Easter Seals
DISABILITY SERVICES

Creating Solutions,
Changing Lives
since 1948

Easter Seals
New Jersey
25 Kennedy Boulevard - Suite 600
East Brunswick, NJ 08816
1.800.471.3086 phone
1.888.525.0416 fax
www.eastersealsnj.org

Memo

To: Participants in Self-Directed Services

From: Janet Marinelli

Date: January 23, 2014

Re: Applications

Enclosed please find the application(s) you requested for a self-hire Direct Support Professional (DSP).

Please note the following changes have been made:

4.4 Please note that the form has changed for the fingerprinting. The new form is under the name of IdentoGO.

Please note also that there is an updated website and revised directions regarding the Danielle's Law On-Line Training.

Rev. 4.4 01/14

APPLICATION DIRECTIONS – PLEASE READ

Revision 4.3 - 11/12

This packet has been designed to assist you in the selection and hiring of your Direct Support Professional (DSP). Since you have selected to hire a DSP who is not affiliated with a community agency, Easter Seals New Jersey (Easter Seals) will be considered the employer of record. You are the supervisor, however, as your DSP is now considered an employee of record of Easter Seals, there are some guidelines that must be followed.

The purpose of this packet is to make the hiring process as easy as possible. To ensure swiftness and accuracy in this process, please make sure that all the required forms are completed and mailed back to Easter Seals within 10 days from receiving it.

When you find that you have a person(s) interested, the following forms must be filled out. They are included within this packet for you. **Please include copies of social security card and driver's license.**

- application form/addendum to the application
- job description form
- employer reference check form (2)
- driver's license check form
- criminal background check form
- Employee Information Form
- I-9 and W4 Forms
- Hepatitis B Acceptance or Declination Form
- Non medical benefits form (Flex/Vacation/Holiday)
- Personal Information Form
- Central Registry of Offenders Against Individuals with Developmental Disabilities check form
- Danielle's Law on-line training **(**Please note Danielle's Law on-line training is now required prior to start date)**

Please return all forms to **Carol Maines or Janet Marinelli,** Administrative Coordinator, Fiscal Intermediary Services at **Easter Seals New Jersey, 25 Kennedy Blvd Suite 600, East Brunswick, NJ 08816**

The Application & Addendum

Have the applicant print all the required information on this form. The position they are applying for is "Direct Support Professional (DSP)". The applicant must sign the last page of the form. Please make sure the DSP initials all 5 of the pre-employment test/checks on the addendum form.
Both you and the DSP are to sign the addendum form as well.

The Job Description

The position description will determine what the DSP will be doing to support you. Essential functions are the basic job duties that the DSP must be able to perform. You need to simply list what you need the DSP to do for you. You may also list what you would like the DSP to do. Here are some questions to ask yourself in developing a position description:

1. What are the tasks that I cannot do independently?
2. What do I need assistance with on a daily basis?
3. What may I need assistance with?

Anything that falls under question number 1 or 2 can be written as "will...."
Anything that falls under question number 3 can be written as " may..."

Employer Reference Check Form

It is good practice to check the two most recent employers of the DSP. **You are responsible for contacting previous employers.** When calling the employers, use the enclosed Reference Check Forms that contain generally accepted questions. If the employer can only verify dates of hire, please write that on the form. If you wish to waive the employer reference check you may do so by writing WAIVED on the form and signing it. It is highly recommended that you complete the employer reference check unless the applicant is a family member or close family friend.

Driver's License Check Form

Any DSP who will have the responsibility of driving should have a clean driving record. Please have the applicant fill out the Driver's License Information Form. Easter Seals will get in touch with you with the results if they are unfavorable.

Permission For Background Check and Release for Information Form

As per DDD regulations, any person directly working with an individual with a disability will have to undergo a Federal and State criminal background check including electronic fingerprinting. Included in this packet is:

1 - "Dear Employee" letter with complete directions for contacting Sagem Morpho and the information required to be fingerprinted.
2 - Sagem Morpho form
3 - Permission for Background Check form

Please review this information with your applicant very carefully!

Employee Information Form

Please complete the following areas on this form. The rest will be completed by Easter Seals.

1. Name, Social Security Number
2. Address, City, State, Zip
3. Telephone number
4. Birth date
5. Marital status
6. Sex, EEO Code, Disabled, Veteran, Citizen
7. Emergency Contact
8. Indicate part time or full time
9. Hourly rate
10. Health insurance declination (if applicable)
11. Bi weekly hours

I-9 and W-4

PLEASE NOTE THAT THE DEPT. OF LABOR & THE DEPT. OF HOMELAND SECURITY REQUIRE THAT THE INFORMATION IN EACH SECTION AND THE SIGNATURE ARE IN THE SAME COLOR INK.

Have the individual complete their part of the I-9 and the W-4 forms. Please complete section 2 of the I-9 form that states that you have seen the original documents that are acceptable according to the list on the back of the form. Please fill in the information in the appropriate column and sign as the authorized representative and your title is Supervisor. Please note the information requested is indicated to the left of List A. Make sure that **you** have seen the **originals** and have the applicant photocopy the documents and send them to Easter Seals along with the packet.

Hepatitis B Form

All DSPs are offered the opportunity to receive a Hepatitis B vaccination. If the DSP chooses this, you will be charged the rate that your local vaccination provider charges. The approximate cost is $250. The DSP will be offered the opportunity to receive the vaccination at any time during their employment, even if he/she decline initially. The DSP is to complete **either** the Hep B Acceptance or Refusal part of the form. You are to sign the form as well.

Non-Medical Benefits Form

As the managing employer, **you** will be choosing the plan of vacation and flex time for your DSP. This is something that will impact your budget and you should check with the Support Broker/ Coordinator before making this decision. There are three options available, but you must **choose only one**. After making your selection, please **complete only one form** and return it along with the application packet. **PLEASE NOTE: VACATION TIME IS ACCRUED DURING THE FIRST YEAR AND ELIGIBLE THE FOLLOWING YEAR. FLEX TIME BEGINS TO ACCRUE AFTER 90 DAYS.**

You should be aware that as an employer, you will be required to comply with universal precautions which include, having bleach on hand as a disinfectant and latex or non-latex gloves.

If you will be expecting your DSP to administer medication it is advised that they attend and pass the DDD Medication Administration course.

Central Registry of Offenders Against Individuals with Developmental Disabilities Consent Form

Please have the applicant complete the top portion of the form and print and sign where indicated. Easter Seals will perform the check against the registry

Drug and Alcohol Screening

All DSPs are required to undergo a urine drug and alcohol screening and results must be received **prior to their first day worked**. In order to schedule an appointment at the nearest collection site the DSP should call the Patient Service Locator. They may do so by calling **1-888-522-2677** and following the automated system.

When going for the screening, the DSP will need to take the Drug Screen Custody and Control Form and his/her driver's license (or photo identification) to the collection site. The Custody Form is included in this packet. Please notify the coordinator at Easter Seals when the drug test has been completed, this way he/she will be able to look for the results when they come in. If the DSP is currently taking medication that shows up in the screening, the Medical Review Officer will contact them regarding their prescription information.

Danielle's Law on-line training

Please follow the enclosed instructions for on-line training for Danielle's Law. **DANIELLE'S LAW ON-LINE TRAINING MUST BE SUCCESSFULLY COMPLETED AND NOTIFICATION RECEIVED FROM EASTER SEALS BEFORE DSP WILL BE GIVEN AUTHORIZATION TO START.**

Just a reminder, the DSP is not to begin employment until the results are received and you are notified by Easter Seals.

If you need any assistance in completing the application, please call Janet Marinelli at (800) 471-3086 extension 225.

Rev 4.3 11/12

CONSUMER NAME : _____

TODAY'S DATE: _____

EASTER SEALS NEW JERSEY
APPLICATION FOR EMPLOYMENT
Self Directed Services

Easter Seals New Jersey is an equal opportunity employer and does not discriminate against otherwise qualified applicants on the basis of race, color, creed, religion, ancestry, age, sex, marital status, national origin, disability or handicap, or veteran status.

PERSONAL: PLEASE PRINT

Name _____ Social Security Number _____
Last First Middle

Address _____ Phone Number: _____
Number & Street City/State Zip Code County

Are you related to the individual? ☐ YES ☐ NO If yes relationship _____

Position Applying For _____ Shift: ☐ F/T ☐ P/T ☐ Day ☐ Evening ☐ Night

Date Available to Start _____ In Case of Emergency Contact _____ Phone Number _____

Have You Ever Applied to Work For This Organization Before? ☐ YES ☐ NO If yes, When? _____ Where? _____

Were you ever a Community Care Provider for DDD? ☐ YES ☐ NO How many people are you currently providing supports for in your home? _____

Are you currently providing services for this individual through any other agency? ☐ YES ☐ NO

If yes name of agency _____

What prompted your Application? ☐ Newspaper ☐ Own Initiative ☐ Referred By: _____ ☐ Other

Are you legally eligible to work in the U.S.? ☐ YES ☐ NO (You will be required to provide documentation to verify eligibility.)

EDUCATION: Please indicate education or training which you believe qualifies you for the position you are seeking.

High School: No. of Years Completed (circle one) 1 2 3 4 Diploma: ☐ YES ☐ NO GED: ☐ YES ☐ NO

School _____ City/State _____

College and/or Vocational School: No. of Years Completed (circle one) 1 2 3 4 Did You Graduate? ☐ YES ☐ NO

School _____ City/State _____ Major/Degree Earned _____

Other Training or Degrees: School _____ City/State _____

Course(s) _____ Degree or Certificate Earned _____

PROFESSIONAL LICENSE OR MEMBERSHIP relative to position applying for:

Type of License(s) Held _____ License Expiration Date _____

Are you currently, or have you been a skill development sponsor with DDD? ☐ YES ☐ NO

If yes, please indicate the beginning and end dates of your license _____

Please indicate the capacity of the license _____

Please indicate the type of license (full, provisional, or suspended) _____

If provisional or suspended, please indicate the reason why _____

_____

SKILLS: What type of office equipment and/or software are you familiar with? _____

_____

RECORD OF CONVICTION: (A conviction will not automatically disqualify you for employment. All factors will be considered.) Have you ever been convicted or pleaded guilty to a crime, i.e. misdemeanor or a felony, other than a minor traffic offense or any convictions as a youthful offender or juvenile? ☐ YES ☐ NO If yes, please explain:

_____

_____

_____

_____

EMPLOYMENT HISTORY: Account for all employment, including periods of unemployment. List most current employer first including U.S. Military Service if experience/skills relevant to the position you are applying for. Do **NOT** show type of Military Service discharge or dates of service. May we contact your present employer? ☐ YES ☐ NO

If any employment was under a different name, indicate name _____

1. Employer _____ Address _____ Telephone _____

Position _____ Dates of Employment: From (Mo/Yr) _____ To (Mo/Yr) _____

Salary _____ Supervisor _____ Reason for Leaving _____

_____

2. Employer _____ Address _____ Telephone _____

Position _____ Dates of Employment: From (Mo/Yr) _____ To (Mo/Yr) _____

Salary _____ Supervisor _____ Reason for Leaving _____

_____

3. Employer _____ Address _____ Telephone _____

Position _____ Dates of Employment: From (Mo/Yr) _____ To (Mo/Yr) _____

Salary _____ Supervisor _____ Reason for Leaving _____

4. Employer _____ Address _____ Telephone _____

Position _____ Dates of Employment: From (Mo/Yr) _____ To (Mo/Yr) _____

Salary _____ Supervisor _____ Reason for Leaving _____

_____

If you wish to describe additional work experience, attach the above information for each position on a separate piece of paper. Please explain any gaps in work history: _____

_____

APPLICANT'S CERTIFICATION AND AGREEMENT

I hereby certify that the facts set forth in the above employment application are true and complete to the best of my knowledge and authorize Easter Seals New Jersey to verify their accuracy and to obtain reference information on my work performance. I hereby release Easter Seals New Jersey from any/all liability of whatever kind and nature which, at any time, could result from obtaining and having an employment decision based on such information.

I understand that, if employed, falsified statements of any kind or omissions of facts called for on this application shall be considered sufficient basis for dismissal.

I understand that should an employment offer be extended to me and accepted that I will fully adhere to the policies, rules and regulations of employment of Easter Seals New Jersey. However, I further understand that neither the policies, rules, regulations of employment or anything said during the interview process shall be deemed to constitute the terms of an implied employment contract. I understand that any employment offered is on a three-month introductory period and at will and that either Easter Seals New Jersey or I may terminate my employment at any time with or without notice or cause.

Signature of Applicant _____ Date: _____

EASTER SEALS NEW JERSEY
APPLICATION ADDENDUM

By submitting your application for employment with Easter Seals New jersey, you are confirming that you understand and agree to undergo, as part of the pre-employment/pre-placement examination, a urine drug and alcohol screening test, motor vehicle abstract and criminal background/fingerprint check. You acknowledge that any offer of employment is conditional on the results of such tests, and that a confirmed positive drug or alcohol test will result in the rescinding of a job offer. By signing this agreement, you are authorizing Lab Corp. to provide the results of the drug and alcohol testing to Easter Seals New Jersey personnel making hiring decisions and you are further agreeing to hold Easter Seals New Jersey, its agents, directors, officers and employees harmless from any and all liability in connection with the testing for drugs and alcohol. By signing this agreement, you acknowledge an invalid driver's license or identification by Easter Seals New Jersey as a high-risk driver, will result in the rescinding of any job offer which includes driving as one of the responsibilities. By signing this agreement you are subject to being fingerprinted for a position in Easter Seals new Jersey, and you acknowledge your offer of employment is contingent upon the background information gathered by the fingerprinting process. By signing this agreement, you affirm that you are not currently listed on the OIG List of Excluded Individuals. All records and information regarding drug and alcohol screening, motor vehicle abstract, and criminal background/fingerprinting checks for pre-employment/pre-placement applicants will be treated as confidential.

I HEREBY AGREE TO THIS EASTER SEALS NEW JERSEY POLICY AND CONSENT TO THE REQUIREMENTS OF THE INITIALLED PRE-EMPLOYMENT/PRE-PLACEMENT EXAMINATIONS AND ANY OTHER PRE-EMPLOYMENT/PRE-PLACEMENT EXAMINATIONS.

Please initial by the pre-employment test/check that you are required to complete.

____ DRUG AND ALCOHOL SCREENING

____ DRIVERS ABSTRACT BACKGROUND CHECK

____ CRIMINAL BACKGROUND FINGERPRINT CHECK

____ OIG (Office of Inspector General) Exclusionary List

____ CENTRAL REGISTRY OF OFFENDERS AGAINST INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

Print Name: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

Form HR(6a)

EASTER SEALS NEW JERSEY
JOB DESCRIPTION

JOB TITLE: Direct Support Professional **DATE:**

GRADE: 1 **STATUS:** Non-Exempt

DEPARTMENT: Fiscal Intermediary Service

REPORTS TO:

BASIC FUNCTION: To support the individual receiving services in any aspect of daily living with which he/she may require assistance. To provide direct individual assistance, guidance and instruction as needed both in the home and the community. To promote self-determination commiserate with the individual's ability to exercise informed choice and risk management, ensuring ongoing opportunities for growth.

SUPERVISION: None

WILL DRIVING BE A REQUIRED JOB FUNCTION? **(please circle one) YES NO**

ESSENTIAL JOB FUNCTIONS:

1. _____

_____

2. _____

_____

3 _____

_____

4. _____

_____

5. _____

_____

PLEASE CONTINUE ON BACK OF FORM

6. _____

_____

7. _____

_____

8. _____

_____

9. _____

_____

10. _____

_____

11. _____

_____

QUALIFICATION:

EDUCATION: High School diploma or equivalent. – Please initial if you waive the requirement _____

EXPOSURE CATEGORY: I or II as per job functions

ACKNOWLEDGMENTS:

_____ _____

Employee Signature Date

_____ _____

Supervisor Signature Date

DIRECT SUPPORT PROFESSIONAL EMPLOYER REFERENCE CHECK

Previous Employer: _____
Address: _____
City, State, Zip: _____
Supervisor's Name: _____
Contact Information: Phone: _____ Fax: _____

I hereby grant permission to release any requested information concerning my performance and salary to Easter Seals New Jersey. This includes any information stated below and any other which is deemed pertinent to my consideration for employment. I release any liability as a result of responding to this request.

Applicant's Signature: _____
Social Security Number: _____

1. What position did this employee hold? _____
2. What are the dates of employment? _____
3. What were the reasons for separation? _____
4. How would you rate the employee's quality of work? _____
5. How would you rate the employee's job knowledge? _____
6. How would you rate the employee's judgment/common sense? _____
7. How would you rate the employee's initiative? _____
8. How would you rate the employee's cooperativeness? _____
9. How would you rate the employee's dependability? _____
10. How would you rate the employee's attendance/punctuality? _____
11. Is there anything else you would like to add about the employee? _____

Name & Title of person releasing the information: _____

Name of person performing check_____ Date of reference check_____

Rev 8/11

DIRECT SUPPORT PROFESSIONAL EMPLOYER REFERENCE CHECK

Previous Employer: _____
Address: _____
City, State, Zip: _____
Supervisor's Name: _____
Contact Information: Phone: _____ Fax: _____

I hereby grant permission to release any requested information concerning my performance and salary to Easter Seals New Jersey. This includes any information stated below and any other which is deemed pertinent to my consideration for employment. I release any liability as a result of responding to this request.

Applicant's Signature: _____
Social Security Number: _____

1. What position did this employee hold? _____
2. What are the dates of employment? _____
3. What were the reasons for separation? _____
4. How would you rate the employee's quality of work? _____
5. How would you rate the employee's job knowledge? _____
6. How would you rate the employee's judgment/common sense? _____
7. How would you rate the employee's initiative? _____
8. How would you rate the employee's cooperativeness? _____
9. How would you rate the employee's dependability? _____
10. How would you rate the employee's attendance/punctuality? _____
11. Is there anything else you would like to add about the employee? _____

Name & Title of person releasing the information: _____

Name of person performing check_____ Date of reference check_____

Rev 8/11

EASTER SEALS NEW JERSEY
DRIVER HISTORY FORM

Driver's Name (Please Print): _____

Home Address: _____

City: _____ State: _____ Zip: _____

Maiden, Nickname or Other names previously used: _____

Gender: ☐ Male or ☐ Female Social Security Number: ___-__-___

Driver's License Number

License Expiration Date: _____ State in which Driver's License was issued: _____

Please answer the following questions.

1. If you have held a license in any other state during the past 36 months, please provide the following information.

Dates		State	License #
From _____	to _____	_____	_____
From _____	to _____	_____	_____
From _____	to _____	_____	_____

2. Have you been convicted of driving while impaired or under the influence of alcohol and/or drugs within the past three years? ☐ Yes or ☐ No If yes, please explain with dates.

_____

_____

3. Have you refused to submit to a Blood Alcohol Content (BAC) test within the past three years? ☐ Yes or ☐ No If yes, please explain with dates.

_____

_____

PLEASE CONTINUE ON BACK OF FORM

4. Have you been convicted of reckless driving, or leaving the scene of an accident, or committing a felony involving a vehicle? ? ☐ Yes or ☐ No If yes, please explain with dates.

_____

_____

5. Have you had your driver's license suspended, revoked or administratively restricted within the past three years? ? ☐ Yes or ☐ No If yes, please explain with dates.

_____

_____

6. Have you been convicted or found at fault for any nonfatal accident involving a motor vehicle during the past three years? ? ☐ Yes or ☐ No If yes, please explain with dates.

_____

_____

7. Have you been convicted or found at fault for any fatal accidents involving a motor vehicle? ☐ Yes or ☐ No If yes, please explain with dates.

_____

_____

8. Have you been convicted of any other moving vehicle violations during the past three years? ☐ Yes or ☐ No If yes, please explain with dates.

_____

_____

I certify that the answers provided to the questions on the form are true.

I authorize Easter Seals New Jersey or its designated representative(s) to obtain information regarding my driving record in any state at any time while I am employed by (or seeking employment with) the company.

I understand that any misstatement of the facts on this form may be grounds for termination of employment.

In the event that my Motor Vehicle Record indicates that I am a "high risk" driver as defined by ESNJ policy. I understand that I may be subject to immediate termination or an offer of employment may be rescinded.

Driver's Signature: _____ Date: _____

ESNJ Representative: _____ Date: _____

Rev 4/07

Easter Seals New Jersey

Employee Certification
Permission for Background Check and Release of Information

Employee Name: _____ SS # _____
(Please Print)

I hereby authorize the Department of Human Services to conduct a criminal background check and I agree to be fingerprinted in order to complete the state and federal background check process. I further authorize the release of all information regarding the results of my background check to the Department of Human Services. Check one of the options listed below:

Option 1 _____ I hereby certify under penalties of perjury, that I have not been convicted of any of the offenses listed below and no such record exists in the State Bureau of Identification in the Division of State Police or in the Federal Bureau of Investigation, Identification Division.

Option 2 _____ I hereby affirm that I have been convicted of the following offense listed below _____ on _____.
(date)

If I have checked Option 2 or the criminal history background check reveals any conviction(s) for the offenses listed below, I understand that I may be subject to termination from employment.

Offenses covered under P.L. 1999, C.358:

In New Jersey, any crime or disorderly person offense:

- involving danger to the person as set forth in: N.J.S.A. 2C:11-1 et seq. through 2C:15-let seq. including the following:

i. Murder
ii. Manslaughter
iii. Death by Auto
iv. Simple assault
v. Aggravated assault
vi. Recklessly endangering another person
vii. Terroristic threats
viii. Kidnapping
ix. Interference with custody of children
x. Sexual assault
xi. Criminal sexual contact
xii. Lewdness
xiii Robbery

PLEASE CONTINUE ON BACK OF FORM

- against the children or incompetents as set forth in N.J.S.A.2C:24-1 et seq. including the following:

i. Endangering the welfare of a child
ii. Endangering the welfare of an incompetent person

- a crime or offense involving the manufacture, transportation, sale, possession or habitual use of a controlled dangerous substance as defined in N.J.S.A. 2C:24-1 et seq.

- in any other state of jurisdiction, conduct which, if committed in New Jersey, would constitute any of the crimes or disorderly persons offenses described above.

Employee Name (please print)	(Date)
Employee Signature	(Date)
Witness Name (please print)	(Date)
Witness Signature	(Date)

Rev 4/07

Easter Seals
DISABILITY SERVICES

Creating Solutions, Changing

Easter Seals

New Jersey / FIS
25 Kennedy Boulevard - Suite 600
East Brunswick, NJ 08816
Telephone: 1.800.471.3086
732-257-6662 phone
TDD: 732.238.4442
1.888.525.0415 fax
www.eastersealsnj.org

Dear Employee:

As an agency, Easter Seals New Jersey wants to assure the safety of all our employees and the people we serve. To ensure the safety and to comply with a Division of Developmental Disabilities policy, Easter Seals New Jersey obtains criminal history checks on all employees under contract by the Division.

The Division has contracted with IdentoG MorphoTrust to conduct electronic fingerprinting. The fingerprinting is done at designated sites throughout the state of New Jersey. **It is necessary for you to schedule an appointment within 10 days of receipt of this letter.**

Please make sure you are using the current version of the form. The form was revised on November 1, 2013 with a start date of **December 9, 2013**. This information will be located at the bottom of the form on the right. It is always a good idea to check with Easter Seals for the information on the most current form.

Once you have completed the form, you can schedule an appointment either by phone at 877-503-5981 or via the web at www.bioapplicant.com/nj. It is much easier to schedule via the website. Please make sure you read the directions on the form as it contains important information regarding the necessary information to bring with you for your appointment. **There is no cost to you to have the fingerprinting done.** Please note in box #6 the instructions are for them to bill Easter Seals.

Once your fingerprints have been completed, you should mail or fax a copy of the receipt to Janet Marinelli at the address at the top of this letter.

If you have any questions or need any assistance in scheduling your fingerprinting, please contact Janet Marinelli @ 1-800-471-3086 X 225.

Revised 11/01/13
Effective 12/09/13

IdentoGO
By MorphoTrust USA

New Jersey Universal Fingerprint Form

www.bioapplicant.com/nj

(1) Originating Agency Number (ORI #)	(2) Category	(3) Statute Number	
NJ920540Z	HSK	30:6D-64	
(4) Reason for Fingerprinting		(5) Document Type	(6) Payment Information
HUMAN SERVICES PRIVATE CONTRACTOR		RB2	BILL STATE AGENCY
(7) Contributor's Case # (Unique Identifier)		(8) Miscellaneous	
PC1096			

(9) First Name	(10) MI	(11) Last Name		
(12) Daytime Phone Number	(13) Social Security Number (Optional)	(14) Date of Birth	(15) Height	(16) Weight
( ) -				
(17) Maiden or Alias Last Name	(18) Place of Birth (US State if US Citizen; Country for all others)		(19) Country of Citizenship	

(20) Home Address

Address City State Zip

(21) Gender (Select one)	(22) Hair Color	(23) Eye Color	(24) Race (Select One)
[ ] Female [ ] Male [ ] Both			[A] Asian/ Pacific Islander (includes Asian Indian) [B] Black [I] American Indian / Alaska Native [W] White (Includes Hispanic/ Spanish Origin) [U] Unknown

(25) Occupation / Position (with respect to Requirement)

(26) Employer / Organization Name (with respect to Requirement): **Easter Seal Society of NJ, Inc.**

Employer Address: **25 Kennedy Blvd., Suite 600**

City : **East Brunswick** State: **NJ** Zip: **08816**

Identification Requirement - *Identification must be presented at the time of printing.* Identification presented MUST be one (1) document that is current (not expired). A combination of documents will not be accepted. The single document must include the following criteria; Photo, Name, Address (home/employer), Date of Birth and is issued by a Federal, State, County or Municipal entity for Identification purposes. Examples of acceptable ID are: 1) Valid U.S. State Photo Driver's License/ Non Driver's License, 2) U.S. Passport, 3) USCIS Permanent Resident ID Card (issued after 5/10/2010), and 4) USCIS Employment Authorization Card (issued after 10/31/2010).

Please READ this form carefully

and follow all of the instructions provided by your agency/employer to complete the fingerprint process. You must have this form (Blocks 1 through 26) completed prior to scheduling your fingerprint appointment via the website or call center. PLEASE PRINT LEGIBLY. It is required you present this completed Universal Fingerprint Form, IDG_NJAPP_110113, at your scheduled appointment.

Appointment Scheduling:

Scheduling is available anytime at **www.bioapplicant.com/nj**. Appointments may also be scheduled through our Call Center. English and Spanish speaking agents are available at **1-877-503-5981**, Monday through Friday, 8:00AM to 5:00PM EST and Saturday, 8:00AM to 12 Noon EST.

Payment:

When an Applicant is responsible for payment, Payment Is Required at the time of scheduling. The following forms of payment are accepted: Visa, MasterCard, or electronic debit (ACH) from a checking account; accounts will be debited immediately. Money Order is the only form of payment accepted at the enrollment center.

Cancel/ Reschedule:

Appointments may be canceled or rescheduled via the website or the call center before the deadline of 5PM EST the business day prior to the scheduled appointment (Saturday Noon for Monday appointments). An appointment fee of $10.00 will be incurred by applicants who do not cancel/reschedule their appointment prior to the deadline; MorphoTrust will refund the remainder of the fee paid (state/federal search fees) to the original payment method.

Unable to be Fingerprinted:

An applicant is considered "Unable to be Fingerprinted" for any of the following reasons: Failure to appear for scheduled appointment; Inability to present proper Identification; Inability to present this completed Universal Fingerprint Form IDG_NJAPP_110113; Information on this form does not exactly match the remainder of the fee paid (state/federal search fees) to the original payment method.

PCN and Receipts:

Upon the completion of fingerprinting you will be assigned a PCN number. The PCN will be recorded on this form and on your receipt. MorphoTrust will not provide *duplicate receipts, PCN Numbers or any appointment/printing information after the time of printing.*

Applicant ID Number:	Payment Authorization:	PCN:
Scheduled Day & Date:	Scheduled Time:	Scheduled Site:
Agency Information: **State and FBI Background Check**		

You **MUST** retain a copy of this form and the receipt of printing for your personal records.

APPLICANTS MUST NOT ALTER, SHARE, OR REUSE THIS FORM

IDG_NJAPP_110113

EMPLOYEE INFORMATION FORM
Fiscal Intermediary Services

FILE #_____
DEPARTMENT#_____

NAME_____ SOC.SECURITY #_____
ADDRESS_____
MAILING ADDRESS IF DIFFERENT_____
CITY_____STATE_____ COUNTY_____ZIP CODE_____
TELEPHONE#(___)_____BIRTHDATE_____
MARRIED_____SINGLE_____DIVORCED_____WIDOWED_____
SEX____EEO CODE (RACE)____DISABLED_____VETERAN____CITIZEN__Y__N

HEALTH INSURANCE

I ELECT NOT TO HAVE COVERAGE AT THIS TIME (employee initials)____

LEGISLATIVE DISTRICT: FEDERAL_____STATE_____

PAYROLL INFORMATION

POSITION TITLE_____EXEMPT_____NON-EXEMPT___X___

HIRE DATE_____RE-HIRE DATE_____

FULL TIME_____PART TIME_____ **IMMEDIATE SUPERVISOR**_____

ANNUAL SALARY_____BI-WEEKLY_____

HOURLY RATE_____

OVERNIGHT RATE_____

BI-WEEKLY HOURS 70___80___OTHER_____

BENEFIT ALLOCATIONS: _____%_____ _____%_____ ____%_____ _____%_____

NON-MEDICAL BENEFITS (Vacation and Flex Time)

OPTION 1_____ OPTION 2_____ OPTION 3_____

TERMINATION

LAST DAY WORKED_____ DATE OF TERMINATION_____
PAY: (CHECK APPROPRIATE BOX)
EARNED VACATION_____ACCRUED VACATION____NO VACATION____

REASON FOR TERMINATION_____

(VOLUNTARY____INVOLUNTARY____UNCONTROLLABLE____)

FIS ADMIN. COORDINATOR SIGNATURE_____DATE_____

HUMAN RESOURCES SIGNATURE_____ DATE_____

Rev 4/07

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

▶START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire 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 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	E-mail Address	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):

☐ A citizen of the United States

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

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

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

For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** *Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date *(mm/dd/yyyy)*:

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

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

Signature of Preparer or Translator:			Date *(mm/dd/yyyy)*:
Last Name *(Family Name)*	First Name *(Given Name)*		
Address *(Street Number and Name)*	City or Town	State	Zip Code

STOP *Employer Completes Next Page* STOP

[illegible]

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 examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

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)*:				

3-D Barcode
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	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative Supervisor	
Last Name *(Family Name)*	First Name *(Given Name)*	Employer's Business or Organization Name Easter Seals NJ	
Employer's Business or Organization Address *(Street Number and Name)* 25 Kennedy Blvd Suite 600	City or Town East Brunswick	State NJ	Zip Code 08816

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

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

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current 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:	Date *(mm/dd/yyyy)*:	Print 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 Birth Abroad issued by the Department of State (Form FS-545)
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. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
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. Native American tribal document
		6. Military dependent's ID card		6. U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		8. Employment authorization document issued by the Department of Homeland Security
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		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.

Form W-4 (2014)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2014 expires February 17, 2015. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,000 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2014. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent . . . . . A _____

B Enter "1" if:
- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less. . . . B _____

C Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . . C _____

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . . . D _____

E Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . . E _____

F Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit . . . F _____
(**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.
- If your total income will be less than $65,000 ($95,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to six eligible children or **less** "2" if you have seven or more eligible children.
- If your total income will be between $65,000 and $84,000 ($95,000 and $119,000 if married), enter "1" for each eligible child . . . G _____

H Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▶ H _____

For accuracy, **complete all worksheets that apply.**
- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074
2014

1 Your first name and middle initial	Last name	2 Your social security number
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ ☐	

5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2) | 5 |

6 Additional amount, if any, you want withheld from each paycheck . . . . . | 6 $ |

7 I claim exemption from withholding for 2014, and I certify that I meet **both** of the following conditions for exemption.
- Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and**
- This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability.

If you meet both conditions, write "Exempt" here . . . . . ▶ | 7 |

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

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

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

For Privacy Act and Paperwork Reduction Act Notice, see page 2.

Cat. No. 10220Q Form **W-4** (2014)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1 Enter an estimate of your 2014 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1950) of your income, and miscellaneous deductions. For 2014, you may have to reduce your itemized deductions if your income is over $305,050 and you are married filing jointly or are a qualifying widow(er); $279,650 if you are head of household; $254,200 if you are single and not head of household or a qualifying widow(er); or $152,525 if you are married filing separately. See Pub. 505 for details . . . . 1 $

2 Enter: { $12,400 if married filing jointly or qualifying widow(er); $9,100 if head of household; $6,200 if single or married filing separately } . . . . . 2 $

3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" . . . . . 3 $

4 Enter an estimate of your 2014 adjustments to income and any additional standard deduction (see Pub. 505) 4 $

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2014 Form W-4* worksheet in Pub. 505.) . . . . . 5 $

6 Enter an estimate of your 2014 nonwage income (such as dividends or interest) . . . . . 6 $

7 **Subtract** line 6 from line 5. If zero or less, enter "-0-" . . . . . 7 $

8 **Divide** the amount on line 7 by $3,950 and enter the result here. Drop any fraction 8

9 Enter the number from the **Personal Allowances Worksheet,** line H, page 1 9

10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 10

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) 1

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3" 2

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet 3

Note. If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet 4

5 Enter the number from line 1 of this worksheet 5

6 **Subtract** line 5 from line 4 6

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . 7 $

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . 8 $

9 Divide line 8 by the number of pay periods remaining in 2014. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2014. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 $

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $6,000	0	$0 - $6,000	0
6,001 - 13,000	1	6,001 - 16,000	1
13,001 - 24,000	2	16,001 - 25,000	2
24,001 - 26,000	3	25,001 - 34,000	3
26,001 - 33,000	4	34,001 - 43,000	4
33,001 - 43,000	5	43,001 - 70,000	5
43,001 - 49,000	6	70,001 - 85,000	6
49,001 - 60,000	7	85,001 - 110,000	7
60,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $74,000	$590	$0 - $37,000	$590
74,001 - 130,000	990	37,001 - 80,000	990
130,001 - 200,000	1,110	80,001 - 175,000	1,110
200,001 - 355,000	1,300	175,001 - 385,000	1,300
355,001 - 400,000	1,380	385,001 and over	1,560
400,001 and over	1,560		

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

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

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

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

EASTER SEALS NEW JERSEY

HEPATITIS B VACCINATION INFORMATION FOR EMPLOYEES

In order to protect its employees from occupational exposure to Hepatitis B, in accordance with OSHA requirements, ESNJ has implemented a Hepatitis B immunization program. All employees who are classified as Exposure Category I or II, as per their position descriptions, are encouraged to receive the immunization free of charge. It is a three part series of injections given over a six-month period.

Once an employee is approved by Easter Seals and requests the series, the Administrative Coordinator will schedule an appointment with an authorized provider who will administer the series. If initially refused, the immunization series can be started at any time during employment with Easter Seals. If employment is terminated for any reason prior to the completion of the series, Easter Seals will not be responsible for any remaining injections.

I understand that ESNJ accepts no responsibility for the administration of the Hepatitis B vaccine, the quality of shots, individual reaction to the shots or the effectiveness of the vaccination series. I further release, absolve, indemnify and hold harmless, ESNJ, its directors, officers, agents, servants and employees from any and all claims in the case of injury which I may sustain as a result of accepting the vaccination series.

EMPLOYEE'S ACCEPTANCE STATEMENT:

I have read the above information and wish to receive the Hepatitis B injection series.

Employee's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

OR

EMPLOYEE'S REFUSAL STATEMENT:

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine at no charge to me. However, I decline (refuse) the Hepatitis B vaccination at this time. I understand that by declining this vaccine I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination at no charge to me.

Employee's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

Easter Seals
DISABILITY SERVICES

Creating Solutions, Changing

Easter Seals

New Jersey / FIS
25 Kennedy Boulevard - Suite 600
East Brunswick, NJ 08816
Telephone: 1.800.471.3086
FAX: 732.432.5970
TDD: 732.238.4442
www.eastersealsnj.org

FLEX/VACATION/HOLIDAY BENEFITS

I understand that the following selection will be implemented for the period January 1, through December 31, and may be changed by my supervisor the following year. **PLEASE NOTE THAT FOR NEW HIRES FLEX DAYS ACCRUE AFTER 90 DAYS, BUT VACATION ACCRUES FOR THE FIRST YEAR AND IS NOT AVAILABLE UNTIL JANUARY OF THE FOLLOWING YEAR.**

OPTION 1	FULL TIME STAFF Scheduled 35 hrs or more per week	PART TIME STAFF Scheduled 20–34 hrs per week	PART TIME STAFF Scheduled Under 20 hrs per week
	15 vacation days **15** flex days **12** paid holidays **	**10** vacation days **10** flex days **Up to 12 paid** holidays ** (if scheduled work day)	**No** vacation days **No** flex days **Up to 6 worked** holidays** paid at time and a half

**** 6 paid holiday option include:** New Year's Day, Memorial Day, July 4th, Labor Day, Thanksgiving, Christmas Day

Employee's Printed Name: _____

Employee's Signature: _____ **Date**_____

Supervisor's Printed Name: _____

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

Return form to:

Janet Marinelli
Easter Seals New Jersey
25 Kennedy Blvd – Suite 600
East Brunswick, N.J. 08816

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DISABILITY SERVICES

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732.257.6662 phone
TDD: 732.238.4442
732.432.5970 fax
www.eastersealsnj.org

FLEX/VACATION/HOLIDAY BENEFITS

I understand that the following selection will be implemented for the period January 1, through December 31, and may be changed by my supervisor the following year. **PLEASE NOTE THAT FOR NEW HIRES FLEX DAYS ACCRUE AFTER 90 DAYS, BUT VACATION ACCRUES FOR THE FIRST YEAR AND IS NOT AVAILABLE UNTIL JANUARY OF THE FOLLOWING YEAR.**

OPTION 2	FULL TIME STAFF Scheduled 35 hrs or more per	PART TIME STAFF Scheduled 20–34 hrs per week	PART TIME STAFF Scheduled Under 20 hrs per week
	10 vacation days **7** flex days **6** paid holidays **	**5** vacation days **5** flex days **Up to 6 paid** holidays ** (if scheduled work day)	**No** vacation days **No** flex days **Up to 6 worked** holidays** paid at time and a half

** **6 paid holiday option include:** New Year's Day, Memorial Day, July 4th, Labor Day, Thanksgiving, Christmas Day

Employee's Printed Name: _____

Employee's Signature: _____ **Date**_____

Supervisor's Printed Name: _____

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

Return form to:

Janet Marinelli
Easter Seals New Jersey
25 Kennedy Blvd. Suite 600
East Brunswick, N.J. 08816

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FLEX/VACATION/HOLIDAY BENEFITS

I understand that the following selection will be implemented for the period January 1, through December 31, and may be changed by my supervisor the following year. **PLEASE NOTE THAT FOR NEW HIRES FLEX DAYS ACCRUE AFTER 90 DAYS, BUT VACATION ACCRUES FOR THE FIRST YEAR AND IS NOT AVAILABLE UNTIL JANUARY OF THE FOLLOWING YEAR.**

OPTION 3	FULL TIME STAFF Scheduled 35 hrs or more per	PART TIME STAFF Scheduled 20–34 hrs per week	PART TIME STAFF Scheduled Under 20 hrs per week
	No vacation days No flex days **6** paid holidays **	**No** vacation days **No** flex days **Up to 6 paid** holidays ** (if scheduled work day)	**No** vacation days **No** flex days **Up to 6 worked** holidays** paid at time and a half

**** 6 paid holiday option include:** New Year's Day, Memorial Day, July 4th, Labor Day, Thanksgiving, Christmas Day

Employee's Printed Name: _____

Employee's Signature: _____ **Date**_____

Supervisor's Printed Name: _____

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

Return form to:

Janet Marinelli
Easter Seals New Jersey
25 Kennedy Blvd. – Suite 600
East Brunswick, N.J. 08816

EASTER SEALS NEW JERSEY
PERSONAL INFORMATION FORM

NAME _____ SOCIAL SECURITY # _____
(Last, First, MI)

SITE/LOCATION: _____ DEPARTMENT: _____

VOLUNTARY SELF- IDENTIFICATION - Check one box only in each category. See reverse for explanations.

RACE/ETHNIC GROUP:
___ American Indian or Alaska Native
___ Asian
___ Black or African American
___ Hispanic or Latino
___ Native Hawaiian or Other Pacific Islander
___ White, not of Hispanic Origin
___ Two or More Races (not Hispanic or Latino)

DISABILITY STATUS:
___ No Disability
___ One or more Disabilities

MILITARY STATUS:
____ Active Duty
____ National Guard/Reserve
____ Vietnam Era Veteran
____ Disabled Vietnam Era Veteran
____ Disabled Veteran

LANGUAGES SPOKEN:
Primary _____
Others _____

EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP: _____

HOME PHONE #: _____ BUSINESS PHONE #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

ADDITIONAL EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP: _____

PHONE #: _____ BUSINESS PHONE #: _____

_____ _____
SIGNATURE DATE

(See reverse for explanations)

EQUAL EMPLOYMENT OPPORTUNITY (EEO)

Easter Seals New Jersey is proud to be an Equal Opportunity Employer. In order to meet the Company's equal employment opportunity and affirmative action obligations under applicable laws and regulations, including Title VII of the Civil Rights Act of 1964, as amended, Executive Order 11246, as amended, Section 503 of the Rehabilitation Act of 1973, and Section 402 of the Vietnam Era Veterans Readjustment Assistance Act of 1974 (38 U.S.C. A212), we request that you complete the self-identification sections on the reverse side of this form. This information will be used for reporting, research, statistical analysis, and compliance purposes.

RACE/ETHNIC SELF-IDENTIFICATION: The following categories do not denote scientific definitions of anthropological origins. For the purpose of this identification, please select the group with which you identify or belong and indicate on the reverse of this form:

- **American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachments.**

- **Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.**

- **Black or African American: A person having origins in any of the Black racial groups of Africa.**

- **Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.**

- **Native Hawaiian or Other Pacific Islander: A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.**

- **White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.**

- **Two or More Races (Not Hispanic or Latino): All persons who identify with more than one of the above five races.**

DISABILITY STATUS:

- **Has One or More Disabilities: A person who has a physical or mental disability which substantially limits one or more major life activities, has a record of such disability, or is regarded as having such a disability.**

VETERAN STATUS:

- **Vietnam Era Veteran: A person who served on active duty for a period of more than 180 days, any part of which occurred between August 5, 1965, and May 7, 1975, and was discharged or released with other than a dishonorable discharge; or was discharged or released from active duty for a service-connected disability, if any part of such active duty was performed between August 5, 1964 and May 7, 1975.**

- **Disabled Veteran: A person who is entitled to disability compensation under laws administered by the Veterans Administration for disability rated at 30 percent or more, or whose discharge or release from active duty was for a disability incurred or aggravated in the line of duty.**

LANGUAGES SPOKEN:

- **Primary and Other Languages: List only languages that you are fluent in verbally and in writing.**

The Central Registry of Offenders Against Individuals with Developmental Disabilities
Employee/Volunteer Consent for Employers to Check Form
N.J.A.C. 10:44D

Please Complete the Following Information:

Employee/Volunteer Last Name: _____ First Name: _____

Other Last/First Names Used: (please list any/all last names used, including maiden name, nicknames or other)

_____ _____ _____

D.O.B.: _____ Last Four (4) Digits of Social Security Number: _____

Agency/Facility Name: Easter Seals New Jersey - FIS

In accordance with *N.J.S.A. 30:6D-73 et seq.*, I understand that providing my employer/prospective employer with the above information is for the purpose of my employer/prospective employer conducting a check of my name/identity against the NJ Department of Human Services'(DHS) Central Registry of Offenders Against Individuals with Developmental Disabilities (Central Registry) for the purpose of working/volunteering at an agency/facility/program, licensed, regulated or contracted with the Department of Human Services.

I understand that while I am awaiting the results of the Central Registry check, I may not work unsupervised with individuals with developmental disabilities and that I must be accompanied by a senior staff member or supervisor in any activities involving individuals with developmental disabilities.

By signing this agreement, I attest that the information I have provided above is factual and correct and I can be terminated from employment/volunteering for failure to provide accurate information.

I further attest that I am currently not on the NJ DHS Central Registry of Offenders Against Individuals with Developmental Disabilities. I understand that if my name appears on the Central Registry, I may not be employed/allowed to volunteer in a program licensed, contracted or funded, directly or indirectly by the State of New Jersey to work with individuals with developmental disabilities.

I understand that also under *N.J.S.A. 30:6D-73 et seq.*, in my capacity as an employee, caregiver or volunteer, in a program or facility licensed, regulated or contracted with DHS, or receiving state funding directly or indirectly, I am required to immediately report any/all allegations of abuse, neglect and/or exploitation against an individual with a developmental disability to the NJ Department of Human Services and that failure to do so, while having reasonable cause to believe such an act was committed, constitutes a disorderly persons offense. I understand that when making such a report, in good faith, I am immune from any civil or criminal liability that might otherwise attach from the act of making the report. I understand that in situations of discrimination or discharge from employment as a result of making a report in good faith, I may seek court relief for such actions.

I further understand that I am required to cooperate with investigations conducted by DHS or its designee(s). I have read and understand the above and hereby give my consent for my name to be checked against the Department of Human Services, Central Registry of Offenders Against Individuals with Developmental Disabilities.

_____ _____ _____

Employee/Prospective Employee/Volunteer Name (please print) Signature Date

Provider Agency Use Only
The above named individual has been checked against the Central Registry of Offenders Against Individuals with Developmental Disabilities in accordance with N.J.A.C. 10:44D

*Registry Check Performed By:*_____ *Date:* _____ *Listed on Registry* *Yes*____ *No*____