EMPLOYMENT APPLICATION PACKET

Personal Information

Date of Application:

First Name:	Last Name:	Phone #:
Current Street Address:		City:
State:	Zip:	Country:
Social Sec #:		Date of Birth:
Email:	Are you US Citizen? ◯ Yes ◉ No	
Are you currently Employed? ◯ Yes ◉ No	Country of Birth:	
Emergency Contact		
Name:	Relationship:	Phone #:

Position	
Position Applying For:	◯ Full Time ◯ Part Time ◯ Per Diem

Other Information

Have you been continuously living in PA for the last 2 years? ◯ Yes ◉ No

Have you ever been convicted of a felony or misdemeanor? ◯ Yes ◯ No

Are you legally eligible to work in the United States? ◯ Yes ◯ No

Are you currently working for another home care? ◯ Yes ◯ No

If yes, which agency? _____

Education		
Type: High School, College, Other	**Name and City**	**Graduation Year**

Previous Employment 1		
Name:	Phone #:	
Address:	City:	State/Zip:
Position/Hourly Wage:	Supervisor's Name:	
Reason for leaving:		

Previous Employment 2		
Name:	Phone #:	
Address:	City:	State/Zip:
Position/Hourly Wage:	Supervisor's Name:	
Reason for leaving:		

Previous Employment 3		
Name:	Phone #:	
Address:	City:	State/Zip:
Position/Hourly Wage:	Supervisor's Name:	
Reason for leaving:		

Reference Form 1	
Name:	
Address:	Phone #:
The individual listed below has applied for a position with Aspire Home Care LLC Name:	
Position applied for:	

Applicant's Authorization to Release Information

I hereby give permission for my previous employer to release this referral information about my position with their company and comments regarding my work ethic and character while in their employ.

Applicant's Signature: _____ Date: _____

THIS SECTION TO BE COMPLETED BY PERSON COMPLETING THIS REFERENCE

Employment Date: From/To: _____. Position: _____

Reason for separation: _____. Would you rehire? If no, why not?

_____

Since this applicant has listed you as reference, we would consider it a favor both to the applicant and to us, if you would give us your opinion. We strive to minimize employee turnover and a frank exchange of information can substantially assist in accomplishing this objective. We would greatly appreciate your answers to the following questions.

EVALUATION	EXCELLENT	GOOD	AVERAGE	POOR
Attendence				
Quality of work				
Integrity				
Cooperation				
Dependability				
Apperance				
Stability				
Overall Rating				

Comments: _____.

Reference Form 2	
Name:	
Address:	Phone #:
The individual listed below has applied for a position with Aspire Home Care LLC Name:	
Position applied for:	

Applicant's Authorization to Release Information

I hereby give permission for my previous employer to release this referral information about my position with their company and comments regarding my work ethic and character while in their employ.

Applicant's Signature: _____ Date: _____

THIS SECTION TO BE COMPLETED BY PERSON COMPLETING THIS REFERENCE

Employment Date: From/To: _____. Position: _____

Reason for separation: _____. Would you rehire? If no, why not?

_____

Since this applicant has given your company as a former employer, we would consider it a favor both to the applicant and to us, if you would give us your opinion. We all strive to minimize employee turnover and a frank exchange of information can substantially assist in accomplishing this objective. We would greatly appreciate your answers to the following questions.

EVALUATION	EXCELLENT	GOOD	AVERAGE	POOR
Attendence				
Quality of work				
Integrity				
Cooperation				
Dependability				
Apperance				
Stability				
Overall Rating				

Comments: _____.

Statement of Driving Status

I,_____, am currently licensed to drive a motor vehicle in the state of PA, I carry auto insurance on my vehicle, and I have supplied Aspire Home Care LLC with a current copy of my license and auto insurance.

Employee Signature: _____ Date: _____

NO CURRENT LICENSE

I,_____ , declare that I DO NOT have a driver's license in the state of Pennsylvania and therefore will find other forms of transportation to get to my scheduled shift. (i.e. public transportation)

Employee Signature: _____ Date: _____

Do's and Don'ts of Home Care

While making your assigned visits please be aware that the following guidelines are always in place:

Do's

- Be courteous and pleasant always.
- Wear your agency issued ID Badge while at all visits.
- Try to do all you can to bring joy to your consumers (positive attitude).
- Report any unusual occurrence to the office immediately.
- Call the office immediately if the consumer does not answer their door for ascheduled visit. Failure to notify the office may be considered abandonment,especially if the consumer has had a medical emergency without your knowledge. **DON'T** assume they aren't home. **CALL THE OFFICE.**
- Always follow your schedule WITHOUT MAKING ANY CHANGES.
- Interact with the scheduling coordinator often, especially if you are available towork but do not have scheduled visits.

Don't

- Do not bring your own personal issues to your consumers.
- Do not use a consumer's phone for personal calls.
- Do not ever borrow money from a consumer for any reason or enter into anytype of legal or financial agreement.
- Do not agree to lifting or moving furniture.
- No scrubbing of floors on hands and knees.
- No window washing (except an occasional wipe down of a window theconsumers commonly sits and looks out from).
- No drapes or curtain washing.
- No hauling heavy trash barrels.
- No raking leaves or shoveling snow.
- No transporting consumer's in your car without a signedconsent/authorization.

Employee Signature: _____ Date: _____

TB TARGETED MEDICAL QUESTIONNAIRE FORM

Employee Name:_____

1. Have you ever had a positive TB skin test or history of TB infection? Yes ◯ No ◯

If YES, please answer the following,

- Have you ever had the BCG vaccine? Yes ◯ No ◯
- Do you have prolonged or recurrent fever? Yes ◯ No ◯
- Have you recently lost weight? Yes ◯ No ◯
- Do you have a chronic cough? Yes ◯ No ◯
- Do you cough up blood? Yes ◯ No ◯
- Do you have night sweats? Yes ◯ No ◯

2. Do you have any of the following risk factors which substantially increase the risk of tuberculosis?

◯Y ◯N a. Silicosis (Lung Disease)

◯Y ◯N b. Gastrectomy

◯Y ◯N c. Intestinal Bypass

◯Y ◯N d. Weight 10% or more below ideal body weight?

◯Y ◯N e. Chronic Renal Disease

◯Y ◯N f. Diabetes Mellitus

◯Y ◯N g. Hematologic Disorder i.e. leukemia or lymphoma

◯Y ◯N h. Prolonged high-dose corticosteroid therapy/immunosuppressive therapy

◯Y ◯N i. Exposure to HIV or AIDS

◯Y ◯N j. Other malignancies

Health Statement

I,_____, hereby attest that the state of my health is such that it will enable me to perform the duties of a healthcare professional. I further specifically attest that I am free of any and all potentially contagious diseases including, but not limited to those listed below:

AIDS/HIV	Anthrax	Chickenpox	Cholera	Diptheria	Encephalitis	Hepatitis A B OR C
Influenza	Leprosy (Hansen's Disease)	Leptospirosis	Malaria	Measles (Rubeola)	Meningitis	Mononucleosis
Mumps	Whooping Cough	Plague	Poliomyelitis	Psittacosis (Ornithosis)	Rabies	Rocky Mountain Spotted Fever
Rubella (German Measles)	Shigellosis	Smallpox	Tetanus	Tularemia	Tuberculosis	Typhoid Fever

Employee Signature: _____ Date: _____

PENNSYLVANIA CRIMINAL CHECK ATTESTATION

By signing this document, I acknowledge that I have been told by the agency that a criminal history check will be performed in my name. I have informed the agency of all aliases used (maiden name, etc.). I understand that I have been employed on a provisional basis that is temporary pending the results of the PA Criminal History check. I also understand that it is the agency's policy not to hire an individual who has been convicted of the offenses enumerated below. I also understand that the agency will search any Employee Misconduct Registry and Nurse Aide Registry to determine whether any acts of abuse, neglect or exploitation have occurred and whether my name is designated on any registry. If my name is on the registries, I understand the Agency will deny me employment.

PART 1: CONVICTION OF EITHER A FELONY OR MISDEMEANOR CHARGE FOR ANY OF THE OFFENSES LISTED BELOW

CC2500	Criminal Homicide	CC3127	Indecent Exposure
CC2502A	Murder I	CC3301	Arson and Related Offenses
CC2502B	Murder II	CC3502	Burglary
CC2502C	Murder III	CC3701	Robbery
CC2503	Voluntary Manslaughter	CC4101	Forgery
CC2504	Involuntary Manslaughter	CC4114	Securing Execution of Documents by Deception
CC2505	Causing or Aiding Suicide	CC4302	Incest
CC2506	Drug Delivery Resulting in Death	CC4303	Concealing Death of a Child
CC2702	Aggravated Assault	CC4304	Endangering Welfare of child
CC2901	Kidnapping	CC4305	Dealing in Infant Children
CC2902	Unlawful Restraint	CC4952	Intimidation of Witnesses or Victims
CC3121	Rape	CC4953	Retaliation Against witness/Victim
CC3122.1 CC3124.1	Statutory Sexual Assault Sexual Assault	CC5903C	Obscene or Other Sexual Materials to Minors
CC3123	Involuntary Deviate Sexual Intercourse	CC5903D	Obscene or Other Sexual Materials
CC3126	Indecent Assault	CC6301	Corruption of Minors

PART II: CONVICTION OF A FELONY CHARGE FOR ANY OF THE OFFENSES BELOW			
CC5902B	Promoting Prostitution	CS13A35	Illegal Sale of Non-Controlled Substance
CS13A12	Acquisition of Controlled Substance by Fraud	CS13A36	Designer Drugs Felony
CS13A14	Delivery by Practitioner	CS13	Any Other Felony Drug conviction appearing on Rap Sheet
CS13A30	Possession with Intent to deliver		
Part III: CONVICTION OF EITHER ONE (1) FELONY CHARGE OR TWO (2) MISDEMEANORS FOR ANY OF THE OFFENSES LISTED BELOW			
CC3901	Theft	CC3929	Retail Theft
CC3921	Theft By Unlawful Taking	CC3929.1	Library Theft
CC3923	Theft By Extortion	CC3929.3	Organized Retail Theft
CC3924	Theft By Property Lost	CC3930	Theft of Trade Secrets
CC3925	Receiving Stolen Property	CC3931	Theft of Unpublished Dramas/Musicals
CC3926	Theft of Services	CC3932	Theft of Leased Properties
CC3927	Theft By Failure to Deposit	CC3933	Unlawful Use of a Computer
CC3928	Unauthorized Use of Motor Vehicle	CC3934	Theft From a Motor Vehicle

I,_____,hereby confirm that I have not been convicted of any felony or misdemeanor listed in PART I; that I have not been convicted of any felony listed in PART II or PART III and that I have not been convicted of any two misdemeanors listed in PART III of this document. I confirm there are no charges currently pending against me with respect to the above in PA or any other state.

Name:	Maiden name or Alias:
Address:	Social Sec #:
Drivers License:	Date:
Signature:	

Orientation/Handbook Acknowledgment

By signing the document below, I am stating that I have completed the required orientation for Aspire Home Care LLC. I am also confirming that I was provided with the Employee Handbook, which has all the rules and regulations pertaining to our company and industry, via email. By signing this document, you are stating that you have/will read our employee handbook which is mandatory.

Employee Signature: _____ Email: _____

HIPAA POLICY

I, _____, an employee of Aspire Home Care LLC, have read and understand this policy on consumers Protected Health Information (PHI) and security. I understand that should any situation arise where I breach consumers confidentiality I will be disciplined up to and including termination. I hereby agree to maintain consumers confidentiality in the strictest manner possible, sharing or discussing consumers information only with those designated care providers or supervisors who have "a need to know" and are actively involved in the care of services provided to the consumer. I further acknowledge that I have been trained in the provisions and laws related to HIPAA compliance during orientation and those consumers must sign written permission to allow their protected health information (PHI) to be disclosed. I further agree that I will protect PHI while driving in my vehicle, servicing consumers in their homes and will not allow any PHI to be visible inside my vehicle. I will not bring any PHI related to other consumers into the homes/facilities of consumers I am servicing.

Employee Signature: _____ Date: _____

INCIDENT/ACCIDENTS REPORTING ACKNOWLEDGEMENT

I,_____, have been thoroughly informed by Aspire Home Care LLC, that I MUST report ALL incidents/accidents and any medical, physical, or mental changes in my consumers immediately to the office. I further understand that in the event that I become injured, even a minor injury, I am required to report that incident to my office as soon as possible after occurrence and no later than 24 hours after the incident.

Employee Signature: _____ Date: _____

OUR AGENCY IS AVAILABLE BY PHONE 24 HOURS A DAY. THE ANSWERING SERVICE WILL RESPOND AFTER 5 PM WEEKDAYS AND ON WEEKENDS/HOLIDAYS

Acknowledgement of Zero Tolerance Sexual Abuse Policy

I,_____, acknowledge that I have received/read the sexual abuse policy and/or have had it explained to me. I understand that the agency will not tolerate any employee,volunteer, or third party who commits abuse. Disciplinary action will be taken against those who are found to have committed sexual abuse. I understand that it is my responsibility to abide by all rules in the policy. I also understand how to report incidents of abuse, including retaliating against an employee exercising his/her rights under the policy.

Employee Signature: _____ Date: _____

Employee Badge Acknowledgement

By signing the document below, I understand that I have received an employee ID Badge from Aspire Home Care LLC. I also understand that I am to wear an ID during all my shifts and when visiting the office.

Employee Signature: _____ Date: _____

Equal Opportunity Employer Sign Off

Aspire Home Care is proud to be an Equal Employment Opportunity and Affirmative Action employer. We do not discriminate based upon race, religion, color, national origin, gender (including pregnancy, childbirth, or related medical conditions), sexual orientation, gender identity, gender expression, age, status as a protected veteran, status as an individual with a disability, or other applicable legally protected characteristics. You can find our full statement in the employee handbook. If you need any accommodations, we will work with you to solve the problem.

Employee Signature: _____ Date: _____

PROHIBITION STATEMENT

NO EMPLOYEE, OWNER OR INDIVIDUAL ASSOCIATED WITH ASPIRE HOME CARE LLC MAY ASSUME POWER OF ATTORNEY OR LEGAL GUARDIANSHIP OVER A CONSUMER UTILIZING THE SERVICES PROVIDED BY SAID AGENCY.

NO EMPLOYEE, OWNER OR INDIVIDUAL ASSOCIATED WITH ASPIRE HOME CARE LLC CAN REQUEST OR REQUIRE A CONSUMER TO ENDORSE CHECKS TO THEM AS AN INDIVIDUAL OR TO THE COMPANY.

I,_____, HAVE READ THIS STATEMENT AND AGREE THAT I UNDERSTAND AND WILL ABIDE BY THIS PENNSYLVANIA STATE MANDATED POLICY.

Employee Signature: _____ Date: _____

PROHIBITION STATEMENT-FALSE CLAIMS

Aspire Home Care LLC prohibits it's owners and employees from the following conduct:

- Knowingly presenting a false or fraudulent claim for payment to federal government
- Knowingly "causing to be presented" a false or fraudulent claim.
- Knowingly using or (causing to be used) a false statement or false record to get the federalgovernment to pay a claim.
- Conspiracy with other individuals or entities to get the federal government to pay a false claim
- Knowingly using or (causing to be used) a false statement or false record to avoid paying all orpart of a financial obligation to the federal government.

Employee Signature: _____ Date: _____

PAYCHEX

Direct Deposit Enrollment/Change Form*

Company Name and/or Client Number Aspire Home Care LLC

Employee/Worker Name_____ **Employee/Worker Number** _____

Employee/Worker: Retain a copy of this form for your records. Return the original to your employer/company.

Empoyer/Company: Please retain a copy of this document for your records.

COMPLETE TO ENROLL / ADD / CHANGE BANK ACCOUNTS ***PLEASE PRINT CLEARLY IN BLACK/BLUE INK ONLY***

☐ Add new	☐ Update existing account	☐ Replace Existing Account	Last 4 digits of the existing account number ☐☐☐☐
Type of Account ☐ Checking ☑ Savings		Account holder's Name:	
Routing/Transit Number			
Checking/Savings Account Number**			
Financial Institution ("Bank") Name			
I wish to deposit (check one): ☐ ____% of Net	☐ Specific Dollar Amount $_____.00	☐ Remainder of Net Pay	

☐ Add new	☐ Update existing account	☐ Replace Existing Account	Last 4 digits of the existing account number ☐☐☐☐
Type of Account ☐ Checking ☐ Savings		Account holder's Name:	
Routing/Transit Number			
Checking/Savings Account Number** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐			
Financial Institution ("Bank") Name			
I wish to deposit (check one): ☐ ____% of Net	☐ Specific Dollar Amount $_____.00	☐ Remainder of Net Pay	

☐ Add new	☐ Update existing account	☐ Replace Existing Account	Last 4 digits of the existing account number ☐☐☐☐
Type of Account ☐ Checking ☐ Savings		Account holder's Name:	
Routing/Transit Number			
Checking/Savings Account Number** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐			
Financial Institution ("Bank") Name			
I wish to deposit (check one): ☐ ____% of Net	☐ Specific Dollar Amount $_____.00	☐ Remainder of Net Pay	

CONFIRMATION STATEMENT ***PLEASE PRINT CLEARLY IN BLACK/BLUE INK ONLY***

I authorize my employer/company to deposit my earnings into the bank account(s) specified above and, if necessary, to electronically debit my account to correct erroneous entries. I certify my account(s) allow these transactions. Furthermore, I certify that the above listed account number accurately reflects my intended receiving account. I agree that direct deposit transactions I authorize comply with all applicable laws. My signature below indicates that I am agreeing that I am either the accountholder or have the authority of the accountholder to authorize my employer/company to make direct deposits into the named account. I understand that this authorization will remain in full force and effect until I notify Company in writing that I wish to revoke my authorization. I understand that the Company requires at least 5 business days prior notice to cancel this authorization.

Employee/Worker Signature : _____ **Date** _____

I confirm that the above named employee/worker has added or changed a bank account for direct deposit transactions processed by Paychex, Inc. I have reviewed the information provided and it is accurate to the best of my knowledge. My signature below indicates that I have the authority to execute this document on behalf of the Client.

Employer/Company Representative Printed Name: _____

Employer/Company Representative Signature: _____ **Date:** _____ MM/DD/YY

*** All fields are required except Employee/Worker Number.**

**** Certain accounts may have restrictions on deposits and withdrawals. Check with your bank for more information specific to your account.**

Note: Digital or Electronic Signatures are not acceptable.

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)					
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)					

Additional Information

☐ 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

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

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)
Aspire Home Care LLC 138 East 26th. Street SUITE 101 ERIE, PA 16504		84-4617085

CLGS-32-6 (8-11)

RESIDENCY CERTIFICATION FORM
Local Earned Income Tax Withholding

TO EMPLOYERS/TAXPAYERS:

This form is to be used by employers and/or taxpayers to report essential information for the collection and distribution of Local Earned Income Taxes. This form must be utilized by employers when a new employee is hired or when a current employee notifies employer of a name and/or address change.

EMPLOYEE INFORMATION - RESIDENCE LOCATION

NAME (Last Name, First Name, Middle Initial)			SOCIAL SECURITY NUMBER
STREET ADDRESS (**No** PO Box, RD or RR)			
SECOND LINE OF ADDRESS			
CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER
MUNICIPALITY (City, Borough or Township)			
COUNTY	RESIDENT PSD CODE		TOTAL RESIDENT EIT RATE

EMPLOYER INFORMATION - EMPLOYMENT LOCATION

EMPLOYER BUSINESS NAME (Use Federal ID Name)			EMPLOYER FEIN
ASPIRE HOME CARE LLC			844617085
STREET ADDRESS WHERE ABOVE EMPLOYEE REPORTS TO WORK (**No** PO Box, RD or RR)			
138 EAST 26TH ST SUITE 101			
SECOND LINE OF ADDRESS			
CITY Erie	STATE PA	ZIP CODE 16504	PHONE NUMBER 814-520-8255
MUNICIPALITY (City, Borough or Township)			
COUNTY Erie	WORK LOCATION PSD CODE		WORK LOCATION NON-RESIDENT EIT RATE

CERTIFICATION

Under penalties of perjury, I (we) declare that I (we) have examined this information, including all accompanying schedules and statements and to the best of my (our) belief, they are true, correct and complete.

SIGNATURE OF EMPLOYEE	DATE (MM/DD/YYYY)
PHONE NUMBER	EMAIL ADDRESS

For information on obtaining the appropriate MUNICIPALITY (City, Borough, Township), PSD CODES and EIT (Earned Income Tax) RATES, please refer to the Pennsylvania Department of Community & Economic Development website:

www.newPA.com

PENNSYLVANIA CHILD ABUSE HISTORY CERTIFICATION

PREVIOUS NAMES USED SINCE 1975 (Include maiden name, nickname and aliases.)			
First	**Middle**	**Last**	**Suffix**
1.			
2.			
3.			
4.			
5.			

PREVIOUS ADDRESSES SINCE 1975 (Please list all addresses since 1975, partial address acceptable; attach additional pages if necessary.)
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

HOUSEHOLD MEMBERS (Please list everyone who lived with you at any time since 1975 to present. Please include parent, guardian or the person(s) who raised you; attach additional pages as necessary.)			
Name (First, Middle, Last)	**Relationship**	**Present Age**	**Gender**
1.	☐ Parent ☐ Guardian ☐ person(s) who raised you		
2.	☐ Parent ☐ Guardian ☐ person(s) who raised you		
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

I affirm that the above information is accurate and complete to the best of my knowledge and belief and submitted as true and correct under penalty of law (Section 4904 of the Pennsylvania Crimes Code). If I selected volunteer, I understand that I can only use the certificate for volunteer purposes.

APPLICANT'S SIGNATURE

DATE

CHILDLINE USE ONLY		
DATE RECEIVED BY CHILDLINE	SUFFICIENT PAYMENT INFORMATION RECEIVED ☐ YES ☐ NO ☐ VALID PAYMENT AUTHORIZATION CODE ☐ WAIVED (supervisor initials) _____	CERTIFICATION ID #