's (Participant) 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** the FI and/or its representatives, to conduct a search and review of my background and/or obtain written participant reports as requested by the Employer(Participant) bearing on my background, in order for the Employer (Participant) 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 Employer (Participant) and the FI (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 Employer (Participant) for employment purposes only.
- **I understand** that under New York Law, a criminal conviction will not necessarily disqualify me from employment with the Employer (Participant), but that the Employer (Participant) 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, in the event I become employed, to report promptly to the Employer (Participant) any future arrests/convictions during the course of my employment 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.

Signature _____ **Date** _____

TO BE COMPLETED BY THE WORKER:

The following information is required for the Fiscal Intermediary (RCIL) to obtain a complete background check:

Worker's 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:		
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: Once you are cleared through the Staff Exclusion List (SEL), you will be contacted to schedule a fingerprinting appointment. Please allow five (5) business days to be contacted for your 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 Employer (Participant), if hired, regardless of the timing or circumstances of discovery..

Signature _____ **Date** _____

HUMAN RESOURCES USE ONLY:

DRIVERS LICENSE CHECK	X		SEL CHECK	X	
SEXUAL OFFENDER	X		OPWDD MHL 16.34	X	
OMIG MEDICAID FRAUD	X		JUSTICE CENTER	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:	Samantha Lamphere	Title: HR Credentialing Specialist
Signature:	Samantha Lamphere	Email: salamphere@rcil.com

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.