Silver Lining
HOMECARE

Silver Lining Home Care is an agency that provides all our patients with quality, compassionate, and supportive services in an ethical manner.

Open 24 hours a day, 7 days a week
718-717-8337 | info@slcareny.com
1115 Avenue U, Brooklyn, NY 11223

"CDPAP APPLICATION "

DOCUMENTS REQUIRED FOR PA REGISTRATION:

(The following documents are required to be submitted and approved PRIOR working with the Consumer).
Please send SCANS of the following documents as PDF attachment to hr@slcareny.com or Fax to 718-717-8794

- Passport OR Green Card
- Social Security Card
- Direct Deposit
- Physical Form-signed, filled out by your doctor **(ATTACHED)**
- TB-Screen Form 2021 filled out, signed, and stamped **(ATTACHED)**
- PPD Test **(Less than 1 year old)** OR Quantiferon **(Less than 1 year old)** Lab Report OR Chest x-ray exam
- Drug Screen Lab Report **(Less than 1 year old)**
- Rubella and Rubeola Titer Laboratory Reports

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CDPAP EMPLOYMENT APPLICATION

Please Print clearly. This application must be completed and all questions regarding your training and work experience answered. All information on this application is confidential, SILVER LINING HOMECARE will not contact your present employer without your consent.

Name: (Last)	**(First)**	**(Middle Initial)**
Other name:(if appliifcable)	**Social Security #:**	
Address:		
City, State, Zip:		**Length of time at this address:**
Cell Phone: ( )	**Other: ( )**	
US Citizen: Yes No	**If no, Immigrant ID/Card:**	
DOB:	**Race:**	**Country of Birth:**
Height:	**Weight:**	**Eyes Color:**	**Hair Color:**
Position Applied for:	**Date Available:**	**Primary Language:**
Emergency Contact Name:	**Emergency Phone Number: ( )**	

EDUCATION/SCHOOLS ATTENDED	NAME OF SCHOOL AND ADDRESS	DID YOU GRADUATE	COURSE OR MAJOR	DIPLOMA OR DEGREE
HIGH SCHOOL				
COLLEGE				
GRADUATE SCHOOL				
BUSINESS SCHOOL				
AIDE TRAINING PROGRAM				

WORK HISTORY (PROVIDE 10 YEARS OF WORK HISTORY)

Name, Address and Phone # of Current/Former Employers	From: Mo/Yr	To: Mo/Yr	Job Title	Supervisor's Name	Salary	Reason for leaving

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Have you ever been bonded? Yes No	**If Yes, by Whom:**
Have you ever been refused a bond? Yes No	**If Yes, by Whom:**
Have you ever been convicted of a crime? Yes No	**If Yes, Explain:**

Professional Licenses:

Profession: **Lic.No:** **Exp. Date:** **Verification:**

Professional Licenses:

Profession: **Lic.No:** **Exp. Date:** **Verification:**

Para-Professional Certification: HHA PCA

School/Training Program: **Verification:**

Para-Professional Certification: HHA PCA

School/Training Program: **Verification:**

The information listed in my application is complete and true. I understand that if employed, false statements on this application are cause for dismissal. I will comply with all of the agency's rules and regulations regarding my employment. SILVER LINING HOMECARE may request information regarding my background which will include work and personal references.

Signature: **Date:**

SILVER LINING HOMECARE does not discriminate because of sex, age, physical handicap, race, creed or national origin. The agency is an equal opportunity employer.

WORK REFERENCES

NAME	Phone Number	RELATIONSHIP

OFFICE USE ONLY:

DATE OF HIRE:

STARTING DATE:

TITLE:

SALARY:

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EMPLOYEE HEALTH ASSESSMENT

Fax: (718) 717-8794

☐ Annual Assessment ☐Other:

Name: **SSN:**

Title: Marital Status: ☐ M ☐S ☐ W ☐ D | Sex: ☐ M ☐ F

Address:

City, State, Zip:

Emergency Name: **Phone:**

Emergency Address:

City, State, Zip:

INDICATE ILLNESS / CONDITIONS EXPERIENCED BY YOU:

CONDITION	YES	NO	CONDITION	YES	NO
DIABETES			WEIGHT GAIN/LOSS 15+ LBS.OR MORE		
KIDNEY DISEASE			CHANGE IN ENERGY LEVEL		
HEART DISEASE			CHEST PAIN/PRESSURE IN CHEST		
HIGH BLOOD PRESSURE			SWELLING IN LEGS AND FEET		
ARTHRITIS			PAIN IN CALF WHEN WALKING		
TUBERCULOSIS			CHANGE IN BOWEL HABITS		
MENTAL ILLNESS			BACK PAIN		
EPILEPSY/CONVULSIONS			PAIN WHEN URINATING/BLOOD IN		
CANCER			INFECTIOUS DISEASE		
MIGRAINE HEADACHES			INCREASED THIRST		
FAINTING OR DIZZINESS			PERSISTANT SORES OR LUMPS		

Do you smoke? ☐Yes ☐No if yes, how much?

Do you drink alcoholic beverages? ☐Yes ☐ No if yes, how much?

Do you take depressant, stimulant, narcotic drugs that alter your behavior? ☐ Yes ☐ No

Do you take prescription medications? ☐Yes ☐No if yes, which medications?

Name of your Physician:

Address: Telephone No:

I have read the above and declare that I have had no injury, illness or ailment other than as specifically identified. I certify that I am not habituated or addicted to any depressants, stimulants, narcotics, drugs, alcohol or other substances that may alter my behavior.

Signature: Date:

RN Signature: Date:

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EMPLOYEE PHYSICAL EXMINATION REPORT

Fax: (718) 717-8794

☐ **Pre-Employment Physical Assessment** ☐ **Annual Assessment** ☐ **Return to work/LOA** ☐ **Other:**

Name:	Marital Status: ☐M ☐S ☐W ☐	Sex: ☐ M ☐ F
Address	SS #:	Title:

PHYSICAL EXAMINATION

HEAD/ENT:	
EYES:	
NECK:	
BREASTS:	
LUNGS:	
CARDIOVASCULAR:	
MUSCULOSKELETAL:	
ABDOMEN:	
GENITOURINARY:	
CENTRAL NERVOUS SYSTEM:	
COMMENTS:	

HT:	WT:	B/P:	PULSE:	RESP:	TEMP:

LABORATORY TEST RESULTS — PLEASE ATTACH LAB REPORTS

TEST	DATE	RESULTS PROVIDE LAB VALUES AND INTERPRETATION	
RUBELLA TITER		☐NON-IMMUNE ☐IMMUNE	**LAB VALUE:**
MEASLES TITER		☐NON-IMMUNE ☐IMMUNE	**LAB VALUE:**
PPD (ANNUALLY)	1. DATE IMPLANTED	1. DATE READ:	RESULTS (mmxmm):
	2. DATE IMPLANTED	2. DATE READ:	RESULTS (mmxmm):
CHEST X-RAY (+PPD)	Date:	Results:	
QUANTIFERON Tb-Gold	Date:	Results:	
DRUG SCREENING	Date:	Results:	

IMMUNIZATIONS:	**DATE**	**DATE**	**DATE**
RUBELLA	1.		
RUBEOLA/MEASLES	1.	2.	
HEPATITIS B VACCINE	1.	2.	3.

☐ **This individual is free from any health impairment that is a potential risk to the patient or other employee or which may interfere with the performance of his/he duties including the habituation or addiction to drugs or alcohol.**

☐ **This individual is able to work with the following limitations:**

☐ **This individual is not physically/mentally able to work.** ***(specify reason):***

Physician Signature: **Lic. No.** **Date:**

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TB SCREEN

Fax: (718) 717-8794

Employee Name: _____ Evaluation Date: _____

Silver Lining Homecare Agency requires an annual screening questionnaire is to be completed by a physician. If the employee has experienced any of the following symptoms, a chest x-ray is indicated.

1.	Chronic Cough	☐ Yes	☐ No
2.	Fever	☐ Yes	☐ No
3.	Night Sweat	☐ Yes	☐ No
4.	Unexplained Weight Loss	☐ Yes	☐ No
5.	Hemoptysis (coughing up blood)	☐ Yes	☐ No
6.	Hoarseness	☐ Yes	☐ No
7.	Wheezing	☐ Yes	☐ No
8.	Shortness of Breath	☐ Yes	☐ No
9.	Chest Pains	☐ Yes	☐ No

According to the Center for Disease Control & Prevention an initial chest x-ray needs to be completed for any person with a positive PPD-test, and pulmonary symptoms suggestive of TB. Although there are no data to support the use of a routine chest x-ray for persons who are asymptomatic, more frequent monitoring of TB should be considered for those who are at increased risk for development of active TB.

Silver Lining Homecare Agency requires a chest x-ray to be completed and on file within 30 days of any newly reported positive PPD result and every 10 years thereafter.

Physician / RN Name: _____

Physician / RN Signature: _____

LICENSE # _____ Date of Chest X-ray: _____

Doctor / RN Stamp below:

Essentially, repeated chest x-ray of asymptomatic tuberculin reactors, whether or not they have completed preventative therapy, is not longer recommended. DOH publication (FDS) 83-82-4

"CDC Personal Health Guideline" AJIC, June 1998m Volume 26, p.318. Revised 12/8/2016

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RUBEOLA IMMUNITY

Employee: **SS#:**

Rubeola Immunity titer/vaccination is not required for this employee as he/she was born prior to 1/1/57.

_____ _____

Signature/Title **Date**

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HEPATITIS B VACCINATION PROGRAM

☐ ALREADY IMMUNIZED

I have already received the Hepatitis B Vaccine.

☐ NO

As an employee of Silver Lining Homecare Agency, Inc., I understand that due to my occupational exposure to blood and or other potentially infectious materials, that I may be at risk of acquiring a Hepatitis B (HBV) infection. At this time, I refuse to have the vaccination and I will follow–up with my physician for testing and/or vaccination, should I so desire. I understand that my refusal to be vaccinated, does not waive any of my employee rights.

☐ NO

I have tested positive for Hepatitis B and therefore, refuse the vaccination.

☐ YES

I request to be given the Hepatitis B vaccine at no charge to me. I understand that if for some reason, I do not complete the series of (3) injections- as determined by the manufacturer's recommendations – then Silver Lining Homecare Agency, Inc., will not be responsible for the series to be re-administered.

Print Name: _____ **Date:** _____

Signature: _____

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Influenza Vaccination Policy for Direct Care Positions

Employee's Name: _____

I have been advised that I should receive the influenza vaccine to protect myself and the patients I serve. I have read the Centers for Disease Control and Prevention's (CDC) Vaccine Information Statement explaining the vaccine and the disease it prevents. I have had the opportunity to discuss the statement and have my questions answered by a healthcare provider. I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare personnel to protect this facility's patients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.
- If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't, my immunity declines over time. This is why vaccination against influenza is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including all patients in this healthcare facility, coworkers, my family and my community.
- **If I choose not to get vaccinated against influenza, I will be required to wear surgical or procedure masks in areas where patients or residents may be present during the influenza season.**

I acknowledge that I have read this document in its entirety and fully understand it.

☐ I understand the benefits and risk associated with the influenza vaccine. I also understand it is not possible to predict all the possible side effects/complications associated with the vaccine. I will obtain the influenza vaccine

☐ I have decided to decline the influenza vaccine by my signature below. I realize that I may re-address this issue at any time and obtain vaccination in the future

Signature: _____ **Date:** _____

Form **W-4**
(Rev. December 2020)
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

2021

Step 1: Enter Personal Information

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

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

TIP: To be accurate, submit a 2021 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Step 3: Claim Dependents

If your 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 and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)
Silver Lining Homecare Agency 1115 Avenue U, Brooklyn NY 11223		47-4769909

NEW YORK STATE OF OPPORTUNITY.

Notice and Acknowledgement of Pay Rate and Payday Under Section 195.1 of the New York State Labor Law for Home Care Aides Wage Parity and Other Jobs

1. Employer Information

Name:

Silver Lining Homecare Agency

Doing Business As (DBA) Name(s):

FEIN (optional):

Physical Address:
1115 Avenue U,
Brooklyn NY 11223
Mailing Address:

Phone: **718-717-8337**

2. Notice given:

- [x] At hiring
- [ ] Before a change in pay rate(s), allowances claimed or payday

Note: Live-in employees must be paid at least 13 hours for each 24 hour period, provided they receive 8 hours of sleep, with five hours of uninterrupted sleep and 3 hours off for meals. If an employee does not receive 5 hours of uninterrupted sleep, the employee must be paid for all 8 hours. If the employee does not receive meal periods free from duty, the employee must be paid for all 3 hours designated for meals.

3. Employee's Rate(s) of Pay for Each Type of Work Shift:

$15 per hour for PCA, HHA or PA Case
$17 per hour for Holiday
$_____ per hour for _____

3a. Wage Parity Rates:

$15 per hour for regular wage
$_____ per hour for additional wage
$4.09 per hour for supplemental wages*

4. Allowances:

- [x] None
- [ ] Tips _____ per hour
- [ ] Meals _____ per meal
- [ ] Lodging _____
- [ ] Other _____

5. Regular Payday: Friday

6. Pay is:

- [x] Weekly
- [ ] Bi-weekly
- [ ] Other: _____

7. Overtime Pay Rate(s) for each type of work or shift:

Overtime pay will be paid for hours worked above 40.
Overtime rates will be 1.5 times the worker's regular rate of pay.
For employees with multiple rates of pay in a week, overtime will be 1.5 times the weighted average of those multiple rates of pay.

8. Employee Acknowledgement:

On this date, I have been notified of my pay rate, overtime rate (if eligible), allowances, supplements and designated payday. I told my employer what my primary language is.

Check one:

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

_____
Print Employee Name

_____
Employee Signature

_____
Date

_____
Preparer's Name and Title

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

Please note: It is unlawful for an employee with protected class status to be paid less than an employee without protected class status, if they are performing substantially equal work. Employers also may not prohibit employees from discussing wages with their co-workers.

*Attach Wage Parity supplement notification page 2.

LS 62 Notice to Wage Parity Home Care Aides - (cont'd)
Benefit Portion of Minimum Rate of Home Care Aide Total Compensation

	Hourly Rate	Type of Supplement	Name & Address of Provider	Agreement/ Plan Information
Supplement Number	*$ XXX*	*(Pension, Welfare, or Other)*	*Insert Name and Address of Company or Organization Providing Benefit*	*Identify plan or agreement that creates the benefit, e.g., Union Local No. 1 Collective Bargaining Agreement or Insurance Company X Benefit Plan*
Supplement Number 1	$ 1.00	PTO	Silver Lining Homecare Agency 1115 Avenue U, Brooklyn NY 11223	PTO Policy
Supplement Number 2	$ 3.09	Flex Benefit Card (medical / vision / dental / child care / commuter benefits / cell phones)	FBA of Syosset, LLC 100 Quentin Roosevelt Blvd, Suite 403 Garden City, NY 11530	Master Services Agreement Between Silver Lining Homecare Agency and FBA of Syosset, LLC
Supplement Number 3				

** WP benefits reflected in the chart will not accrue on an hourly basis for any hours worked on a non-wage parity case, such as a CHHA case. However, sick time will accrue at the rate of 1 hour for every 30 hours worked up to the maximum of 56 hours per year.*

List any additional benefits and attach listing to this document.

Copies of the above listed agreements or summaries may be obtained by:

Contact Silver Lining Homecare Agency's HR Department at 718-717-8337

Employee Acknowledgement:

On this day I have been notified of my pay rate, overtime rate, allowances, supplements/benefits, and designated payday provided on this form (LS 62) attached and this addendum on the date given below.

My primary language is _____. I have been given this notice in my primary language ☒ Yes ☐ No.

Employee Name (Print): _____

Employee Signature: _____ Date Signed: _____

Preparer's Name and Title: _____

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

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

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

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

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

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

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

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

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

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

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

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
Arsenieva	Polina	Silver Lining Homecare Agency

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code
1115 Avenue U	Brooklyn	NY	11223

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

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

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

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

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

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

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

Refer to the instructions for more information about acceptable receipts.

Silver Lining HOMECARE

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1115 Avenue U, Brooklyn, NY 11223

Personal Assistant Acknowledgement of receipt of POLICY PERTAINING TO FALSE CLAIMS AND FALSE STATEMENT

1. I acknowledge that I have received a copy of the SILVER LINING HOMECARE POLICY PERTAINING TO FALSE CLAIMS AND FALSE STATEMENT.
2. I have been informed by my Consumer or Designated Representative regarding the policy for Federal and State False Claim Act and False Claims.

PA Signature_____ **Date** _____

Corporate Compliance Education Acknowledgement Form

This is to certify that I _____ (Print Employee Name) have received Corporate Compliance Training and Educational Materials from my Consumer enrolled in the SILVER LINING HOMECARE. pertaining to the Federal False Claims Act, New York False Claims Act, Whistleblower Protection and Identifying Fraud and Abuse Law, as well as where to report these issues should be suspected or uncovered.

PA Signature_____ **Date** _____

SILVER LINING HOMECARE HIPAA ACKNOWLEDGMENT

I have been informed regarding HIPAA Privacy Rules by as provided to me by SILVER LINING HOMECARE and I acknowledge compliance with these rules as per N.Y.S. mandate.

I understand that the major goal of the privacy rule is to assure that all out Consumers health information is properly protected, while allowing the flow of vital healthcare/clinical information to all employees participating in providing patient care/services, as such, we can provide and promote high quality safe and effective home health care.

SILVER LINING HOMECARE also protects the public's health and they well-being by implementing disciplinary action upon notifications on any HIPAA violations by our employees.

PA Attestation to Comply with CDPAP Regulation

1. I understand that it is against the New York State CDPAP regulations to work as a Personal Assistant in the SILVER LINING HOMECARE if I am a spouse or parent of the Consumer.
2. I agree to complete a pre-employment physical before I begin work and then annually.
3. I am not the Designated Representative of the Consumer enrolled in the SILVER LINING HOMECARE

4. I am not an employment of SILVER LINING HOMECARE agent or affiliated individual.

5. I understand that I must inform SILVER LINING HOMECARE If my relationship with the Consumer changes.

6. I understand that I must not work for a Consumer who is in the Hospital or Nursing Home or other health related facility other than the Consumers Home.

7. I understand that I must inform SILVER LINING HOMECARE if I am related to a Consumer other than a parent or spouse enrolled on the SILVER LINING HOMECARE

a. Do you reside in the home of the Consumer? **Yes_____No_____**

b. Are you related to the Consumer by blood, marriage or adoption? **Yes___No___** If yes, identify what is your relationship is _____

8. I have received my photo identification card and will wear it all times while Care Connect for the Consumer. I also agree to return my photo identification card upon termination of employment.

PA Signature_____ **Date** _____

The Personal Assistant's Guide to The Consumer Direct Personal Assistance Program
Acknowledgement of receipt of Information

I have received, read and understand my role and responsibility as Personal Assistant working for a Consumer of his/her Designated Representative participating in the SILVER LINING HOMECARE I have had an opportunity to ask questions concerning my wage and benefit package. I understand that SILVER LINING HOMECARE is the Fiscal Intermediary and is responsible for processing on behalf of the Consumer, the payroll and benefit administration for the PA. I understand that SILVER LINING HOMECARE is a joint employer with the Consumer. I understand that I am hired, trained, supervised and receive my schedule by the Consumer and/or their Designated Representative. I also understand, it is the Consumer or Designated Representative who can terminate my services or dismiss me from working for them if they choose to do so.

I have read all the above statements and will comply with these requirements. I also understand that failure to abide by the rules stated above could considerate Medicaid Fraud and could subject me to investigation and possible criminal prosecution by the Office of the Attorney General Medicaid Fraud Control unit, and the Medicaid Inspector General.

PA Signature_____ **Date** _____

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PAID TIME OFF POLICY

Purpose: To provide home health aides, personal care aides, and personal assistants ("Aides") who work for Silver Lining (the "Company") with paid time off that will meet the requirements of New York State and New York City Paid Sick Leave Law and the Wage Parity Law (collectively, the "Laws").

Coverage: All Aides will be covered by this policy.

Effective Date: September 30, 2020. This policy replaces the previous Paid Time Off policy.

Accrual Rates: Accrual of PTO will begin with the first worked shift/hours of work. Aides will accrue one (1) hour of paid time off ("PTO") for every 15 hours worked. Unless otherwise prohibited by law, PTO pursuant to this policy will accrue for every hour worked, until the Aide reaches 56 hours of accrual during a calendar year. Once 56 hours of PTO have been accrued, Aides will accrue PTO only during the first 40 hours of work each week. Thus, in such a case, no accrual of PTO will be done for work time exceeding 40 hours.

Any PTO accrued by an Aide who had been employed and working for the Company prior to September 30, 2020 ("Existing Aide") may be used through December 31, 2020. Effective September 30, 2020, Existing Aides will accrue PTO in accordance with this policy. Existing Aides who have accrued and unused PTO as of 11:59 p.m. on December 31, 2020 will have their PTO hours "carried over" to 2021. Earned and unused PTO by such Aides will not be paid out upon the year's end; instead it will carry over and be available to the Aide for use in the following calendar year.

Aides who are hired on September 30, 2020 or thereafter ("New Aide") will begin to accrue PTO under this policy upon hire. New Aides may use accrued PTO upon accrual; there will be no waiting period to use PTO.

The above accrual rates will not apply for hours that are private pay nonwage parity hours. For such hours of work, the Aide will accrue at least 1 hour of PTO for every 30 hours worked, for a total and maximum of 56 hours per year. The remainder of this policy including, but not limited to the provisions regarding the scope of use of accrued paid time hours, carry-over, and rights upon termination will apply to paid time off that is earned during private pay nonwage parity hours.

In accordance with the Laws, the hourly rate of PTO accruals will be stated on Aides' paystubs.

Definitions:

The following terms will have the defined meaning under this policy:

1. "Year" means the calendar year.

2. "PTO" means paid time off that is granted to the Aide. The PTO under this policy may be used for any reason permitted by the Westchester County Paid Sick Leave Law, New York City Safe and Sick Leave, Domestic Worker Bill of Rights, and New York State Paid Sick Leave Law.

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3. "Family Member" includes an Aide's child, grandchild, current or former spouse, current or former domestic partner, parent, sibling, or grandparent, a child or parent of an Aide's spouse or domestic partner, any other individual related by blood to the Aide, and any other individual whose close association with the Aide is the equivalent of a family relationship.

4. "Parent" means a biological, foster, step or adoptive parent or a legal guardian of an Aide or a person who stood in loco parents when the Aide was a minor child.

5. "Child" means a biological, adopted or foster child, a legal ward, or a child of an Aide standing in loco parentis.

Permitted Uses of PTO: Time accrued under this policy may be used for vacation, travel, and leisure time. In addition, PTO accrued under this policy may be used for:

1. The Aide's own mental or physical illness, injury, or health condition, need for medical diagnosis, care, or treatment of a mental or physical illness, injury, or health condition, or need for preventive medical care ("Sick Time").
2. Care of a family member who needs medical diagnosis, care, or treatment of a mental or physical illness, injury, or health condition or needs preventive medical care (also, "Sick Time").
3. Closure of the Aide's place of business by order of a public official due to a public health emergency or such Aide's need to care for a child whose school or childcare provider has been closed by order of a public official due to a public health emergency.
4. An absence due to any of the following reasons when the Aide or the Aide's family member has been the victim of a family offense matter, sexual offense, stalking, or human trafficking ("Safe Time"):
    a. to obtain services from a domestic violence shelter, rape crisis center, or other shelter or services program for relief from a family offense matter, sexual offense, stalking or human to trafficking; participate in safety planning, temporarily or permanently relocate, or take other actions to increase the safety of the Aide or Aide's family members from future family offense matters, sexual offenses, stalking or human trafficking;
    b. to meet with a civil attorney or other social service provider to obtain information and advice on, and prepare for or participate in any criminal or civil proceeding, including but not limited to, matters related to a family offense matter, sexual offense, stalking, human trafficking, custody, visitation, matrimonial issues, orders of protection, immigration, housing, discrimination in employment, housing or consumer credit;
    c. to file a complaint or domestic incident report with law enforcement;
    d. to meet with a district attorney's office;
    e. to enroll children in a new school; or
    f. to take other actions necessary to maintain, improve, or restore the physical, psychologic, or economic health or safety of the Aide or the Aide's family member or to protect those who associate or work with the Aide.

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Increments of Leave: PTO accrued and used under this policy may be used in increments of 30 minutes or higher.

Notice of Leave Related to PTO: Aides must give as much notice as practical under the circumstances for use of PTO. Where PTO will be used as vacation time, Aides must submit a request in writing at least two weeks in advance of the first day off from work.

Where PTO will be used as Safe Time or Sick Time, Aides must provide no less than 7 calendar days' notice for foreseeable or pre-scheduled absence. However, where it is not feasible to give advance notice, the Aide must notify his or her coordinator as soon as practicable in the circumstances that the Aide will be absent. Failure to give proper notice, where notice is possible, may result in denial of the leave or disciplinary action. Texting a supervisor regarding an absence is not acceptable. The Company reserves the right to request documentation regarding leave related to Safe Time or Sick Time, where permitted by Law.

Confidentiality Related to Safe and Sick PTO: The Company will not require the disclosure of details relating to an Aide's or his or her family member's medical condition or require the disclosure of details relating to an Aide's or his or her family member's status as a victim of family offenses, sexual offenses, stalking, or human trafficking as a condition of providing Sick Time or Safe Time.

Health information about an Aide or an Aide's family member, and information concerning an Aide's or his or her family member's status or perceived status as a victim of family offenses, sexual offenses, stalking or human trafficking obtained solely for the purposes of utilizing leave under this policy will be treated as confidential and will not be disclosed except by the affected Aide, with the written permission of the affected Aide or as required by law.

Carry-Over and Forfeiture of Earned and Unused PTO: Accrued and unused PTO will not be paid out at the end of the Year. Instead, all accrued and unused PTO will carry over from one Year to the next. There is no limit on the annual usage of earned PTO; any PTO that has been earned and accumulated by an Aide may be used in totality in any given calendar year. The Company, however, will not advance any PTO to Aides who have not earned or who have exhausted all their accumulated PTO.

All accrued and unused PTO will not be paid out upon termination of employment, regardless of the reasons for said termination. Therefore, Aides are strongly encouraged to use up their PTO benefit while employed.

Anti-Retaliation: No Aide will be subjected to any adverse employment action as a result of requesting or utilizing PTO as Safe Time or Sick Time. The Company will not utilize an Aide's usage of Safe Time or Sick Time as a motivating factor in any adverse employment action.

Discipline: Failure to adhere to the terms of this policy may result in discipline, including termination. Each case of suspected violations will be investigated by the Company. Aides, where appropriate, will be given an opportunity to provide a statement related to their adherence to this policy. The Company will make a determination on the proper course of action with respect to each Aide, based on the totality of circumstances.

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Relationship to Other Leaves: Aides on a leave of absence pursuant to federal, state, or local law may be required to use any accrued PTO for such absences. PTO will not accrue for any Aide who is on an unpaid leave of absence.

Questions: If you have any concerns or questions about this policy, please contact our HR Department at **718-717-8337**

By signing below, I confirm that I have received this PTO policy, that I understand the PTO policy, and that I will comply with its terms as a condition of my initial or continued employment with the Company.

_____
Name of Caregiver

_____
Signature of Caregiver

_____
Date

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THE PERSONAL ASSISTANT'S GUIDE TO THE CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM

ACKNOWLEDGEMENT OF RECEIPT

I have received the Personal Care Assistant's guide and I have chosen to participate in the CDPAP as a Personal Care Assistant. I understand that Silver Lining Homecare, Inc. is a Fiscal Intermediary and I am hired, supervised, scheduled and trained by the consumer and/or designated representative.

Print Name: _____

Signature: _____ Date: _____

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ACKNOWLEDGEMENT

I acknowledge receipt of the Agency's "Sleep and Meal Period Policy for Employees on Duty for 24 Hours or More," together with the Sleep and Meal Period Exception Certification Form, and by my signature below, I hereby agree to the terms and conditions set forth in this policy. I specifically and expressly agree that I will follow this policy and will notify my coordinator any time I work a shift of 24-hour or more and: (1) I am unable to enjoy a total of at least 3 hours of Bona Fide Meal Periods; (2) I am unable to enjoy at least an 8-hour Bona Fide Sleep Period; or (3) the sleeping facilities in the patient's home are inadequate.

_____ _____

Signature **Date**

_____

Print Name

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ACKNOWLEDGEMENT

By signing below, You confirm that You have read and understand the terms and conditions of the FAIR Program, which require You to submit all Claims to binding arbitration on an individual basis.

_____ _____

Signature **Date**

_____

Print Name

Silver Lining
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ACKNOWLEDGEMENT

Silver Lining Homecare Agency has provided me with written notice of my rights under the Human Rights Law, by signing below I acknowledge the receipt of the Sexual Harassment Policy and "STOP SEXUAL HARASSMENT ACT FACTSHEET"

_____ _____

Signature **Date**

_____

Print Name

Silver Lining
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Medical Coverage Waiver Form

I was offered the Health insurance plan offered by my employer.

I understand that I must pay __$35/week__ for this coverage which is within __9.50%__ of my income. Although it is affordable, I choose not to enroll.

I am declining coverage for the following reason:

__ I am covered with Medicaid or another Govt Program

__ I have coverage through my spouse

__ I have coverage through another employer

__ Other reason _____

_____ _____

Signature **Date**

_____

Print Name

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The Personal Care Assistant's Guide to the Consumer Directed Personal Assistance Program (CDPAP)
Fiscal Intermediary for the Consumer Directed Personal Assistance Program

Personal Care Assistant Transportation (sign one)

I will provide Silver Lining Homecare Agency, Inc. with my driver's license and insurance card in order to transport my patient in my car and/or the patient's car.

_____ _____

Personal Care Assistant Signature **Date**

OR

I will not be transporting my patient in my car and/or my patient's car.

_____ _____

Personal Care Assistant signature **Date**

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The Personal Care Assistant's Guide to the Consumer Directed Personal Assistance Program (CDPAP)
Fiscal Intermediary for the Consumer Directed Personal Assistance Program

Agreement between Silver Lining Homecare Agency, Inc. and Personal Care Assistant Live-In

1. All personal care assistants (PCA's) assigned to live-in cases are to be present in the consumer home for 24 hours each working day.

2. During each live in day, based on a 13-hour day, PCA's are to perform tasks in accordance with the verbal or written care plan.

3. **PCA's may not work in excess of 13 hours in any day and no more than 6 live in days per week.**

4. During each 24-hour day, PCA's are to take eleven hours for personal time which will include hours of sleep, meal breaks and other personal time, remaining on premises at all such times.

8 hours of sleep time
2-hour meal breaks
1 hour of personal time – reading, watching television, etc.

5. If any PCA finds it impossible to take the specified breaks from work duties because such times are constantly interrupted by the needs of the patient, she/he must call the administrator and Silver Lining Homecare Agency, Inc.

I understand and will abide by the agency's rules stated in this agreement regarding time worked on live-in cases.

_____

Signature

_____

Print Name

_____

Tel: 718-717-8337 1115 Avenue U, Brooklyn, NY 11223 Fax: 718-717-8794

SILVER LINING HOMECARE AGENCY AIDE TIME AND ACTIVITY REPORT

PATIENT: **Week Ending:**

EMPLOYEE: Social Security No:

	DATE	TIME IN	TIME OUT	HOURS	EMPLOYEE SIGNATURE	CLIENT/REPRESENTATIVE SIGNATURE
Sun						
Mon						
Tue						
Wed						
Th						
Fri						
Sat						
			TOTAL			

TASK / ACTIVITY	Sun	M	T	W	Th	F	Sat
Universal Precautions							
Supervise Safety of Patient							
PERSONAL CARE : ☐ Bed ☐ Tub ☐ Shower							
Hair Care ☐ Shampoo ☐ Comb/Brush							
☐ Shave ☐ Nail care (DO NOT CUT NAILS) ☐ Foot Care							
☐ Oral Hygiene/Mouth Care ☐ Denture Care							
☐ Skin Care: ☐ Lotion ☐ Other:							
☐ Dressing: ☐ Total ☐ Assist							
☐ Meals ☐BF ☐Lunch ☐Dinner ☐Snack							
☐ Assist/Feed Patient							
☐ Ambulation ☐Assist ☐Cane ☐Walker ☐ W/C							
☐ Transfer ☐ Bed ☐ Chair							
☐ ROM ☐ Turn Q2hours ☐ Ostomy/Catheter Care							
☐ Non-Sterile Dressing (HHA ONLY)							
☐ Medications ☐Assist ☐Remind							
☐ Observe/Report Physical/Mental Changes							
☐ Record ☐Intake ☐ Output (HHA ONLY)							
☐ Record Temperature ☐ Record Wt (HHA ONLY)							
☐ Toileting ☐ Toilet ☐ Commode ☐ Urinal/Bedpan							
☐ Incontinent ☐ Bowel ☐ Bladder ☐ Diapers							
☐ Bladder Training ☐ Bowel Training							
☐ Exercise Program: (As per PT Inst.) (HHA ONLY)							
HOUSEHOLD							
☐ Light Dusting ☐ Light Vaccuming ☐ Wet Mop							
☐ Bathroom ☐ Patient Area							
☐ Kitchen ☐ Clean Stove ☐ Clean Refrigerator							
☐ Linen Change ☐Laundry							
☐ Shopping/Errands ☐ Escort to Appointments							

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SILVER LINING HOMECARE AGENCY AIDE TIME AND ACTIVITY REPORT

PATIENT: **Week Ending:**

EMPLOYEE: Social Security No:

	DATE	TIME IN	TIME OUT	HOURS	EMPLOYEE SIGNATURE	CLIENT/REPRESENTATIVE SIGNATURE
Sun						
Mon						
Tue						
Wed						
Th						
Fri						
Sat						
			TOTAL			

TASK / ACTIVITY	Sun	M	T	W	Th	F	Sat
Universal Precautions							
Supervise Safety of Patient							
PERSONAL CARE : ☐ Bed ☐ Tub ☐ Shower							
Hair Care ☐ Shampoo ☐ Comb/Brush							
☐ Shave ☐ Nail care (DO NOT CUT NAILS) ☐ Foot Care							
☐ Oral Hygiene/Mouth Care ☐ Denture Care							
☐ Skin Care: ☐ Lotion ☐ Other:							
☐ Dressing: ☐ Total ☐ Assist							
☐ Meals ☐BF ☐Lunch ☐Dinner ☐Snack							
☐ Assist/Feed Patient							
☐ Ambulation ☐Assist ☐Cane ☐Walker ☐ W/C							
☐ Transfer ☐ Bed ☐ Chair							
☐ ROM ☐ Turn Q2hours ☐ Ostomy/Catheter Care							
☐ Non-Sterile Dressing (HHA ONLY)							
☐ Medications ☐Assist ☐Remind							
☐ Observe/Report Physical/Mental Changes							
☐ Record ☐Intake ☐ Output (HHA ONLY)							
☐ Record Temperature ☐ Record Wt (HHA ONLY)							
☐ Toileting ☐ Toilet ☐ Commode ☐ Urinal/Bedpan							
☐ Incontinent ☐ Bowel ☐ Bladder ☐ Diapers							
☐ Bladder Training ☐ Bowel Training							
☐ Exercise Program: (As per PT Inst.) (HHA ONLY)							
HOUSEHOLD							
☐ Light Dusting ☐ Light Vaccuming ☐ Wet Mop							
☐ Bathroom ☐ Patient Area							
☐ Kitchen ☐ Clean Stove ☐ Clean Refrigerator							
☐ Linen Change ☐Laundry							
☐ Shopping/Errands ☐ Escort to Appointments							

Tel: 718-717-8337 timesheets@slcareny.com Fax: 718-717-8794

If you have a problem:

1. Re-read this instruction manual and attempt to re-enter your Clock In or Out

2. If that does not work, do not give up. ***YOU WILL NOT BE CLOCKED IN/OUT.***

3. Contact your manager at the agency. Write their contact information below for reference.

Manager Name:

Manager Phone Number:

HHA eXchange

Clock In and Out Instructions

Silver Lining Homecare Agency

Dial:

English: 646-813-5206
Russian: 646-813-5207

TO CALL IN

1. From the patient's home phone, dial the number on the cover of this guide.
2. Press 1 to Call In.
3. Enter your Assignment ID.
4. Confirm the entry.

   *- If you enter your number **INCORRECTLY**, you will be asked to retype your Assignment ID again. If you fail to enter a valid Assignment ID after multiple attempts you not be able to Call In. Contact your agency.*

   *- If you enter your Assignment ID **CORRECTLY** you will hear:*

5. Your call has been successfully registered.

Write your Assignment ID below for reference.

TO CALL OUT

1. From the patient's home phone, dial the number on the cover of this guide.
2. Press 2 to Call Out.
3. Enter your Assignment ID.
4. Confirm the entry.

   *- If you enter your number **INCORRECTLY**, you will be asked to retype your Assignment ID again. If you fail to enter a valid Assignment ID after multiple attempts you not be able to Call In. Contact your agency.*

   *- If you enter your Assignment ID **CORRECTLY** you will hear:*

5. Enter the 3-digit ID # for the first duty performed for the first patient.

   *- If you enter an **INVALID DUTY ID**, you will be told so and asked to enter the next Duty ID.*

   *- If you enter a **VALID DUTY ID**, you will be asked to enter the next Duty ID.*

6. Enter each Duty ID. When finished, type 000.

The system will say:

Your Call-Out has been registered successfully. Goodbye.

SPECIAL SCENARIOS

If you are calling for a shared (Mutual) case (two Patients at once):

1. Follow the calling instructions on the left.
2. You will clock **IN** *ONCE* at the beginning of the visit, and clock out ONCE at the end of the visit.
3. When you clock **OUT**, first enter the duties for the primary patient and then enter 000.
4. Enter the duties for the secondary patient and again enter 000.
5. The system will then complete the clock-out

If you are calling for a Live-In:

1. Follow the calling instructions on the left.
2. You will clock **IN** *ONCE* when you first arrive with the Patient.
3. Each day after, you will only clock **OUT.**
4. The system will ask for duties and clock you **OUT** for yesterday, and automatically clock you **IN** for today

Silver Lining
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Silver Lining Home Care is an agency that provides all our patients with quality, compassionate, and supportive services in an ethical manner.

CDPAP Employee Welcome Package

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Silver Lining HOMECARE

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The Personal Care Assistant's Guide to the Consumer Directed Personal Assistance Program (CDPAP)

TERMS OF SERVICE

BETWEEN THE Silver Lining Homecare Agency, Inc. (Fiscal Intermediary) AND CONSUMER/DESIGNATED REPRESENTATIVE

The purpose of the CDPAP is to allow chronically ill and/or physically disabled individuals receiving home care services under the Medical Assistance program greater flexibility and freedom of choice in obtaining such services. In order to participate in the CDPAP it is important that the consumers clearly understand their roles and responsibilities.

RESPONSIBILITIES OF THE FISCAL INTERMEDIARY

The fiscal intermediary shall have the following responsibilities:

Process each CDPA's wages and benefits including establishing the amount of each assistant's wages and benefits; process all income tax and other required wage withholdings; and comply with workers' compensation, disability and unemployment insurance requirements.

Ensure that the health status of each consumer directed personal assistant is assessed pursuant to 10 NYCRR § 766.11(c) and (d) or any successor regulation.

Maintain records for each CDPAP which shall include, at a minimum, time records, the CDPA health assessments required pursuant to 10 NYCRR § 766.11(c) and (d) or any successor regulation, and the information needed for payroll processing and benefit administration.

Maintain records for each consumer, including copies of the authorizations, reauthorizations, and the contracts between the consumer and the FI.

Obtain a signed agreement with consumer outlining consumer's responsibilities as contained in 18 NYCRR § 505.28. Use best efforts to notify the MCO if the FI becomes aware that the consumer has been admitted to a higher level of care such as an inpatient hospital or skilled nursing facility. Monitor enrollment in MCO on the 1st and 15th of each month; provided, however, that such monitoring on the part of the FI shall not relieve the MCO of the MCO's responsibility to notify the FI in the event of a consumer's disenrollment in the MCO or in the event of a determination that the consumer is no longer authorized to participate in the CDPAP program.

Monitor the ability of the consumer, or the ability of the consumer's designated representative, if applicable, to fulfill the consumer's responsibilities under the consumer directed personal assistance program and notify the MCO promptly in the event that the FI becomes aware of any circumstances that may affect the ability of the consumer, or that of the consumer's designated representative, if applicable, to fulfill such responsibilities.

Comply with applicable NYSDOH regulations regarding the responsibilities of providers enrolled in the medical assistance program.

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Enter into an Agreement with the consumer that stipulates that the consumer and, as applicable, the consumer's designated representative shall be solely responsible to the following responsibilities:

RESPONSIBILITIES OF THE CONSUMER/DESIGNATED REPRESENTATIVE

The Consumer/Designated Representative shall have the following responsibilities:

Understand the purpose of the CDPAP and the responsibilities of the LDSS, fiscal intermediary and consumer/designated representative.

Be responsible for recruiting, hiring, training, supervising, scheduling and terminating the qualified individual of their choosing in adequate numbers to meet their needs.

Maintain an appropriate home environment and provide training as necessary.

Review the plan of care with each personal assistant (PA) outlining their responsibilities and ensure that the PA only performs the tasks identified on the plan of care during authorized hours.

Comply with Labor Laws, providing equal employment opportunities as specified in the Consumer's agreement with the CDPAP fiscal intermediary.

Inform the LDSS and the fiscal intermediary of any change in status or condition, including but not limited to; hospitalizations, address and telephone number changes.

Assure the accurate and timely submission of the PA's required paperwork to the CDPAP fiscal intermediary including time sheets, annual worker health assessments, and required employment documents.

Develop and maintain a contingency plan to assure adequate supports are available to meet needs.

Ensure that each PA has submitted timecards reflective of hours worked within the weekly authorized hours by signing timesheet.

Distribute paychecks to each PA, if applicable.

Cooperate with the LDSS and comply with Medicaid Program requirements to be available for the required reassessment.

Consumer and, as applicable, the consumer's designated representative shall be solely responsible to:

Manage the plan of care authorized by the MCO, including recruiting and hiring a sufficient number of CDPAs to provide authorized services as set forth in the plan of care authorized by the MCO; training, supervising and scheduling each CDPA; terminating the CDPA's employment with the consumer; and assuring that each CDPA completely and safely performs the personal care services, home health aide services and skilled nursing tasks included on the consumer's MCO approved plan of care;

Notify the MCO within 5 business days of any changes in the consumer's medical condition or social circumstances including but not limited to, any hospitalization of the consumer or change in the consumer's address or telephone number;

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Timely notify the FI of any changes in the employment status of each CDPA;

Attest to the accuracy of each time record for each CDPA;

Transmit the CDPA's time records to the FI according to the FI's policies and procedures;

Timely distribute each CDPA's paycheck, if needed;

Arrange and schedule substitute coverage when a CDPA is temporarily unavailable for any reason;

Acknowledge and agree that: (1) any person who receives, directly or indirectly, an overpayment from the Medicaid program is obligated to report and return the overpayment, within sixty days of the identification of the overpayment. Failure to do so may expose the person to liability under the False Claims Act, including whistleblower actions, treble damage and penalties; and (2) that the Office of the Medicaid Inspector General or MCO may suspend payments to the FI and CDPA, if applicable, pending an investigation of a credible allegation of fraud against the FI or CDPA, as applicable, unless the state determines there is good cause not to suspend such payments; and

Comply with applicable labor laws and provide equal employment opportunities to CDPAs in accordance with applicable laws.

Notify the FI and/or MCO of any disclosure of information that the MCO has taken reasonable measures to maintain as confidential and which derives independent economic value from not being generally known or readily ascertainable by the public (Proprietary information). Proprietary information includes the compensation arrangements between the MCO and the FI and the amount the FI pays the CDPA and any other information relating to the MCO's business that is not public information.

BOTH PARTIES ACCEPT THE ROLES AND RESPONSIBILITIES IN THE CDPAP AS EXPLAINED ABOVE.

_____

Patien's Signature

_____

Patien's Print Name

or

Consumer/Designated Representative

_____

Date

_____

Signature

_____

Print Name

Silver Lining Homecare Agency, Inc.

Fiscal Intermediary

_____

Date

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Fiscal Intermediary for the Consumer Directed Personal Assistance Program

The Consumer Directed Personal Assistance Program (CDPAP) is an alternative to traditional home care. The CDPAP is Medicaid program that enables self-directing individuals or their designated representative, to assume the responsibilities of their own care. The consumer and/or designated representative are responsible for recruiting, interviewing, hiring, training, supervising, scheduling and termination.

What is my role as a Personal Care Assistant?

As a Personal Care Assistant you are hired by the consumer and/or designated representative to assist the consumer with their individual needs to live safely in their home within the approved hours authorized by NYS Medicaid/Managed Care. By accepting this position, you are agreeing to accept training and supervision at the direction of the consumer or their designated representative. You are responsible to complete the full application and submit the documents needed to work on the CDPAP. You may not submit a time slip or clock in until your application forms are completed and submitted for approval. Silver Lining Homecare Agency, Inc. must give this approval.

As a Personal Care Assistant, the Department of Health requires that you pass and submit a physical within the past year, provide proof of immunizations, a PPD or Chest x-ray (if you have a history of a positive PPD), and complete a health assessment. All forms are in the Personal Care Assistant application. It is your responsibility to keep your compliance up to date yearly.

As a Personal Care Assistant you may not work on the consumer directed program while the consumer is hospitalized. These hours will not be paid to you by Silver Lining Homecare Agency, Inc. and will not be billed to NYS Medicaid/Managed Care.

What is the role of Silver Lining Homecare Agency, Inc.?

As the Fiscal Intermediary Silver Lining Homecare Agency, Inc. will keep a record, which consists of the Personal Assistant's original application forms, annual health assessments and the information needed for payroll processing and benefit administration. We act as an employer of record for insurance, unemployment and worker compensation benefits for each Personal Assistant.

Who is my employer?

As a Personal Care Assistant you are employed by the consumer or their designated representative.

Safety

In the case of accidents that result in injury, regardless of how insignificant the injury may appear, Personal Assistants should immediately notify your consumer or designated representative and Silver Lining Homecare Agency, Inc. Such reports are necessary to comply with OSHA regulations and workers compensation benefits laws.

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Live in

All Personal Assistants who work on a live in case are to be present in the consumer's home for 24 hours each working day.

During each live in day, Personal Assistants are to perform tasks in accordance with the verbal and written care plan. Personal Assistants may not work in excess of 13 hours in any day.

During each 24 hour day, Personal Assistants are to take eleven hours for personal time which will include hours of sleep, meal breaks and other personal time, remaining on premises at all such times.

Transporting the client

You must provide Silver Lining Homecare Agency, Inc. with your current unexpired driver's license and insurance card in order to be authorized to transport your consumer in your car or your consumer's car.

Corporate compliance Purpose

To ensure Silver Lining Homecare Agency, Inc. complies with applicable federal and state laws and regulations and to make a sincere effort to prevent, detect and correct any fraud, abuse or waste in connection with federally funded health care programs and private health plans.

Policy

It is the policy of Silver Lining Homecare Agency, Inc.to be in compliance with all federal and state rules, laws and regulations. This includes compliance with all reimbursement rules as required by Medicare, Medicaid, and relevant third party payers. It also includes compliance with relevant federal and state abuse laws including but not limited to the Deficit Reduction Act of 2005 and the Federal and NYS False Claims Act. Compliance issues relating to accurate and truthful documentation, honest and lawful dealing with others and prohibitions against receiving or giving remuneration in turn for referrals are also included. As part of this compliance program, all Personal Assistants are urged to raise any concerns about the accuracy or propriety of any documentation or billing practice or any other compliance issue without concern for retaliation. Such issues may be raised to the Silver Lining Homecare Agency, Inc. Compliance Officer, _____ at _____ ext. _____. All concerns will be reviewed and appropriate action will be taken.

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Deficit Reduction Act Of 2005

Silver Lining Homecare Agency, Inc. takes fraud and abuse very seriously. It is our policy to provide information to all employees, contractors and agents about the federal and state false claims acts remedies available under these acts and how employees and others can use them, and about whistleblower protections available to anyone who claims a violation of federal or state false claims acts. We also will advise our employees, contractors and agents of the steps the agency has in place to detect health care fraud and abuse. This act is designed to improve federal and state oversight and enforcement actions against fraud and abuse in the Medicaid program. It requires any entity receiving more than 5 million dollars in Medicaid funds per year must instruct their workforce on the following issues:

- The Federal False Claims Act
- The Federal Program Fraud Civil Remedies Act
- State laws pertaining to civil or criminal penalties for false claims and statements
- Role of such laws in preventing and detecting fraud, waste and abuse
- Whistleblower protections under such laws
- Policies and procedures of Silver Lining Homecare Agency, Inc. (Provider) for preventing and detecting fraud, waste and abuse

Federal False Claims Act The False Claims Act is a law that prohibits a person or entity from knowingly presenting or causing to be presented a false or fraudulent claim for payment or approval to the Federal Government and from 'knowingly" making, using or causing to be made a false record or statement to get a false or fraudulent claim paid or approved by the Federal Government. These prohibitions extend to claims submitted to federal healthcare programs, such as Medicare and Medicaid. A person or entity found guilty of violation can be obligated to civil penalty up to 11,000 plus three times the amount of actual damages. A person or entity can also find themselves excluded from the Medicaid programs if found in violation.

New York False Claims Act The NY False Claims Act closely tracts the federal False Claims Act. It imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including health care plans such as Medicaid. The penalty for filing a false claim is 6,000-12,000 per claim and the recoverable damages are between two and three times the value of the amount falsely received.

Silver Lining Homecare Agency utilizes HHA Exchange for the provision of home health aide services to keep track of home health aide attendance in real time throughout the day utilizing tools provided by their EVV such as the call dashboard or attendance reports_ and will review and verify all services through their electronic verification vendor/ verification organization prior to submission to Contractors for payment.

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How do I get paid?

Federal and state laws require Silver Lining Homecare Agency, Inc. to keep accurate records of time worked in order to calculate Personal Care Assistant pay and benefits. Time worked is all the time actually spent on the job performing assigned duties within the authorized time. You are not permitted to work anywhere else at the same time you are working for your consumer.

All Personal Assistants are required to submit all paperwork to the office weekly by the end of the week. Paperwork received after 12 noon will be considered late and processed the following week. The payroll cycle is from Sunday to Saturday. All paperwork must be signed by the consumer/designated representative and Personal Care Assistant at the end of each day. Dates, times, signatures and patient information must be filled out correctly. We will not be able to process incomplete paperwork.

Personal Care Assistants must clock in and out for each shift that is worked. Failure to use the call in system properly will cause a delay in your pay due to the additional processing time needed for timesheets.

Checks are mailed weekly to the consumer's home or to your home. This determination is made by the consumer.

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Personal Care Assistant Benefit Overview Compensation and Benefits

Rate of pay

Your rate of pay varies depending on the contract the consumer is being serviced under and county, state and federal wage laws.

Compensated days off

Personal Assistants who qualify for compensated days off will receive up to 40 hours (5 days) per calendar year. These hours are accrued at the rate of one hour for every 30 hours worked.

Compensated days off will not be counted as hours worked for purposes of determining whether overtime premium pay is due to the Personal Assistant.

Sick Leave

Employees accrue sick leave at the rate of one hour for every 30 hours worked, up to a maximum of 40 hours of sick leave per calendar year.

Benefits offered through the CDPAP Health benefits, Dental/Life/Vision.

Health Benefits

If you work 40 hours a week consecutively for 3 months you qualify to enroll in health benefits through Silver Lining Homecare Agency, Inc. If you choose not to enroll after three months you may qualify during open enrollment. It is your responsibility to fill out the enrollment papers and submit them to Silver Lining Homecare Agency, Inc.

Silver Lining Homecare Agency, Inc. pays administrative costs associated with all benefits programs and any Personal Care Assistant contributions are deducted in installments from Personal Care Assistant's weekly pay.

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AGREEMENT REGARDING THE FACT-FINDING AND ISSUE RESOLUTION ("FAIR") PROGRAM AND ARBITRATION

1. Overview of the FAIR Program. Silver Lining Homecare Agency, Inc. values each employee and looks forward to good relations with and among all of its employees. Occasionally, however, disagreements may arise between you and Silver Lining Homecare Agency, Inc. or between employees in a context that involves Silver Lining Homecare Agency, Inc. We believe that the resolution of such disagreements will be best accomplished by internal dispute resolution and, where that fails, by binding arbitration that is conducted by an arbitrator. For these reasons, Silver Lining Homecare Agency, Inc. has adopted this Fact-finding and Issue Resolution Program (the "FAIR Program").

2. Effect of This Document. By singing this agreement, you agree that all "Claims" (as defined below in Paragraph 3) between "You" and the "Agency" (as defined below in Paragraph 3) shall be resolved exclusively by the internal dispute resolution procedures and the binding arbitration procedures described in this document.

The FAIR Program is an essential element of your employment and, for current employees, continued employment with the Agency. Although the FAIR Program is a binding agreement between you and the Agency, it does not create a contract of employment or otherwise affect the at-will nature of your employment. You indicate your agreement to be bound by the FAIR Program's terms and conditions by signing this document.

3. What Does The FAIR Program Cover?

A. The FAIR Program applies to any and all Claims, regardless of when those claims arose or accrued or were first asserted. For avoidance of doubt, the provisions of this agreement apply to claims that accrued, arose, or were asserted before execution of this agreement and to claims that accrued, arose, or were asserted after execution of this agreement. The provisions of this agreement also apply to Claims that arose after your employment with the Agency ends.

C. For purposes of the FAIR Program and this document, the "Agency" and/or "Silver Lining Homecare" means Silver Lining Homecare Agency, Inc. and its parents, subsidiaries, affiliates, predecessors, and successors, as well each of their current and former owners, members, managers, shareholders, partners, directors, officers, employees, and agents.

D. *"You"* and "*Your*" refers to you and any other person who may assert your rights.

E. "*Claim*" includes any claim, dispute, allegation, controversy, or action between You and the Agency that in any way arises from, or relates to, your employment with the Agency or the termination of your employment with the Agency. A Claim encompasses, for example, any

employment, labor, wage-and-hour, overtime, and compensation claims, including, without limitation, any Claim that may arise under the following laws:

- Title VII of the Civil Rights Act of 1964
- the Civil Rights Act of 1991
- the Age Discrimination in Employment Act of 1967
- the Americans with Disabilities Act of 1990
- the Fair Labor Standards Act of 1938 or any state wage and hour laws, such as the New York Labor Law
- New York Public Health Law Section 3614-c, also known as the Wage Parity Law
- the Rehabilitation Act of 1973
- the Older Workers Benefit Protection Act
- the Family and Medical Leave Act of 1993
- the Occupational Safety and Health Act of 1970
- the Worker Adjustment and Retraining Notification Act of 1988
- any state anti-discrimination, anti-retaliation, or whistleblower laws (including, without limitation, the New York State Human Rights Law and the New York State Whistleblower Law)
- any other federal, state, or local statute, regulation, or common-law doctrine regarding employment, employment discrimination, harassment, terms and conditions of employment, termination of employment, compensation, breach of contract, or defamation.
- disputes about the validity, enforceability, coverage or scope of the FAIR Program or any part thereof.

The above list is not exclusive, and is only provided to illustrate examples of Claims.

4. <u>Are Any Claims Excluded From The Fair Program?</u>

The term "Claim" does not include the following, which are for a court or an agency and not an arbitrator to decide:

- controversies, claims or other disputes for injunctive relief for unfair competition or unauthorized use or disclosure of confidential information or trade secrets
- claims for workers' compensation (except that claims for interference with or retaliation for filing a workers' compensation claim will be considered a Claim subject to arbitration under the FAIR Program)
- unfair labor practice charges under the National Labor Relations Act
- claims for unemployment compensation benefits
- claims for employee welfare benefits (e.g., medical, health, dental)
- claims for retirement benefits under the Employee Retirement Income Security Act ("ERISA") (except that claims for interference with or retaliation for exercising protected rights under ERISA shall be considered Claims subject to arbitration under the FAIR Program)

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The FAIR Program does ***not*** prevent You from filing a charge, testifying, assisting, or otherwise participating in any investigation or proceeding conducted by the equal employment opportunity commission, or another government agency to the extent that You have a protected right to do so. But if You take such action in relation to a claim, controversy, or other dispute that would constitute a Claim and you have not fully pursued such dispute through the FAIR Program, the Agency may request the agency in question to defer its processing or investigation of such charge until the FAIR Program has been completed. Notwithstanding Your rights under this subsection, You agree that, to the maximum extent permitted by law, You may recover monetary relief with respect to a Claim only through the FAIR Program.

Further, the FAIR Program does not require the Agency to begin arbitration proceedings or initiate any other procedure before taking any action regarding your employment with which you might disagree, such as coaching, counseling, warning, reprimand, suspension, investigation, discipline, demotion, changing your days or hours of work, or termination.

5. Can A Claim Be Resolved in Court? No. Under the FAIR Program, You and the Agency each waive your respective rights to have a Claim decided by a court, judge, jury and, where permitted by law, an administrative agency. Instead, You and the Agency hereby agree that the internal dispute resolution and arbitration procedures set forth below are the sole and exclusive methods for resolving any and all Claims.

6. Submitting a Claim Under the FAIR Program? If You believe that You have a Claim against the Agency, You should first give the Agency a chance to investigate and resolve the Claim before You file a demand for arbitration (the arbitration process is explained further below). You do not need to use any specific form to submit a Claim. Simply write a letter explaining your Claim and the relief sought, and submit the Claim letter to the Human Resources Manager. If You do not receive a response from the Agency within 30 days of the date that you submitted Your letter to Human Resources, or you disagree with the response from the Agency, and you wish to pursue the Claim further, You must submit your Claim exclusively to binding arbitration with the American Arbitration Association ("AAA") in accordance with the AAA's Employment Arbitration Rules and Mediation Procedures.

7. How Much Time do You Have to File a Claim? An arbitration proceeding must be commenced within the time period prescribed by the statutes of limitations applicable to the Claim being asserted. For purposes of statute of limitations, an arbitration proceeding is deemed commenced when a demand for arbitration is filed with the AAA.

8. How Does The Arbitration Process Begin? To start the arbitration process, the party wishing to file a Claim must file a written demand in accordance with the rules of the AAA for starting the arbitration process. More information about the AAA may be obtained at www.adr.org or by calling 1.800.778.7879.

9. How Is the Arbitrator Selected? Arbitrators will be selected by the parties in accordance with the AAA's Employment Arbitration Rules and Mediation Procedures. The arbitrator must be a licensed attorney or a retired judge selected from the AAA's Employment Arbitration Rules and Mediation Procedures Employment Dispute Resolution Roster, or a similar list if such list is unavailable. Unless the parties agree otherwise, the arbitrator must be a retired or former judge or a lawyer who has at least 5 years of experience with employment-related claims.

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10. Can An Attorney Represent You? Yes. Any party may be represented by an attorney. If you need assistance finding an attorney, there may be resources available to you, such as the American Bar Association (www.americanbar.org and 800-285-2221 or 202-662-1000) or the Legal Aid Society (www.legal-aide.org or 212-577-3300 or 718-722-3100).

11. When And Where Will The Arbitration Hearing Take Place? The arbitration hearing will be conducted by the arbitrator in whatever manner will most expeditiously permit full presentation of evidence and arguments of the parties. The arbitrator will set the time, date, and place of the hearing, notice of which must be given to the parties at least 30 calendar days in advance, unless the parties agree otherwise. Any arbitration hearing will take place within Kings County, State of New York, unless the parties agree otherwise.

12. What Rules And Law Apply To The Arbitration? Arbitration under the FAIR Program will be conducted pursuant to the AAA's Employment Arbitration Rules and Mediation Procedures, except that under no circumstances will an arbitrator have the authority to hear or decide any Claim on a class, collective, or other group or representative basis. The arbitrator must apply the substantive law, including the applicable burdens of proof and persuasion, that would be applied by a court hearing the Claim in the venue of the arbitration. The arbitrator may grant relief that could be granted by a court hearing the Claim, including an award of attorneys' fees and costs.

13. Can Claims Be Heard On A Class, Representative, Or Collective Basis? No. Notwithstanding anything to the contrary: (a) no arbitrator is permitted to hear or decide any Claim on a class, collective, or other group or representative basis; (b) all Claims between You and the Agency must be decided individually; and (c) the AAA's Supplementary Rules for Class Action Arbitration (and any similar rules) will not have any applicability to any Claim. This means that if You have a Claim, neither You nor the Agency will have the right, with respect to that Claim, to do any of the following in court or before an arbitrator: (a) pursue or obtain any relief from a class, collective, or other group or representative action; (b) act as a private attorney general; or (c) join or consolidate a Claim with the Claim of any other person. Thus, the arbitrator shall have no authority or jurisdiction to process, conduct, or rule upon any class, collective, private attorney general, or other representative or group proceeding under any circumstances. If there is more than one Claim between You and the Agency, those Claims may be heard in a single arbitration.

14. Who Pays For The Arbitration? The party claiming to be aggrieved is responsible for paying the applicable filing fee in effect and established by the AAA at the time the demand for arbitration is made. If You file the demand for arbitration and cannot obtain a waiver of the filing fee, You can ask the Agency to pay the filing fee. The Agency will review every such request in good faith and consider whether to cover all or part of such filing fee.

The arbitrator will charge a fee for his/her services and his/her costs. The parties will equally share the arbitrator's fees and other costs of the arbitration. However, if sharing equally in the cost of the arbitrator's fees would cause you financial hardship, You can ask the Agency to pay, in full, the arbitrator's fees and other costs. The Agency will pay all of the arbitrator's costs and fees as necessary to implement this FAIR Program.

Each party will be responsible for its own attorneys' fees and costs, but the arbitrator may award either party reasonable attorneys' fees and costs in accordance with the applicable law.

15. Are The Parties Entitled to Discovery Or Depositions? Yes. All discovery will be governed by the AAA rules.

16. Can You have Witnesses Testify At The Arbitration? Yes. At the hearing, the parties will have the right to present proof through testimony and documentary evidence, and to cross-examine witnesses who testify at the hearing. The arbitrator will require all witnesses to testify under oath. The arbitrator(s) will also have the authority to decide whether any person who is not a witness may attend the hearing.

17. The Arbitrator's Decision/Award. The Arbitrator will issue his or her award promptly after the arbitration hearing concludes or post-hearing briefs are received. The arbitrator's award will set forth the factual and legal basis for the award, including his or her legal reasoning, and contain a summary of the facts, the issues, the governing law applied, and the relief requested and awarded. It should also identify any other issues resolved and the disposition of any statutory claims. The arbitrator's award will be final and binding on the parties.

18. How Long Does the FAIR Program Apply to You? The FAIR Program will remain in effect and survive the cessation of Your employment relationship or affiliation with the Agency, regardless of the reason for such cessation.

19. Miscellaneous Provisions Regarding the Fair Program:

- Choice of Law. The FAIR Program and the terms of this agreement shall be governed by the Federal Arbitration Act ("FAA"). The parties acknowledge and agree that the FAIR Program evidences a transaction involving interstate commerce.
- Severability. If any part or provision of the FAIR Program or this agreement is held to be invalid, illegal, or unenforceable, such holding will not affect the legality, validity, or enforceability of the remaining parts, and each provision of the FAIR Program and this agreement will be valid, legal, and enforceable to the fullest extent permitted by law. However, in the event the provision prohibiting class, collective, or representative actions is found to be unlawful or unenforceable, then the entire FAIR Program and this agreement will be considered null and void.
- Notices. Any notice required to be given to You will be directed to Your last known address as reflected in the records of the Agency. Any notice required to be given to the Agency will be directed to the Administrator at 1115 Avenue U, Brooklyn, NY 11223
- Amendment. The Agency reserves the right to amend or terminate the FAIR Program. Such amendments may be made by providing notice to You, electronically or in writing, of such amendment or termination.
- Waiver. No waiver may be granted by either party, except in writing. No waiver of any provision of the FAIR Program will constitute a waiver of any other provision of the FAIR Program (whether or not similar), nor will such waiver constitute a continuing waiver unless otherwise expressly provided in such writing.

STOP SEXUAL HARASSMENT ACT FACTSHEET

All employers are required to provide written notice of employees' rights under the Human Rights Law both in the form of a displayed poster **and** as an information sheet distributed to individual employees at the time of hire. This document satisfies the information sheet requirement.

The NYC Human Rights Law

The NYC Human Rights Law, one of the strongest anti-discrimination laws in the nation, protects all individuals against discrimination based on gender, which includes sexual harassment in the workplace, in housing, and in public accommodations like stores and restaurants. Violators can be held accountable with civil penalties of up to $250,000 in the case of a willful violation. The Commission can also assess emotional distress damages and other remedies to the victim, can require the violator to undergo training, and can mandate other remedies such as community service.

Sexual Harassment Under the Law

Sexual harassment, a form of gender-based discrimination, is unwelcome verbal or physical behavior based on a person's gender.

Some Examples of Sexual Harassment

- unwelcome or inappropriate touching of employees or customers
- threatening or engaging in adverse action after someone refuses a sexual advance
- making lewd or sexual comments about an individual's appearance, body, or style of dress
- conditioning promotions or other opportunities on sexual favors
- displaying pornographic images, cartoons, or graffiti on computers, emails, cell phones, bulletin boards, etc.
- making sexist remarks or derogatory comments based on gender

Retaliation Is Prohibited Under the Law

It is a violation of the law for an employer to take action against you because you oppose or speak out against sexual harassment in the workplace. The NYC Human Rights Law prohibits employers from retaliating or discriminating "in any manner against any person" because that person opposed an unlawful discriminatory practice. Retaliation can manifest through direct actions, such as demotions or terminations, or more subtle behavior, such as an increased work load or being transferred to a less desirable location. The NYC Human Rights Law protects individuals against retaliation who have a good faith belief that their employer's conduct is illegal, even if it turns out that they were mistaken.

Report Sexual Harassment

If you have witnessed or experienced sexual harassment inform a manager, the equal employment opportunity officer at your workplace, or human resources as soon as possible.

Report sexual harassment to the NYC Commission on Human Rights. Call 718–722–3131 or visit NYC.gov/HumanRights to learn how to file a complaint or report discrimination. You can file a complaint anonymously.

State and Federal Government Resources

Sexual harassment is also unlawful under state and federal law where statutes of limitations vary.

To file a complaint with the New York State Division of Human Rights, please visit the Division's website at **www.dhr.ny.gov**.

To file a charge with the U.S. Equal Employment Opportunity Commission (EEOC), please visit the EEOC's website at **www.eeoc.gov**.