2ND CHANCE MENTAL HEALTH CENTER, LLC
1541 Port St. Lucie Boulevard, Suite F
Port St. Lucie, FL 34952
Phone: (772) 335-0166
Fax: (772) 335-0169

Application Packet Checklist

Applicant Name: _____ Position: _____

Date Resume Received: _____ Interview Date(s): _____

Hiring Status: _____

Start Date: _____

Date documents requested: _____

Please submit all documents to Administrative Assistant within 5 days.

Initial or N/A	Form	Date Received/Notes
	Application Packet Checklist	
	Emergency Contact Information	
	Application-complete	
	Resume	
	References	
	References Checked	
	Interview Questions/Comments	
	Writing Sample	
	Official Transcript	
	Copy of Social Work License	
	Level 2 Screening	
	Local Criminal Background Check	
	Driver's License/Photo ID	
	CDL Verified- Drivers only	
	Copy of SS card	
	I-9	
	W-4	
	Affidavit of Good Moral Character	
	Confidentiality Statement	
	Alcohol and Drug Free Workplace	
	Disclosure and Authorization Form	
	ACHA Background Screening Requirements	
	Signed Position Description	
	Signed Hire Letter	
	New Employee Payroll Information	
	Employee Orientation Form	
	Staff Training Record Placed in file	
	CEU's (previous-placed in training record)	
	Key Inventory Sheet	

File Completed by (include title): _____ Date: _____

2ND CHANCE MENTAL HEALTH CENTER, LLC

EMPLOYMENT APPLICATION

An Equal Opportunity Employer

2nd Chance Mental Health Center, LLC is an equal opportunity employer. This application will not be used for limiting or excluding any applicant from consideration for employment on any basis prohibited by local, state or federal law. Applicants requiring reasonable accommodation in the application and/or interview process should notify a representative of the organization.

Date	First Name	Middle Name	Last Name	Home Phone

Street Address	City	State	Zip	Cell Phone

Social Security Number	Exemptions	Date of Birth	Preferred Contact Method?	Other Phone

Position Desired	Minimum Salary	Email Address

High School Name & Location:	Graduated? Year ☐ Yes ☐ No	GED? Year ☐ Yes ☐ No

College, University or Professional School (Transcripts required)

Name & Location of School	Dates	Major	Certificate	Degree	GPA

Job Related Training or Course Work (Use extra sheets if needed)

Name & Location of School	Dates	Course of Study	Credit Hours	Certificate	Grade

License, Registration or Certification

Type of License, Registration or Certification	Number	Date Received	Expiration Date	State Licensing Agency

Has any state licensing authority ever revoked or suspended or placed conditions on your professional license? ☐ Yes ☐ No

Explain Circumstances and Outcome:

List Software You Know and Circle the Number Indicating your Expertise (5 is highest)

Name	Skill Level	Name	Skill Level	Name	Skill Level
Word	1 2 3 4 5	Internet	1 2 3 4 5		1 2 3 4 5
Excel	1 2 3 4 5		1 2 3 4 5		1 2 3 4 5
Outlook	1 2 3 4 5		1 2 3 4 5		1 2 3 4 5

Background Information

Have you ever been convicted of a Felony or a First Degree Misdemeanor? ☐ Yes ☐ No

If "Yes", What charges? _____

Where convicted: _____ Date of Conviction: _____

Have you ever pled Nolo Contendere or Pled Guilty to a crime which is a Felony or First Degree Misdemeanor? ☐ Yes ☐ No

If "Yes", What charges? _____

Where convicted: _____ Date of Conviction: _____

Have you ever had the adjudication of guilt withheld for a crime which is a Felony or a First Degree Miscdemeanor? ☐ Yes ☐ No

If "Yes", What charges? _____

Where convicted: _____ Date of Conviction: _____

NOTE: A "YES" answer to these questions will not automatically bar you from employment. The nature, job-relatedness, severity and date of the offense in relation to the position for which you are applying are considered.

Citizenship

2nd Chance Mental Health Center, LLC only hires U.S. citizens and lawfuly authorized alien workers. You will be required to provide identification and either proof of citizenship or proof of authorization to work in the U.S.

1. Are you a U.S. citizen? ☐ Yes ☐ No
2. If "NO", are you legally authorized to accept employment with the specific hiring authority to which you are applying? ☐ Yes ☐ No

Please list below family members who work at 2nd Chance Mental Health Center, LLC

Name	Relationship	Job

PLEASE READ CAREFULLY, SIGN AND DATE:

I hereby warrant that the facts stated in the foregoing application are true and complete. I do further authorize 2nd Chance Mental Health Center LLC to investigate, request and receive any information it deems appropriate, in its sole discretion, relating to my past employment, education and/or other activities. I indemnify 2nd Chance Mental Health Center, LLC against any liability which may result from such investigation and receipt of information. Any omission, false answer or statement or implication by me to 2nd Chance Mental Health Center, LLC shall be sufficient cause for denial of, or discharge from, any employment which may be offered to me.

If I am employed by 2nd Chance Mental Health Center, LLC, I agree to strictly obey the work rules and regulations of 2nd Chance Mental Health Center, LLC as well as any changes in said work rules and regulations as they may occur from time to time. I understand that I will be given a copy of 2nd Chance Mental Health Center, LLC's policies and procedures if I am hired and I agree to abide by same. I understand that nothing contained in this employment application or in the granting of an interview is intended to create an employment contract between 2nd Chance Mental Health Center, LLC and myself. No promises regarding employment have been made to me and I understand that no such promise or guarantee is binding upon 2nd Chance Mental Health Center, LLC unless made in writing. I understand that employment in Florida is "At Will" and as such I can quit my employment or be terminated at any time by 2nd Chance Mental Health Center, LLC. I understand that I am on a probationary status for the first six months of employment.

I agree that I will settle any and all previously unasserted claims, disputes or controversies arising out of, or relating to, my application or candidacy for employment, employment and/or cessation of employment with 2nd Chance Mental Health Center, LLC, exclusively by final and binding arbitration before a neutral Arbitrator. By way of example only, such claims include, but are not limited to, claims under federal, state, and local statutory or common law, such as the Age Discrimination in Employment Act, Title VII of the Civil Rights Act of 1964, as amended, including the amendments of the Civil Rights Act of 1991, the Family & Medical Leave Act of 1993, the Americans with Disabilities Act, the law of contract and the law of tort.

Confidentiality

2nd Chance Mental Health Center, LLC employees and volunteers shall not permit the unauthorized disclosure of protected health and/or mental health information except as permitted or required by law, 2nd Chance Mental Health Center, LLC's policy complies with 45 C.F,R. Parts 160, 162 and 164 federal regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and applicable Florida Statutes.

As defined by the Act, protected health information is information which can be used to identify an individual and which relates to the past, present or future physical or mental health condition of an individual, provision of health care to an individual, or the past, present or future payment for health and/or mental health care provided to an individual.

As defined by the Act, disclosure means the release, transfer, provision of, access to, or divulging in any other manner of information outside the entity holding the information.

Employees who disclose or permit the unlawful disclosure of protected health information will be subject to disciplinary action. Employees and volunteers who violate the privacy provisions of the act may also be subjected to criminal penalties under Federal Law.

Alcohol and Drug Free Work Place

I understand that 2nd Chance Mental Health Center , LLC operates and Drug/Alcohol Free Work Place and I understand that I will be given a copy of 2nd Chance Mental Health Center, LLC's Substance Abuse Policy and agree to abide by same. I understand that I may be required to submit to a blood and/or urine test pre-employment, on a random basis, and if injured on a job. In case of an injury, the test will be used to determine if any substances, legal or illegal, contributed to my injury.

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS DOCUMENT AND AGREE TO ABIDE BY ITS TERMS. I FURTHER UNDERSTAND THAT COMPLIANCE WITH THIS POLICY IS A CONDITION OF EMPLOYMENT. I UNDERSTAND THAT THIS SIGNED APPLICATION WILL BE COME A PART OF MY PERSONNEL FILE.

Signature:_____ Date:_____ Witness:_____

agency for persons with disabilities
State of Florida

AFFIDAVIT OF GOOD MORAL CHARACTER

State of Florida County of _____

Before me this day personally appeared _____ who, being duly sworn, says:

I am an applicant for employment as a direct service provider or other individual screened pursuant to Chapter 435, Florida Statutes, and Section 393.0655, Florida Statutes, or I am currently employed as a direct service provider with:

_____

By signing this form, I swear and affirm that I have not been found guilty of or entered a plea of guilty or nolo contendere (no contest) to, regardless of the adjudication, any of the following charges under the provisions of the Florida Statutes or under any similar statute of another jurisdiction. I attest that I have not been arrested for any of the following offenses and am currently awaiting disposition. I also attest that I have not been adjudicated delinquent for any of the following offenses, regardless of whether the records have been sealed or expunged.

I understand that I must acknowledge the existence of any criminal records relating to the following list of offenses. I understand that I am also obligated to notify my employer of any possible disqualifying offenses that may occur while employed in a position subject to background screening under Chapter 435, Florida Statutes. I further understand that the list stated below is subject to change and may include offenses that were not previously included.

NOTE: *The following list of offenses has been updated August 1, 2010, and includes offenses specifically applicable to direct service providers under Chapter 393, Florida Statutes.*

Offenses Relating to:

Sections:	393.0674	Felony offenses for the release or use of information from juvenile records of the Agency for Persons with Disabilities for any purpose other than screening for employment
	393.135	Sexual misconduct with certain developmentally disabled clients or threats and/or coercion relating to reports or testimony of sexual misconduct
	394.4593	Sexual misconduct with certain mental Health patients
	409.920	Medicaid provider fraud
	409.9201	Medicaid fraud
	415.111	The filing or disclosure of information from reports of adult abuse, neglect, or exploitation of aged persons or disabled adults
	741.30	Criminal acts that constitute domestic violence as defined in section 741.28, Florida Statutes
	782.04	Murder
	782.07	Manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child
	782.071	Vehicular homicide
	782.09	Killing of an unborn child by injury to the mother
Chapter:	784	Assault, battery, and culpable negligence, if the offense was a felony.
Sections:	784.011	Assault, if the victim of offense was a minor
	784.03	Battery, if the victim of offense was a minor
	787.01	Kidnapping
	787.02	False imprisonment
	787.025	Luring or enticing a child for an unlawful purpose
	787.04(2)	Taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings
	787.04(3)	Carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person
	790.115(1)	Exhibiting firearms or weapons within 1,000 feet of a school

CONTINUED ON NEXT PAGE

	790.115(2)(b)	Possessing an electric weapon or device, destructive device, or other weapon on school property
	794.011	Sexual battery
	794.041	Former offenses for prohibited acts of persons in familial or custodial authority
	794.05	Unlawful sexual activity with certain minors
Chapter:	796	Prostitution
Section:	798.02	Lewd and lascivious behavior
Chapter:	800	Lewdness and indecent exposure
Section:	806.01	Arson
Sections:	810.02	Burglary
	810.14	Voyeurism, if the offense is a felony
	810.145	Video voyeurism, if the offense is a felony
Chapter:	812	Felony offenses for theft and/or robbery and related crimes
Sections:	817.034	Fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems
	817.234	False and fraudulent insurance claims
	817.505	Patient brokering
	817.563	Felony offenses for the fraudulent sale of controlled substances
	817.568	Criminal use of personal identification information
	817.60	Obtaining a credit card through fraudulent means
	817.61	Felony offenses for the fraudulent use of credit cards
	825.102	Abuse, aggravated abuse, or neglect of an elderly person or disabled adult
	825.1025	Lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult
	825.103	Felony offenses for the exploitation of an elderly person or disabled adult
	826.04	Incest
	827.03	Child abuse, aggravated child abuse, or neglect of a child
	827.04	Contributing to the delinquency or dependency of a child
	827.05	Negligent treatment of children
	827.071	Sexual performance by a child
	831.01	Forgery
	831.02	Uttering forged instruments
	831.07	Forging bank bills, checks, drafts, or promissory notes
	831.09	Uttering forged bank bills, checks, drafts, or promissory notes
	843.01	Resisting arrest with violence
	843.025	Depriving a law enforcement, correctional, or correctional probation officer means of protection or communication
	843.12	Aiding in an escape
	843.13	Aiding in the escape of juvenile inmates in correctional institution
Chapter:	847	Obscene literature
Section:	874.05(1)	Encouraging or recruiting another to join a criminal gang
Chapter:	893	Drug abuse prevention and control if the offense was a felony or if any other person involved in the offense was a minor
Sections:	916.0175	Sexual misconduct with certain forensic clients and reporting requirements for such sexual misconduct
	944.35(3)	Inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm
	944.40	Escape
	944.46	Harboring, concealing, or aiding an escaped prisoner
	944.47	Introduction of contraband into a state correctional facility
	985.701	Sexual misconduct in juvenile justice programs
	985.711	Contraband introduced into detention facilities

CONTINUED ON NEXT PAGE

ONE OF THE FOLLOWING STATEMENTS MUST BE SIGNED:

Under the penalty of perjury, which is a first degree misdemeanor, punishable by a definite term of imprisonment, not exceeding one year and/or a fine not exceeding $1,000 pursuant to ss.837.012, or 775.082, or 775.083, Florida Statutes, I attest that I have read the foregoing, and I am eligible to meet the standards of good character for this caretaker position. This means that I have not been found guilty of or entered a plea of guilty or nolo contendere (no contest) to, regardless of adjudication, any of the offenses listed above or any similar statute of another jurisdiction. I attest that I have not been arrested for any of the above offenses and I am not currently awaiting disposition of any of the above offenses. I also attest that I have not been adjudicated delinquent for any of the above offenses, regardless of whether those records have been sealed or expunged.

_____
Signature of Affiant

OR

To the best of my knowledge and belief, my record may contain one or more of the foregoing disqualifying acts or offenses.

_____
Signature of Affiant

OR

I swear or affirm that I am a licensed physician, licensed nurse, or other professional licensed and regulated by the Department of Health. I will be providing services that are within the scope of my licensed practice, and I am not subject to the screening provisions of section 393.0655, Florida Statutes.

_____
Signature of Affiant

Sworn to and subscribed before me this _____ day of _____, _____

_____ _____
My commission expires NOTARY PUBLIC, STATE OF FLORIDA

My signature, as a Notary Public, verifies the affiant's identification has been validated by

_____

Employment History -- List Most Recent Experience First (DO NOT WRITE "SEE RESUME")

From (Month and Year)	To (Month and Year)	Company or Client Name, Address and Phone		
Starting Salary	Ending Salary			
Your Beginning Title		Supervisor's Name:	Supervisor's Title:	Supervisor's Email:
Your Ending Title		Your Duties		
Your Reason for Leaving				

From (Month and Year)	To (Month and Year)	Company or Client Name, Address and Phone		
Starting Salary	Ending Salary			
Your Beginning Title		Supervisor's Name:	Supervisor's Title:	Supervisor's Email:
Your Ending Title		Your Duties		
Your Reason for Leaving				

From (Month and Year)	To (Month and Year)	Company or Client Name, Address and Phone		
Starting Salary	Ending Salary			
Your Beginning Title		Supervisor's Name:	Supervisor's Title:	Supervisor's Email:
Your Ending Title		Your Duties		
Your Reason for Leaving				

From (Month and Year)	To (Month and Year)	Company or Client Name, Address and Phone		
Starting Salary	Ending Salary			
Your Beginning Title		Supervisor's Name:	Supervisor's Title:	Supervisor's Email:
Your Ending Title		Your Duties		
Your Reason for Leaving				

Who Shall We Call in Case of Emergency		
Name	Relationship	Phone Number

Office Use Only:

PLEASE READ CAREFULLY, SIGN AND DATE:

I hereby warrant that the facts stated in the foregoing application are true and complete. I do further authorize **2nd Chance Mental Health Center, LLC** to investigate, request and receive any information it deems appropriate, in its sole discretion, relating to my past employment, education and/or other activities. I indemnify **2nd Chance Mental Health Center, LLC** against any liability which may result from such investigation and receipt of information. Any omission, false answer, or statement or implication by me to **2nd Chance Mental Health Center, LLC** shall be sufficient cause for denial of, or discharge from, any employment which may be offered to me.

I understand that this application is not a contract, offer or promise of employment. If hired, I will be able to resign at any time for any reason. Likewise, 2nd Chance Mental Health Center, LLC can terminate my employment at any time, with or without any reason or notice, regardless of the successful completion of my introductory period. I understand that no supervisor or other representative of 2nd Chance Mental Health Center, LLC other than the President or CEO has any authority to enter into any agreement for employment for any specified period of time or to make any agreement contrary to the forgoing.

If I am employed by **2nd Chance Mental Health Center, LLC**, I agree to strictly obey the work rules and regulations of **2nd Chance Mental Health Center, LLC** as well as any changes in said work rules and regulations as they may occur from time to time. I understand that I will be given a copy of **2nd Chance Mental Health Center, LLC**' policies and procedures if I am hired and I agree to abide by same. I understand that I am on a probationary status for the first six months of employment.

I agree that I will settle any and all previously unasserted claims, disputes or controversies arising out of, or relating to, my application or candidacy for employment, employment and/or cessation of employment with **2nd Chance Mental Health Center, LLC**, exclusively by final and binding arbitration before a neutral Arbitrator. By way of example only, such claims include but are not limited to claims under federal, state, and local statutory or common law, such as the Age Discrimination in Employment Act, Title VII of the Civil Rights Act of 1964, as amended, including the amendments of the Civil Rights Act of 1991, the Family & Medical Leave Act of 1993, the Americans with Disabilities Act, the law of contract and the law of tort.

Confidentiality

2nd Chance Mental Health Center, LLC employees and volunteers shall not permit the unauthorized disclosure of protected health information except as permitted or required by law. **2nd Chance Mental Health Center, LLC's** policy complies with 45 C.F.R. Parts 160, 162 and 164 federal regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and applicable Florida Statutes. I understand that as a condition of employment I will be required to sign a confidentiality agreement which will become a part of my employment file.

As defined by the Act, protected health information is information which can be used to identify an individual and which relates to the past, present or future physical or mental health or condition of an individual, provision of health care to an individual, or the past, present or future payment for health care provided to an individual.

As defined by the Act, disclosure means the release, transfer, provision of, access to, or divulging in any other manner of information outside the entity holding the information.

Employees who disclose or permit the unlawful disclosure of protected health information will be subject to disciplinary action. Employees and volunteers who violate the privacy provisions of the Act may also be subjected to criminal penalties under Federal Law.

Alcohol and Drug Free Work Place

I understand that **2nd Chance Mental Health Center, LLC** operates a Drug/Alcohol Free Work Place and I understand that I will be given a copy of **2nd Chance Mental Health Center, LLC's** Substance Abuse Policy and agree to abide by same. I understand that I may be required to submit to a blood and/or urine test pre-employment, on a random basis and if injured on a job. In case of an injury, the test will be used to determine if any substances, legal or illegal, contributed to my injury.

Non-Compete Agreement

I understand that, as a condition of employment, I may be required to sign a Non-Compete Agreement to protect **2nd Chance Mental Health Center, LLC** from the loss of trade secrets, valuable confidential business information, substantial referral and other relationships or goodwill associated with our organization.

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS DOCUMENT AND AGREE TO ABIDE BY ITS TERMS. I FURTHER UNDERSTAND THAT COMPLIANCE WITH THIS POLICY IS A CONDITION OF EMPLOYMENT. I UNDERSTAND THAT THIS SIGNED APPLICATION WILL BECOME A PART OF MY PERSONNEL FILE.

Signature:_____ Date:_____ Witness:_____

REFERENCES

ON THE LEFT SIDE, PLEASE LIST BELOW THE NAMES OF THE SUPERVISORS ON YOUR LAST THREE JOBS, along with the information we need to contact them. If you have left an oranization or client on bad terms, please take this opportunity to explain your side of the story so that we can take it into account when we check with your supervisors to hear their version. THE RIGHT SIDE OF THIS FORM IS FOR OFFICE USE ONLY.

Your Name	Your Former Names (if any)	Your Social Security Number

Your Supervisor's Name	Person Contacted / Date of Contact
Company or Client Name	Rehire? ☐ Work Dates Correct ☐ Salalry Accurate ☐ Yes ☐ No
Company/Client Address City, State and Zip	Job Title:
Your Job Title:	
Company or Client Phone / Company or Client Email	
Dates of Employment Month/Year Month/Year From:_____ To:_____ / Starting Salary: Ending Salary:	

Your Supervisor's Name	Person Contacted / Date of Contact
Company or Client Name	Rehire? ☐ Work Dates Correct ☐ Salalry Accurate ☐ Yes ☐ No
Company/Client Address City, State and Zip	Job Title:
Your Job Title:	
Company or Client Phone / Company or Client Email	
Reason for Leaving	

Your Supervisor's Name	Person Contacted / Date of Contact
Company or Client Name	Rehire? ☐ Work Dates Correct ☐ Salalry Accurate ☐ Yes ☐ No
Company/Client Address City, State and Zip	Job Title:
Your Job Title:	
Company or Client Phone / Company or Client Email	
Reason for Leaving	

By signing below, I hereby authorize 2nd Chance MHC to investigate, request and receive any information it deems appropriate in its sole discretion, relating to my past employment, education and/or other activities. I indemnify 2nd Chance Mental Health Center, LLC against any liability which may result from such investigation and receipt of information. Any omission or false answer or statement or implication by me to Home Helpers or any of its clients shall be sufficient cause for denial of, or discharge from, any employment which may be offered me.

Signature: _____ Date:_____ Phone:_____

For Office Use Only

Date Completed	Reference Completed By	Overall Evaluation

2ND CHANCE MENTAL HEALTH CENTER, LLC
1541 SE Port St. Lucie Boulevard, Suite F
Port St. Lucie, FL 34952
Phone: (772) 335-0166
Fax: (772) 335-0169

DISCLOSURE AND AUTHORIZATION FORM TO OBTAIN CONSUMER REPORTS FOR EMPLOYMENT PURPOSES

Please Read Carefully Before Signing the Authorization

DISCLOSURE

In considering you for employment and, if you are employed, in considering you for subsequent promotion, assignment, reassignment, retention, or discipline, 2nd Chance Mental Health Center, LLC ("the Company") may request and rely upon one or more consumer reports or investigative consumer reports about you that we obtain from a consumer reporting agency, such as IntelliCorp Records, Inc.

For explanation purposes:

- a "consumer report" is a written, oral or other communication of any information by a consumer reporting agency bearing on your credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living which is used or expected to be used or collected in whole or in part for the purpose of serving as a factor in making an employment-related decision about you. Such information may include, for example, credit information, criminal history reports, or driving records; and

- an "investigative consumer report" is a consumer report in which information on your character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with your prior employers, neighbors, friends, or associates, or with others who may have knowledge concerning any such items of information. .In the event an investigative consumer report is requested about you, you are entitled to additional disclosures regarding the nature and scope of the investigation requested, as well as a written summary of your rights under the Fair Credit Reporting Act ("FCRA").

Under the FCRA, before the Company can obtain a consumer report or investigative consumer report about you for employment purposes, we must have your written authorization. Before we take adverse action on the basis, in whole or in part, of information in that report, you will be provided a copy of that report, the name, address, and telephone number of the consumer reporting agency, and a summary of your rights under the FCRA.

2ND CHANCE MENTAL HEALTH CENTER, LLC
1541 SE Port St. Lucie Boulevard, Suite F
Port St. Lucie, FL 34952
Phone: (772) 335-0166
Fax: (772) 335-0169

AUTHORIZATION

I have read and understand the foregoing Disclosure, and authorize the Company to obtain and rely upon consumer reports or investigative consumer reports in considering me for employment and, if I am employed, in considering me for subsequent promotion, assignment, reassignment, retention, or discipline. By my signature below, I authorize the Company to obtain any such reports and to share the information received with any person involved in the employment decision about me.

I do ☐ I do not ☐ authorize you to contact my *current* employer for Employment and Reference Verifications.

(This will authorize immediate inquiries to the Human Resources Department and to any listed supervisors or references in the Employment/Reference Section of your application.)

I also agree that this Disclosure and Authorization in original, faxed, photocopied, or electronic (including electronically Signed) form will be valid for any consumer reports or investigative consumer reports that may be requested about me by or on behalf of the Company.

_____

Applicant Signature Date

ATTESTATION OF COMPLIANCE
with Background Screening Requirements

Authority: This form shall be used by **all employees** to comply with:

- the attestation requirements of **section 435.05(2), Florida Statutes**, which state that every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer; **AND**

- the proof of screening within the previous 5 years in **section 408.809(2), Florida Statutes**, which requires proof of compliance with level 2 screening standards that have been screened through the Care Provider Background Screening Clearinghouse created under Section 435.12, F.S., or screened within the previous 5 years by the Agency, Department of Health, Department of Elder Affairs, the Agency for Persons with Disabilities, Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S., and in accordance with the standards in Section 408.809(2), F.S., if that agency is not currently implemented in the Care Provider Background Screening Clearinghouse.

This form must be maintained in the employee's personnel file. If this form is used as proof of screening for an administrator or chief financial officer to satisfy the requirements of an **application for a health care provider license**, please attach a copy of the screening results and submit with the licensure application.

Employee/Contractor Name:
Health Care Provider/ Employer Name:
Address of Health Care Provider:

You must attest to meeting the requirements for employment and you may not have been arrested for and awaiting final disposition of, have been found guilty of, regardless of adjudication, or have entered a plea of nolo contendere (no contest) or guilty to, or have been adjudicated delinquent and the record has not been sealed or expunged for, any offense prohibited under *any* of the following provisions of state law or similar law of another jurisdiction:

Criminal offenses found in section 435.04, F.S.

(a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.

(b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.

(c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.

(d) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(e) Section 782.04, relating to murder.

(g) Section 782.071, relating to vehicular homicide

(h) Section 782.09, relating to killing of an unborn child by injury to the mother.

(i) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.

(j) Section 784.011, relating to assault, if the victim of the offense was a minor.

(k) Section 784.03, relating to battery, if the victim of the offense was a minor.

(l) Section 787.01, relating to kidnapping.

(m) Section 787.02, relating to false imprisonment.

(n) Section 787.025, relating to luring or enticing a child.

(o) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.

(p) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.

(q) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.

(r) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.

(s) Section 794.011, relating to sexual battery.

(t) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.

(u) Section 794.05, relating to unlawful sexual activity with certain minors.

(v) Chapter 796, relating to prostitution.

(w) Section 798.02, relating to lewd and lascivious behavior.

(x) Chapter 800, relating to lewdness and indecent exposure.

(y) Section 806.01, relating to arson.

(z) Section 810.02, relating to burglary.

(aa) Section 810.14, relating to voyeurism, if the offense is a felony.

(bb) Section 810.145, relating to video voyeurism, if the offense is a felony.

(cc) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.

(dd) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

(ee) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.

(ff) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.

(gg) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.

(hh) Section 826.04, relating to incest.

(ii) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child

(jj) Section 827.04, relating to contributing to the delinquency or dependency of a child.

(kk) Former s. 827.05, relating to negligent treatment of children.

(ll) Section 827.071, relating to sexual performance by a child.

(mm) Section 843.01, relating to resisting arrest with violence.

(nn) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.

(oo) Section 843.12, relating to aiding in an escape.

(pp) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.

(qq) Chapter 847, relating to obscene literature.

(rr) Section 874.05(1), relating to encouraging or recruiting another to join a criminal gang.

(ss) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

(tt) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.

(uu) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.

(vv) Section 944.40, relating to escape.

(ww) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.

(xx) Section 944.47, relating to introduction of contraband into a correctional facility.

(yy) Section 985.701, relating to sexual misconduct in juvenile justice programs.

(zz) Section 985.711, relating to contraband introduced into detention facilities.

(3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

Criminal offenses found in section 408.809(4), F.S.

(a) Any authorizing statutes, if the offense was a felony.

(b) This chapter, if the offense was a felony.

(c) Section 409.920, relating to Medicaid provider fraud.

(d) Section 409.9201, relating to Medicaid fraud.

(e) Section 741.28, relating to domestic violence.

(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.

(h) Section 817.234, relating to false and fraudulent insurance claims.

(i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.

(j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.

(k) Section 817.505, relating to patient brokering.

(l) Section 817.568, relating to criminal use of personal identification information.

(m) Section 817.60, relating to obtaining a credit card through fraudulent means.

(n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.

(o) Section 831.01, relating to forgery.

(p) Section 831.02, relating to uttering forged instruments.

(q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.

(r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.

(s) Section 831.30, relating to fraud in obtaining medicinal drugs.

(t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony

(u) Section 895.03, relating to racketeering and collection of unlawful debts.

(v) Section 896.101, relating to the Florida Money Laundering Act.

☐ **I have been granted an Exemption from Disqualification through the Agency for Healthcare Administration (AHCA).**

Date of Decision: _____

☐ **I have been granted an Exemption from Disqualification through the Florida Department of Health.**

Date of Decision: _____

*****A copy of the Exemption from Disqualification decision letter must be attached*****

If you are also using this form to provide evidence of prior Level 2 screening (fingerprinting) in the last 5 years and have not been unemployed for more than 90 days, please provide the following information. **A copy of the prior screening results must be attached.**

Purpose of Prior Screening:_____

Screening conducted by: Date of Prior Screening: _____

☐ Agency for Healthcare Administration
☐ Department of Health
☐ Agency for Persons with Disabilities
☐ Department of Elder Affairs
☐ Department of Financial Services
☐ Department of Children and Families

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

Attestation

Under penalty of perjury, I, _____, hereby swear or affirm that I meet the requirements for qualifying for employment in regards to the background screening standards set forth in Chapter 435 and section 408.809, F.S. In addition, I agree to immediately inform my employer if arrested or convicted of any of the disqualifying offenses while employed by any health care provider licensed pursuant to Chapter 408, Part II F.S.

_____	_____	_____
Employee/Contractor Signature	Title	Date

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 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:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
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				

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

2nd Chance Mental Health Center
New Employee Payroll Information

Name (First, Middle, Last): _____

Home Street Address: _____

City, State & Zip Code: _____

Home Phone: _____

Email: _____

Hire Date: _____

Social Security Number: _____

Birthdate: _____

Gender:
[ ] Male [ ] Female

Withholding Status:
[ ] Single [ ] Married [ ] Married but Withholding at a Higher Rate

Number of Deductions/Allowances: _____

Override or Additional Money to be Deducted from Paycheck: _____

Pay Type and Rate:
[ ] Hourly Amount per Hour: _____

[ ] Salary Amount Biweekly: _____

Employee Type:
[ ] Part-time [ ] Temporary [ ] Full-time

2ND CHANCE MENTAL HEALTH CENTER, LLC
1541 Port St. Lucie Boulevard, Suite F
Port St. Lucie, FL 34952
Phone: (772) 335-0166
Fax: (772) 335-0169

DRUG-FREE WORKPLACE POLICY STATEMENT

2nd Chance Mental Health Center, LLC's drug free work place policy complies with section 112.0455 of the Florida Statutes, known as the Drug-Free Workplace Act and applicable federal regulations under the Federal Drug-Free Workplace Act of 1988 (41 U.S.C. 701 et seq.0. The purpose of the policy is to establish and maintain a drug-free workplace. Consequently, 2nd Chance Mental Health Center, LLC employees shall not use illegal drugs. The unlawful manufacture, distribution, dispensing and/or possession of any illegal drug are prohibited in the workplace. Employees or applicants who unlawfully use drugs or who are under the influence of illegal drugs while in the workplace are not suitable for employment with 2nd Chance Mental Health Center, LLC.

Drug means alcohol, including distilled spirits, wine, malt beverage and intoxicating liquors, amphetamines, cannabinoids, cocaine, phencyclidine (PCP), hallucinogens, methaqualone, opiates, barbiturates, benzodiazepines, synthetic narcotics, designer drugs, or a metabolite of any of the above substances.

Any employee who unlawfully manufactures, distributes, dispenses or possesses illegal drugs n the workplace is subject to disciplinary action up to and including dismissal.

2nd Chance Mental Health Center, LLC may utilize the provisions of Section 112.0455, Florida Statutes, to require drug tests of job applicants and full-time, or part-time employees.

Drug screening tests are performed in the following circumstances:
1. Pre-employment Testing
2. Post Accident
3. Upon Reasonable Suspicion

1. **Pre-employment Testing**: During the hiring process, applicants will be required to undergo a drug screening scheduled by the Director. Results of the test will be disclosed to the applicant but will otherwise remain confidential (subject to any contrary interpretation under Chapter 119, Florida Statutes). A final determination that the applicant has conclusively tested positive for a controlled substance shall be sufficient cause to deny employment.

2. **Post Accident:** If, during the course of doing 2nd Chance business and/or operating a 2nd Chance owned or rented vehicle, the employee is involved in a vehicular accident, unless he/she requires immediate medical treatment, he/she is required to undergo drug screening immediately following the accident. Upon notification of the accident, the immediate supervisor must notify the Director who will arrange the testing. The supervisor will transport the employee to the testing site.

3. **Upon Reasonable Suspicion**: If, during the term of employment, a full-time or part-time employee is found to be in possession of or using a controlled substance; or reasonable suspicion exists to support a determination that the employee has used, possessed or is using a controlled substance, the office may require the employee to undergo an appropriate drug screening test at the expense of the office. Results of the test will be disclosed to the employee but will otherwise remain confidential (subject to a contrary interpretation under Chapter 119). A final determination that the employee has conclusively tested positive for a controlled substance for the first time during the period of employment with this office will be sufficient cause for requiring the employee to participate in an employee assistance program or a drug rehabilitation program.

Participation in an employee assistance program or a drug rehabilitation program will be at the employee's expense unless the cost is covered by the employee's chosen health insurance plan. Failure to enter a program approved by the office, or failure to successfully complete the program, or failure to sign a written consent form allowing the office to obtain information regarding the progress and successful completion of the program will be sufficient cause to terminate his/her employment. All testing shall be conducted in a manner designed to cause the least possible embarrassment to the applicant or employee. Determinations of reasonable suspicion and testing will be carried out in compliance with the provisions of Section 112.0455. Each applicant required to submit to drug testing shall be given written notice and an opportunity to respond prior to testing.

Depending on the severity of a drug problem and the circumstances of an individual case, drug abuse may serve as the basis for discipline or termination.

I hereby acknowledge receipt of a copy of 2nd Chance Mental Health Center, LLC's Drug-Free Workplace Policy Statement.

I have read 2nd Chance Mental Health Center, LLC's Drug-Free Workplace Policy Statement and understand my compliance with this policy is a condition of employment. I also understand that this signed receipt of 2nd Chance Mental Health Center, LLC's Drug-Free Workplace Policy Statement will become a permanent part of my personnel file.

Print Name: _____

Signature: _____

Date: _____

2ND CHANCE MENTAL HEALTH CENTER, LLC
1541 Port St. Lucie Boulevard, Suite F
Port St. Lucie, FL 34952
Phone: (772) 335-0166
Fax: (772) 335-0169

Emergency Contact Information

EMPLOYEE NAME: _____

Work Location: _____

In the event of an emergency please contact:

Name_____ Relationship _____

Street Address _____

City /State _____

Phone Number_____

Secondary Contact:

Name_____ Relationship _____

Street Address_____

City /State_____

Phone Number _____

Form W-4 (2019)

Future developments. For the latest information about any future developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

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. You may claim exemption from withholding for 2019 if **both** of the following apply.

- For 2018 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2019 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2019 expires February 17, 2020. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2019 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income not subject to withholding outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2019. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married filing jointly and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

Nonwage income. If you have a large amount of nonwage income not subject to withholding, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Additional Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Specific Instructions

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. ***Head of household please note:*** Generally, you may claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you may be eligible to claim a child tax credit for each of your eligible children. To qualify, the child must be under age 17 as of December 31, must be your dependent who lives with you for more than half the year, and must have a valid social security number. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line F. Credit for other dependents. When you file your tax return, you may be eligible to claim a credit for other dependents for whom a child tax credit can't be claimed, such as a qualifying child who doesn't meet the age or social security number requirement for the child tax credit, or a qualifying relative. To learn more about this credit, see Pub. 972. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total

---------- **Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.** ----------

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

Employee's Withholding Allowance Certificate

▶ **Whether you're 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

2019

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 filing separately, check "Married, but withhold at higher Single rate."	
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 800-772-1213 for a replacement card.** ▶ ☐	

5	Total number of allowances you're claiming (from the applicable worksheet on the following pages)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2019, 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 boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)	**9** First date of employment	**10** Employer identification number (EIN)

income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line G. Other credits. You may be able to reduce the tax withheld from your paycheck if you expect to claim other tax credits, such as tax credits for education (see Pub. 970). If you do so, your paycheck will be larger, but the amount of any refund that you receive when you file your tax return will be smaller. Follow the instructions for Worksheet 1-6 in Pub. 505 if you want to reduce your withholding to take these credits into account. Enter "-0-" on lines E and F if you use Worksheet 1-6.

Deductions, Adjustments, and Additional Income Worksheet

Complete this worksheet to determine if you're able to reduce the tax withheld from your paycheck to account for your itemized deductions and other adjustments to income, such as IRA contributions. If you do so, your refund at the end of the year will be smaller, but your paycheck will be larger. You're not required to complete this worksheet or reduce your withholding if you don't wish to do so.

You can also use this worksheet to figure out how much to increase the tax withheld from your paycheck if you have a large amount of nonwage income not subject to withholding, such as interest or dividends.

Another option is to take these items into account and make your withholding more accurate by using the calculator at *www.irs.gov/W4App*. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Two-Earners/Multiple Jobs Worksheet

Complete this worksheet if you have more than one job at a time or are married filing jointly and have a working spouse. If you don't complete this worksheet, you might have too little tax withheld. If so, you will owe tax when you file your tax return and might be subject to a penalty.

Figure the total number of allowances you're entitled to claim and any additional amount of tax to withhold on all jobs using worksheets from only one Form W-4. Claim all allowances on the W-4 that you or your spouse file for the highest paying job in your family and claim zero allowances on Forms W-4 filed for all other jobs. For example, if you earn $60,000 per year and your spouse earns $20,000, you should complete the worksheets to determine what to enter on lines 5 and 6 of your Form W-4, and your spouse should enter zero ("-0-") on lines 5 and 6 of his or her Form W-4. See Pub. 505 for details.

Another option is to use the calculator at *www.irs.gov/W4App* to make your withholding more accurate.

Tip: If you have a working spouse and your incomes are similar, you can check the "Married, but withhold at higher Single rate" box instead of using this worksheet. If you choose this option, then each spouse should fill out the Personal Allowances Worksheet and check the "Married, but withhold at higher Single rate" box on Form W-4, but only one spouse should claim any allowances for credits or fill out the Deductions, Adjustments, and Additional Income Worksheet.

Instructions for Employer

Employees, do not complete box 8, 9, or 10. Your employer will complete these boxes if necessary.

New hire reporting. Employers are required by law to report new employees to a designated State Directory of New Hires. Employers may use Form W-4, boxes 8, 9, and 10 to comply with the new hire reporting requirement for a newly hired employee. A newly hired employee is an employee who hasn't previously been employed by the employer, or who was previously employed by the employer but has been separated from such prior employment for at least 60 consecutive days. Employers should contact the appropriate State Directory of New Hires to find out how to submit a copy of the completed Form W-4. For information and links to each designated State Directory of New Hires (including for U.S. territories), go to ***www.acf.hhs.gov/css/employers.***

If an employer is sending a copy of Form W-4 to a designated State Directory of New Hires to comply with the new hire reporting requirement for a newly hired employee, complete boxes 8, 9, and 10 as follows.

Box 8. Enter the employer's name and address. If the employer is sending a copy of this form to a State Directory of New Hires, enter the address where child support agencies should send income withholding orders.

Box 9. If the employer is sending a copy of this form to a State Directory of New Hires, enter the employee's first date of employment, which is the date services for payment were first performed by the employee. If the employer rehired the employee after the employee had been separated from the employer's service for at least 60 days, enter the rehire date.

Box 10. Enter the employer's employer identification number (EIN).

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself	A	
B	Enter "1" if you will file as married filing jointly	B	
C	Enter "1" if you will file as head of household	C	
D	Enter "1" if: • You're single, or married filing separately, and have only one job; or • You're married filing jointly, 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.	D	
E	**Child tax credit.** See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $71,201 ($103,351 if married filing jointly), enter "4" for each eligible child. • If your total income will be from $71,201 to $179,050 ($103,351 to $345,850 if married filing jointly), enter "2" for each eligible child. • If your total income will be from $179,051 to $200,000 ($345,851 to $400,000 if married filing jointly), enter "1" for each eligible child. • If your total income will be higher than $200,000 ($400,000 if married filing jointly), enter "-0-"	E	
F	**Credit for other dependents.** See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $71,201 ($103,351 if married filing jointly), enter "1" for each eligible dependent. • If your total income will be from $71,201 to $179,050 ($103,351 to $345,850 if married filing jointly), enter "1" for every two dependents (for example, "-0-" for one dependent, "1" if you have two or three dependents, and "2" if you have four dependents). • If your total income will be higher than $179,050 ($345,850 if married filing jointly), enter "-0-"	F	
G	**Other credits.** If you have other credits, see Worksheet 1-6 of Pub. 505 and enter the amount from that worksheet here. If you use Worksheet 1-6, enter "-0-" on lines E and F	G	
H	Add lines A through G and enter the total here ▶	H	

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, or if you have a large amount of nonwage income not subject to withholding and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.
- If you **have more than one job at a time** or are **married filing jointly and you and your spouse both work,** and the combined earnings from all jobs exceed $53,000 ($24,450 if married filing jointly), see the **Two-Earners/Multiple Jobs Worksheet** on page 4 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 above.

Deductions, Adjustments, and Additional Income Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income not subject to withholding.

1	Enter an estimate of your 2019 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 10% of your income. See Pub. 505 for details	1	$
2	Enter: $24,400 if you're married filing jointly or qualifying widow(er); $18,350 if you're head of household; $12,200 if you're 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 2019 adjustments to income, qualified business income deduction, and any additional standard deduction for age or blindness (see Pub. 505 for information about these items)	4	$
5	**Add** lines 3 and 4 and enter the total	5	$
6	Enter an estimate of your 2019 nonwage income not subject to withholding (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero, enter "-0-". If less than zero, enter the amount in parentheses	7	$
8	**Divide** the amount on line 7 by $4,200 and enter the result here. If a negative amount, enter in parentheses. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, above	9	
10	**Add** lines 8 and 9 and enter the total here. If zero or less, enter "-0-". If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 of that worksheet on page 4. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet

Note: Use this worksheet *only* if the instructions under line H from the **Personal Allowances Worksheet** direct you here.

1 Enter the number from the **Personal Allowances Worksheet,** line H, page 3 (or, if you used the **Deductions, Adjustments, and Additional Income Worksheet** on page 3, the number from line 10 of that worksheet) . . . . . 1 _____

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you're married filing jointly and wages from the highest paying job are $75,000 or less and the combined wages for you and your spouse are $107,000 or less, don't 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 2019. For example, divide by 18 if you're paid every 2 weeks and you complete this form on a date in late April when there are 18 pay periods remaining in 2019. 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 - $5,000	0	$0 - $7,000	0
5,001 - 9,500	1	7,001 - 13,000	1
9,501 - 19,500	2	13,001 - 27,500	2
19,501 - 35,000	3	27,501 - 32,000	3
35,001 - 40,000	4	32,001 - 40,000	4
40,001 - 46,000	5	40,001 - 60,000	5
46,001 - 55,000	6	60,001 - 75,000	6
55,001 - 60,000	7	75,001 - 85,000	7
60,001 - 70,000	8	85,001 - 95,000	8
70,001 - 75,000	9	95,001 - 100,000	9
75,001 - 85,000	10	100,001 - 110,000	10
85,001 - 95,000	11	110,001 - 115,000	11
95,001 - 125,000	12	115,001 - 125,000	12
125,001 - 155,000	13	125,001 - 135,000	13
155,001 - 165,000	14	135,001 - 145,000	14
165,001 - 175,000	15	145,001 - 160,000	15
175,001 - 180,000	16	160,001 - 180,000	16
180,001 - 195,000	17	180,001 and over	17
195,001 - 205,000	18		
205,001 and over	19		

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 - $24,900	$420	$0 - $7,200	$420
24,901 - 84,450	500	7,201 - 36,975	500
84,451 - 173,900	910	36,976 - 81,700	910
173,901 - 326,950	1,000	81,701 - 158,225	1,000
326,951 - 413,700	1,330	158,226 - 201,600	1,330
413,701 - 617,850	1,450	201,601 - 507,800	1,450
617,851 and over	1,540	507,801 and over	1,540

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.

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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.

2nd Chance Mental Health Center, LLC

Key Inventory Sheet

Staff Name: _____

Key	Date Received (+ initials)	Date Returned (+ initials)
Front Door Key	_____	_____
Office Key	_____	_____
Supply Closet Key	_____	_____
Vehicle Key		
License Plate # _____	_____	_____
License Plate # _____	_____	_____
License Plate # _____	_____	_____
Drawer Key	_____	_____
Closet key –Clinical Side	_____	_____
Other _____	_____	_____
Other _____	_____	_____