Red Tomato Farm & Inn

Real Farm. Real People.

3581 Ritner Highway Newville, PA 17241

Red Tomato Farm & Inn Referral Form

Pre-Vocational Program

Date: _____

Referring Agency Name: _____

Referring Agency Phone Number: _____

Supports Coordinator Name: _____

Participant Information

Name of Individual: _____

Date of Birth: _____

Gender: ☐ Male ☐ Female

Address: _____

Phone Number: _____

Residence (check one): ☐ Group Home ☐ Resides with Family/Guardian/Caregiver

☐ Other:_____

Name of Parent/Guardian/Caregiver _____

Address:_____

Phone Number:_____

What is the best time to contact Parent/Guardian/Care Taker?

_____

How do you think this individual would enjoy attending Red Tomato Farm? What are the pre-vocational interests of this individual?

_____

_____

What day(s) is this individual interested in attending Red Tomato Farm?

☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday

Please provide as much information as possible with the referral (check all that apply and are attached to referral. Items with asterisk must be included before participant can start):

☐ Current Physical/TB Test* ☐ Psychological/Psychiatric Evaluation(s) ☐ List of Medication*

☐ ISP* ☐ Lifetime Medical History* ☐ Other documents

☐ BSP ☐ Assessment(s)

Please fax completed forms to *HEMPFIELD BEHAVIORAL HEALTH: 717-221-8006*

or Mail to HEMPFIELD BEHAVIORAL HEALTH 2019 NORTH 2ND ST. HARRISBURG, PA 17102

For RTF Use Only

Pre-Admission Interview Date:_____ Employment Documents Given to Participant? ☐YES ☐NO

Date employment documents completed: _____ Received by: _____

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PARTICIPANT INFORMATION SHEET

Name:	
Admission Date:	
Date of Birth / Birth Place:	
Height:	
Weight:	
Eye Color:	
Hair Color:	
Race:	
Sex:	
Language:	
Identifying Marks:	
Allergies:	
Religious Affiliation:	

CURRENT MEDICATIONS

Medication Name	Dosage	Purpose

Likes/Strengths:

Dislikes/Triggers:

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PARTICIPANT PHOTO IDENTIFICATION

Participant Name:

Address:

Phone Number:

Date of Birth:

Allergies:

MCI:

Date of Picture:
(Attach photo)

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Participant Contact Information Form

Please Print

Participant Name:

Contact #1: Emergency Contact

Name:	
Phone Number:	
Relationship to Participant:	
Can this person consent for emergency medical treatment?	

Contact #2:

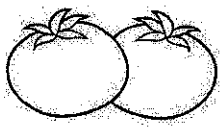
Name:	
Phone Number:	
Relationship to Participant:	
Can this person consent for emergency medical treatment?	

Contact #3:

Name:	
Phone Number:	
Relationship to Participant:	
Can this person consent for emergency medical treatment?	

Physician:

Name:	
Address:	
Phone Number:	



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Consent to Participate

Participant Name: _____ DOB:_____

I have been informed and provided a brochure about the services provided by the Red Tomato Farm and Inn at Hempfield Behavioral Health, and consent for the individual named above to participate in the Pre-Vocational Program. I have been made aware of the risks inherent in farm activities including livestock, farm work, outdoor exposure, and tools and machinery.

I am aware that I may terminate participation from Hempfield Behavioral Health (Red Tomato Farm) at anytime.

I am aware that Hempfield Behavioral Health agrees to maintain the confidentiality of any information regarding applicants, program participants, or their immediate families which may be obtained through applications, forms, interviews, test reports from public agencies, counselors, or any other sources. Without permission of the applicant, such information shall be divulged only as necessary for the purpose related to the performance or evaluation of the contract and the persons having responsibilities under the contract.

I am aware that Hempfield Behavioral Health also will provide client information to *Case Management Unit or County MHID Services* if that agency has made the referral for treatment. I understand that services for my participation will be billed to a third party.

I am aware that the above named individual in the process of emergency treatment by a health professional and information from Hempfield Behavioral Health is required for emergency treatment, necessary and limited related information to the emergency may be released without my consent.

I am aware that new or previously unreported incidents of sexual or physical abuse will be reported. In addition, any knowledge of potential danger to self or others may result in breach of confidentiality to the appropriate parties.

I have read this consent, had it explained to me, and understand its contents. I ☐ ACCEPT / ☐ REJECT a copy of this consent.

_____ _____

Participant Signature Date

_____ _____

Parent/Guardian Signature and Relationship to Participant (if Participant is unable to sign) Date

_____ _____

Hempfield Behavioral Health Staff Date

_____

HBH Staff print name and credentials

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Pre-Vocational Client Rights and Responsibilities

Participant Name: _____ DOB: _____

Participants, public, parents, and guardians will be treated with respect and dignity, and may expect all issues that affect their care to be handled in a confidential manner.

Additionally, clients have the right to:

- Choose a Provider of your choice
- Receive impartial access to necessary treatment and/or accommodations, regardless of race, color, religious creed, disability, ancestry, national origin, age, sex, or sources of payment for care
- Considerate, respectful treatment at all times
- Conduct interviews and be examined in surroundings designed to assure reasonable visual and auditory privacy
- Review communications and other records pertaining to their care, including the source of payment for treatment, and to have that information treated as confidential in accordance with the laws
- Obtain complete and current information concerning diagnosis (to the degree known), treatment, and any known prognosis, and to participate in decision-making regarding their treatment planning
- Give informed consent before the start of any procedure or treatment
- Receive information in a medium that they can understand. If a client does not speak or understand the predominant language of the community, they are able to request funds for an interpreter
- Receive materials that describe important information about their care in a format that is easy to understand and easy to read
- A clear process for complaints and comments, with resolution in a timely manner
- Employees will be trained in clients rights during employee orientation
- Any complaints of discrimination may be filed with the U.S. Department of Health and Human Services Office of Civil Rights, The Department of Public Welfare Bureau of Equal Opportunity, and/or The Pennsylvania Human Relations Commission:

Department of Public Welfare
Bureau of Equal Opportunity
223 Health & Welfare Building
Harrisburg, PA 17120

PA Human Relations Commission
Harrisburg Regional Office
333 Market St. 8th Fl.
Harrisburg, PA 17011

U.S. Dept. of Health and Human Services
Office for Civil Rights
Suite 372m Public Ledger Bldg.
150 S. Independence Mall West
Philadelphia, PA 19106-9111

As part of these rights, clients accept certain responsibilities which are outlined below:

- Respectful and courteous treatment of clinical and administrative staff
- Prompt and regular attendance at scheduled appointments
- Full and complete disclosure of symptoms and changes in symptoms
- Active participation in evaluations and treatment sessions
- Prompt payment for services
- Presentation of accurate insurance and third party information

- Notice of changes in insurance status
- Completion of homework assignments
- Collection of information for treatment and service evaluation
- Use of the grievance procedure for conflict resolution
- Reporting dissatisfaction with any component of treatment and offering suggestions for improvement
- Disclosing other treatments and treatment providers

I have read this consent, have had it explained to me, and I understand its contents.

I ☐ ACCEPT / ☐ REJECT a copy of this consent.

_____ _____

Participant Signature Date

_____ _____

Parent/Guardian Signature and Relationship to Participant (if Participant is unable to sign) Date

_____ _____

Hempfield Behavioral Health Staff Date

_____

HBH Staff print name and credentials

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Accident Waiver and Release of Liability

Participant Name: _____ DOB: _____

I assume all of the risks of participating in any and all activities at the Red Tomato Farm. I understand that there are certain risks associated with farming, working outside and working with live animals.

I verify that I am physically fit and have not been advised to not participate by a qualified medical professional. I verify that there are no health-related reasons or problems which preclude my participation in activities at the Red Tomato Farm.

I release Hempfield Behavioral Health and its representatives from all liability, to me or my representative for all claims, demands, losses or damages, related to participation in activities at the Red Tomato Farm.

I have read this consent, had it explained to me, and understand its contents.

I ☐ ACCEPT / ☐ REJECT a copy of this consent.

_____ _____

Participant Signature Date

_____ _____

Parent/Guardian Signature and Relationship to Participant (If Participant is unable to sign) Date

_____ _____

Hempfield Behavioral Health Staff Date

_____

HBH Staff print name and credentials

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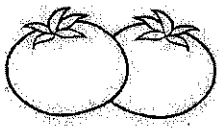

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Authorization to Videotape

Participant Name:_____ Participant DOB: _____

I consent to let Hempfield Behavioral Health videotape for educational and marketing purposes. These images may appear on our website or Facebook or in educational or marketing presentations.

I agree that Hempfield Behavioral Health has complete ownership of these images and may use them for any purpose consistent with the mission of HBH. These uses may include: illustrations, publications, advertisements, and promotional or educational materials. I acknowledge that I will not receive any compensation.

I understand that I am NOT required to be videotaped and I am under no obligation to be recorded. I understand that my access to services will NOT be affected by my decision to not be videotaped. I may revoke this consent at any time by informing the therapist and/or contacting the President, Dr. Howard S. Rosen at 717-221-8004.

I may contact Dr. Howard S. Rosen, Ph.D. 717-221-8004 at any time with questions or concerns.

I have read this consent, have had it explained to me, and I understand its contents.

I ☐ ACCEPT / ☐ REJECT a copy of this consent.

_____ _____

Participant Signature Date

_____ _____

Parent/Guardian Signature and Relationship to Participant (if Participant is unable to sign) Date

_____ _____

Hempfield Behavioral Health Staff Date

_____

HBH Staff print name and credentials

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Authorization to Photograph

Name of Participant: _____ Participant DOB: _____

I consent to let Hempfield Behavioral Health photograph the above mentioned participant.

Hempfield Behavioral Health would like to photograph you for educational and marketing purposes. These images may appear in our printed brochure, publications, website or Facebook.

I agree that Hempfield Behavioral Health has complete ownership of these pictures and may use them for any purpose consistent with the mission of HBH. These uses may include: illustrations, publications, advertisements, and promotional or educational materials. I acknowledge that I will not receive any compensation.

I understand that I am NOT required to be photographed and I am under no obligation to be photographed. I understand that my access to services will NOT be affected by my decision to not be photographed. I may revoke this consent at any time by informing the Program Director and/or contacting the President, Dr. Howard S. Rosen at 717-221-8004. I may contact Dr. Howard S. Rosen, Ph.D. 717-221-8004 at any time with questions or concerns.

I have read this consent, have had it explained to me, and I understand its contents.
I ☐ ACCEPT / ☐ REJECT a copy of this consent.

_____ _____

Participant Signature Date

_____ _____

Parent/Guardian Signature and Relationship to Participant (if Participant is unable to sign) Date

_____ _____

Hempfield Behavioral Health Staff Date

_____

HBH Staff print name and credentials

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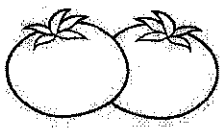

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TRANSPORTATION AUTHORIZATION

Participant Name:_____ Participant DOB:_____

I authorize Hempfield Behavioral Health staff to transport the individual listed above in the HBH vans or staff vehicles. I understand that all riders must wear seat belts.

I have read this consent, have had it explained to me, and I understand its contents.

I ☐ ACCEPT / ☐ REJECT a copy of this consent.

_____ _____

Participant Signature Date

_____ _____

Parent/Guardian Signature and Relationship to Participant (if Participant unable to sign) Date

_____ _____

Hempfield Behavioral Health Staff Date

_____

HBH Staff print name and credentials

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PERMISSION FOR MEDICAL SERVICES

Participant Name: _____ Participant DOB: _____

I hereby give permission to Hempfield Behavioral Health to secure all routine medical services or emergency first aid for the above mentioned individual.

I understand that Hempfield Behavioral Health will make every reasonable effort to contact me whenever a condition arises that requires other than routine medical services. However, in the event that an emergency exists and I cannot be reached within a reasonable time, I give permission to Hempfield Behavioral Health to secure any and all medical services to meet the medical emergency.

I have read this consent, have had it explained to me, and I understand its contents.

I ☐ ACCEPT / ☐ REJECT a copy of this consent.

_____ _____

Participant Signature Date

_____ _____

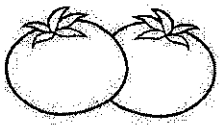
Parent/Guardian Signature and Relationship to Participant (if Participant is unable to sign) Date

_____ _____

Hempfield Behavioral Health Staff Date

_____

HBH Staff print name and credentials



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PERMISSION FOR OUTINGS

Participant Name: _____ Participant DOB: _____

I give permission for the staff of Hempfield Behavioral Health to take the above mentioned participant on day outings during program hours.

I, _____, do not give permission for the staff of Hempfield Behavioral Health to take the above mentioned participant on day outings during program hours.

I have read this consent, have had it explained to me, and I understand its contents.

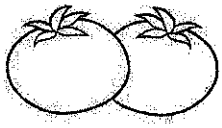
I ☐ ACCEPT / ☐ REJECT a copy of this consent.

_____ _____
Participant Signature Date

_____ _____
Parent/Guardian Signature and Relationship to Participant Date
(if Participant is unable to sign)

_____ _____
Hempfield Behavioral Health Staff Date

_____
HBH Staff print name and credentials



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Water Safety/Swimming Pool Use

Name of Participant: _____Participant DOB: _____

Participants at Red Tomato Farm & Inn regularly use the pool on premises or go on field trips to state parks with beaches. In signing this consent, participant acknowledges that he/she is aware of pool/beach rules regarding running on pool surfaces, no diving, no pushing, shoving, or other rough horseplay in the water. Participant acknowledges that they can swim, tread water, or float and are aware of the inherent dangers of swimming. Participants who cannot swim acknowledge that they understand their obligation to stay in shallow water no higher than waist-deep. Participants with seizure disorders will be required to have a staff within arm's reach and to wear a floatation vest.

I have read this consent, have had it explained to me, and I understand its contents.
I ☐ ACCEPT / ☐ REJECT a copy of this consent.

_____ _____

Participant Signature Date

_____ _____

Parent/Guardian Signature and Relationship to Participant (if Participant is unable to sign) Date

_____ _____

Hempfield Behavioral Health Staff Date

_____

HBH Staff print name and credentials

Hempfield Behavioral Health
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Hempfield Behavioral Health Permission for Exchange of Information

I, _____, hereby authorize Hempfield Behavioral Health to release/receive information contained in the record of _____ DOB: _____.

NAME OF AGENCY / PERSON: Referring Agency: _____

ADDRESS: _____

THE FOLLOWING INFORMATION MAY BE RELEASED / RECEIVED:

- ☐ Family History
- ☐ Treatment / Service Plan
- ☐ Progress Reports
- ☐ Discharge Summaries
- ☐ Individual Support Plan
- ☐ Other:
- ☐ Neurological Reports
- ☐ Physical Exam / Immunizations
- ☐ Attendance Data
- ☐ Individual Education Plan
- ☐ Medical Reports
- ☐ Case Management Intake / Assessment
- ☐ Vocational Skills Assessment
- ☐ Behavior Plan
- ☐ Achievement Tests
- ☐ Psychological / Psychiatric Evals

For the purpose of: _____

Effective Date(s) From: _____ To: _____

I fully understand the nature of this consent and that this authorization shall remain in effect from the date of my signature for a period not exceeding 1 year. However, I may revoke this authorization at any time by written, dated communication to the Executive Director or designee. A photo static copy of this authorization will be considered valid, and all information will be held in strict confidence. I understand that the policy of Hempfield Behavioral Health is to release only that information about a present or former recipient of services, which, in judgment of its personnel, is considered essential to the purpose for which the authorization is requested. It is also a policy of Hempfield Behavioral Health **to release only information generated by them and not other agencies or institutions.** I ACCEPT ☐ / REJECT ☐ A COPY of this release.

_____ _____

Participant Signature Date

_____ _____

Parent/Legal Guardian and Relationship (if Participant is unable to sign) Date

_____ _____

Witness Signature and Title Date

_____

Witness Print Name and Credentials

To be completed if the recipient of services is physically unable to provide a signature, but has indicated verbally or behaviorally that he/she consents to the release.

We affirm that _____ was physically unable to provide a signature, understands the nature of this consent, and freely gave his/her verbal or behavioral consent. This authorization shall remain in effect from this date to _____ (1 year hence). However, this may be revoked by verbal or behavioral communication to the Executive Director or his/her designee.

_____ _____

Witness Signature and Relationship Date

_____ _____

Program Representative Signature and Title Date

Hempfield Behavioral Health
2019 N. 2nd St. Harrisburg, PA 17102
717-221-8004 (phone) 717-221-8006 (fax)

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Hempfield Behavioral Health Permission for Exchange of Information

I, _____, hereby authorize Hempfield Behavioral Health to release/receive information contained in the record of _____ DOB: _____.

NAME OF AGENCY / PERSON: County MHIDD: _____

ADDRESS: _____

THE FOLLOWING INFORMATION MAY BE RELEASED / RECEIVED:

- ☐ Family History
- ☐ Treatment / Service Plan
- ☐ Progress Reports
- ☐ Discharge Summaries
- ☐ Individual Support Plan
- ☐ Other:
- ☐ Neurological Reports
- ☐ Physical Exam / Immunizations
- ☐ Attendance Data
- ☐ Individual Education Plan
- ☐ Medical Reports
- ☐ Case Management Intake / Assessment
- ☐ Vocational Skills Assessment
- ☐ Behavior Plan
- ☐ Achievement Tests
- ☐ Psychological / Psychiatric Evals

For the purpose of: _____

Effective Date(s) From: _____ To: _____

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_____ _____
Participant Signature Date

_____ _____
Parent/Legal Guardian and Relationship (if Participant is unable to sign) Date

_____ _____
Witness Signature and Title Date

_____
Witness Print Name and Credentials

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We affirm that _____ was physically unable to provide a signature, understands the nature of this consent, and freely gave his/her verbal or behavioral consent. This authorization shall remain in effect from this date to _____ (1 year hence). However, this may be revoked by verbal or behavioral communication to the Executive Director or his/her designee.

_____ _____
Witness Signature and Relationship Date

_____ _____
Program Representative Signature and Title Date

Hempfield Behavioral Health
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Hempfield Behavioral Health Permission for Exchange of Information

I, _____, hereby authorize Hempfield Behavioral Health to release/receive information contained in the record of _____ DOB: _____.

NAME OF AGENCY / PERSON: Group Home:_____

ADDRESS:_____

THE FOLLOWING INFORMATION MAY BE RELEASED / RECEIVED:

- ☐ Family History
- ☐ Treatment / Service Plan
- ☐ Progress Reports
- ☐ Discharge Summaries
- ☐ Individual Support Plan
- ☐ Other:
- ☐ Neurological Reports
- ☐ Physical Exam / Immunizations
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- ☐ Case Management Intake / Assessment
- ☐ Vocational Skills Assessment
- ☐ Behavior Plan
- ☐ Achievement Tests
- ☐ Psychological / Psychiatric Evals

For the purpose of: _____

Effective Date(s) From: _____ To: _____

I fully understand the nature of this consent and that this authorization shall remain in effect from the date of my signature for a period not exceeding 1 year. However, I may revoke this authorization at any time by written, dated communication to the Executive Director or designee. A photo static copy of this authorization will be considered valid, and all information will be held in strict confidence. I understand that the policy of Hempfield Behavioral Health is to release only that information about a present or former recipient of services, which, in judgment of its personnel, is considered essential to the purpose for which the authorization is requested. It is also a policy of Hempfield Behavioral Health **to release only information generated by them and not other agencies or institutions.** I ACCEPT ☐ / REJECT ☐ A COPY of this release.

_____ _____

Participant Signature Date

_____ _____

Parent/Legal Guardian and Relationship (if Participant is unable to sign) Date

_____ _____

Witness Signature and Title Date

_____

Witness Print Name and Credentials

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We affirm that _____ was physically unable to provide a signature, understands the nature of this consent, and freely gave his/her verbal or behavioral consent. This authorization shall remain in effect from this date to _____ (1 year hence). However, this may be revoked by verbal or behavioral communication to the Executive Director or his/her designee.

_____ _____

Witness Signature and Relationship Date

_____ _____

Program Representative Signature and Title Date

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ANNUAL PHYSICAL EXAMNINATION FORM

Part One: TO BE COMPLETED BY STAFF PRIOR TO MEDICAL APPOINTMENT

Name: _____ Date of Exam: _____
Address: _____ SSN: _____
_____ DOB: _____

DIAGNOSES/ SIGNIFICANT HEALTH CONDITIONS

Axis 1	
Axis 2	
Axis 3	

CURRENT MEDICAIONS *(attach a second page if needed):*

Medication Name	Strength	Dose	Frequency	Diagnosis	Prescribing Physician

Allergies/Sensitivities:_____
Contraindicated Medications: _____

IMMUNIZATIONS:
Tetanus/Diphtheria *(every 10 years)*: ___/___/___
Hepatitis B: ___/___/___ ___/___/___ ___/___/___
Flu shot: ___/___/___ Pneumovax: ___/___/___
Other *(specify)*: _____

TB SCREENING: *(every 2 years by Mantoux method, if positive initial chest x-ray should be done)*

DATE Given _____ Date read_____ Results_____
Chest X-ray (date) _____ Results _____

OTHER MEDICAL/ LAB/ DIANOSTIC TESTS:

GYN EXAM W/pap **Date** _____ **Results:** _____
(Women over age 18)
Mammogram: **Date**_____ **Results:** _____
(Every 2 year-women ages 40-49, yearly for women 50 and over)
Prostate Exam: **Date** _____ **Results:** _____
(Digital method-males 40 and over)
Hemoccult **Date** _____ **Results:** _____
Urinalysis **Date** _____ **Results:** _____
CBS/ Differential **Date** _____ **Results:** _____
Hepatitis B Screening **Date** _____ **Results:** _____
PSA **Date** _____ **Results:** _____

Other *(specify)*_____

Hempfield Behavioral Health
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Part Two: GENERAL PHYSICAL EXAMINATION

Blood Pressure:____/____ Pulse: ____/____ Respirations:____/____ Temp: ____/____ height: ____/____ Weight: ____/____

EVALUATION OF SYSTEMS

System Name	Normal Findings?	Comments/ Description
Eyes	☐Yes ☐No	
Ears	☐Yes ☐No	
Nose	☐Yes ☐No	
Mouth/ Throat	☐Yes ☐No	
Head/ Face/ Neck	☐Yes ☐No	
Breasts	☐Yes ☐No	
Lungs	☐Yes ☐No	
Cardiovascular	☐Yes ☐No	
Extremities	☐Yes ☐No	
Abdomen	☐Yes ☐No	
Gastrointestinal	☐Yes ☐No	
Endocrine	☐Yes ☐No	
Musculoskeletal	☐Yes ☐No	
Integumentary	☐Yes ☐No	
Renal/ Urinary	☐Yes ☐No	
Reproductive	☐Yes ☐No	
Lymphatic	☐Yes ☐No	
Nervous System	☐Yes ☐No	
VISION SCREEENING	☐Yes ☐No	Is further evaluation recommended by specialist? ☐Yes ☐No
HEARING SCREENING	☐Yes ☐No	Is further evaluation recommended by specialist? ☐Yes ☐No

Additional Comment:

Lifetime medical history summary reviewed? ☐Yes ☐No

Medication added, changed, or deleted *(from this appointment)*: _____

Special medication considerations or side effects: _____

Recommendations for health maintenance: *(including need for lab work at reg. intervals, exercise, hygiene, weight control, etc.)*

_____

Recommended diet and special instructions: _____

Information pertinent to diagnosis and treatment in case of emergency:

_____

Free of Communicable Diseases? ☐Yes ☐No (if no, list specific precautions to prevent the spread of disease to others)

_____

Limitations or restrictions for activities *(including work day, lifting, standing, and bending)* ☐No ☐Yes *(specify):*

_____

Change in health status from previous year? ☐No ☐Yes (*specify):*_____

Hempfield Behavioral Health
2019 North 2nd St. Harrisburg, PA 17102
717-221-8004 (phone) 717-221-8006 (Fax)

Continuation of same level of care (e.g., ICF, CLA, Other) ☐Yes ☐No (*specify):*_____

Specialty consults recommended? ☐No ☐Yes (*specify):*_____

Name of Physician *(please print)*	Physician's Signature	Date

Physician Address: _____ **Physician Phone:** _____

Hempfield Behavioral Health
2019 North 2nd St. Harrisburg, PA 17102
717-221-8004 (phone) 717-221-8006 (Fax)

DCED-CLGS-06 (1-11)

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF COMMUNITY & ECONOMIC DEVELOPMENT
GOVERNOR'S CENTER FOR LOCAL GOVERMENT SERVICES

LOCAL EARNED INCOME TAX RESIDENCY CERTIFICATION FORM

TO EMPLOYERS/TAXPAYERS:

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

EMPLOYEE INFORMATION - RESIDENCE LOCATION

NAME (Last, First, Middle Initial)			SOCIAL SECURITY NUMBER
FIRST LINE OF ADDRESS (If PO Box, please include actual street address)			
SECOND LINE OF ADDRESS			
CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER
MUNICIPALITY (City, Borough, Township)			
COUNTY	PSD CODE		TOTAL RESIDENT EIT RATE

EMPLOYER INFORMATION - EMPLOYMENT LOCATION

EMPLOYER NAME (Use Federal ID Name)			EMPLOYER FEIN
Hempfield Behvioral Health			25-1877136
FIRST LINE OF ADDRESS (If PO Box, please include actual street address)			
3581 Ritner Highway			
SECOND LINE OF ADDRESS			
CITY	STATE	ZIP CODE	PHONE NUMBER
Newville	PA	17241	717-221-8004
MUNICIPALITY (City, Borough, Township)			
West Pennsboro Township			
COUNTY	PSD CODE		MUNICIPAL NON-RESIDENT EIT RATE
Cumberland	2 1 0 1 1 0		1.0%

CERTIFICATION

SIGNATURE OF EMPLOYEE	DATE
PHONE NUMBER	EMAIL ADDRESS

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

www.newPA.com

Select Get Local Gov Support, >Municipal Statistics

HEMPFIELD

BEHAVIORAL HEALTH, INC.

INNOVATION • COMMUNITY • EXPERIENCE

Appendix "X": Payroll Notification Form- Direct Deposit Information

Employee Name:	Position:
SSN:	Email:
Address:	Phone:

Employees of Hempfield Behavioral Health may be paid by direct deposit to a maximum of 2 checking/savings accounts. You may deposit either the whole amount into one account or you may deposit a percentage into two separate accounts. We are not able to deposit a portion into one account and then have the employee receive a live check for the remaining amount of the check. In order for the payroll department to establish the accounts in the payroll system, the following information is required:

Payroll Account for Net Pay

This is the account into which the entire amount of your net pay will be deposited.

Selected one: Checking ☐ Savings ☐

Percentage deposited:_____%

Bank Institute Name:_____

Routing #:_____ Account #:_____

Employees may elect to have the remaining percentage of their net pay deposited into a second checking or savings account. If you elect to have this voluntary deduction, please complete the following information:

Selected one: Checking ☐ Savings ☐

Percentage deposited:_____%

Bank Institute Name:_____

Routing #:_____ Account #:_____

I authorized the above action and understand that a new authorization will be required to make any changes to the above information.

_____ Date:_____

Employee Signature

Howard S. Rosen, PhD President
2019 North 2nd Street, Harrisburg, PA 17102
717-221-8004 phone ▪ 717-221-8006 fax

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

▶ **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 08/31/2019

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	
Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name	
Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

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 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		
		9. Driver's license issued by a Canadian government authority		**8.** Employment authorization document issued by the Department of Homeland Security
		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 Part 8 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Form W-4 (2017)

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 2017 expires February 15, 2018. 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 can't claim exemption from withholding if your total income exceeds $1,050 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 don't apply to supplemental wages greater than $1,000,000.

Basic instructions. If you aren't 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 2017. 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're single and have only one job; or • You're married, have only one job, and your spouse doesn't 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 (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F
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 $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 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

2017

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 2017, 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)

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 2017 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% of your income, and miscellaneous deductions. For 2017, you may have to reduce your itemized deductions if your income is over $313,800 and you're married filing jointly or you're a qualifying widow(er); $287,650 if you're head of household; $261,500 if you're single, not head of household and not a qualifying widow(er); or $156,900 if you're married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,700 if married filing jointly or qualifying widow(er); $9,350 if head of household; $6,350 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 2017 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 2017 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2017 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 $4,050 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 2017. 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 2017. 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 - $7,000	0	$0 - $8,000	0
7,001 - 14,000	1	8,001 - 16,000	1
14,001 - 22,000	2	16,001 - 26,000	2
22,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 70,000	5
44,001 - 55,000	6	70,001 - 85,000	6
55,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 95,000	10	140,001 and over	10
95,001 - 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 - $75,000	$610	$0 - $38,000	$610
75,001 - 135,000	1,010	38,001 - 85,000	1,010
135,001 - 205,000	1,130	85,001 - 185,000	1,130
205,001 - 360,000	1,340	185,001 - 400,000	1,340
360,001 - 405,000	1,420	400,001 and over	1,600
405,001 and over	1,600		

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.

Pennsylvania New Hire Reporting Program
Center for Workforce Information & Analysis

New Hire Reporting Form

COMMONWEALTH OF PENNSYLVANIA
Department of Labor & Industry

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY

1. Instructions for completing this form:

- Unless noted as optional, all fields on this form are required.
- Please type or print **legibly** in black or blue ink **only**.
- This form may be duplicated as needed.

The table at right provides details on the information to be submitted using this form.

2. Submitting this form:

- **By Fax: 866-748-4473 (TOLL FREE)**
  or 717-657-HIRE (717-657-4473) (Local)
- **By Mail:** Commonwealth of Pennsylvania
  New Hire Reporting Program
  P.O. Box 69400
  Harrisburg, PA 17106-9400

3. Questions?

Contact New Hire Customer Service at:
888-PAHIRES (888-724-4737) for more information.

4. Save time and postage costs.

Online reporting is fast, free and paperless.
For more information about how to get started, please visit

www.pacareerlink.state.pa.us

Or contact our customer service at 888-PAHIRES (888-724-4737)

New Hire Information that Must Be Reported	
Required Employer Information:	**Required New Hire Employee Information:**
Employer Federal Employer Identification Number (FEIN) If your company has more than one FEIN, please use the same FEIN used to report your quarterly wage information when reporting new hires.	**Employee Social Security Number** The number assigned to the individual by the Social Security Administration. *Please verify for accuracy.*
Employer Company Name Legal name associated with the FEIN.	**Employee Full Legal Name** First, middle and last name *Nicknames are NOT acceptable*
Employer Street Address Address to which income withholding orders should be sent. *P.O. Boxes are not acceptable*	**Employee Street Address** Permanent address of the new hire employee. *P.O. Boxes are not acceptable*
Employer City, State and Zip Code Self-explanatory.	**Employee City, State of Hire and Zip Code** Self-explanatory.
Employer Contact Person Name Employer's representative authorized to answer questions on the New Hire Report, should they be contacted by our program for additional information. This can be someone from the payroll company.	**Employee Date of Hire** The first day the new hire employee performs services for wages or any other form of compensation. *This cannot be more than three years from the current date.*
Employer Contact Person Phone Number Phone number for the Employer Contact Person.	**Employee Date of Birth** Optional – the date of birth for the new hire employee.
Note: Multi-state employers MAY NOT use this form to report their new hire information. Multi-state employers MUST report by electronic means (Internet, SFTP), and MUST include the state of hire for each new hire employee being reported. Contact New Hire Customer Service at 888-PAHIRES (888-724-4737) for more information.	

New Hire Reporting: Lending a Hand to Pennsylvania's Children

Pennsylvania New Hire Reporting Program
Center for Workforce Information & Analysis

New Hire Reporting Form

COMMONWEALTH OF PENNSYLVANIA
Department of Labor & Industry

REQUIRED EMPLOYER INFORMATION:
(Please type or print **LEGIBLY** in blue or black ink **ONLY**)

Employer FEIN:

Employer Name:

Employer Address (Street, City, State, Zip):
PO Box's are not acceptable

Employer Contact Name:

Employer Contact Phone Number:

Employer Contact Fax Number:

Employer Contact Email:

Please fax this form to:
866-PAHIRES (866-748-4473) (TOLL FREE)
Or 717-657-HIRE (717-657-4473) (Local)

Or mail this form to:
Commonwealth of Pennsylvania
New Hire Reporting Program
P.O. Box 69400
Harrisburg, PA 17106-9400

Questions?
Contact New Hire Customer Service at 888-PAHIRES (888-724-4737)
Or by email at: RA-LI-CWDS-NewHire@pa.gov

This form may be duplicated as needed

Save time and postage costs.

Online reporting is fast, free and paperless.
For more information about how to get started, please visit

www.pacareerlink.state.pa.us

Or contact our customer service at 888-PAHIRES (888-724-4737)

REQUIRED EMPLOYEE INFORMATION: (Please type or print **LEGIBLY** in blue or black ink **ONLY**)

ONE EMPLOYEE PER BOX

Employee Social Security Number

Legal Name (First) (Middle) (Last)

Street Address (Post Office Box is not acceptable) Apartment Number (if available)

Zip Code City State

Date of Hire (MM/DD/YYYY)
(Must be within 3 years of current date)
Date of Birth (MM/DD/YYYY)

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