Sunbridge
home health care

1313 13th Avenue Decatur, AL 35601
Office: 256-580-5800
Fax: 256-580-5801

Applicant Information

Date of Application:
M M / D D / Y Y

PERSONAL INFORMATION

Last Name: First Name: MI:

Address:

Apartment/Unit: City: State: Zip:

Phone:		Are you a citizen of the United States?	Yes No
Email:		If no, are you authorized to work in the US?	Yes No
Social Security:		Have you ever worked for this company?	Yes No
Nursing License #:		If yes, when?	
Position Applied For:		Have you ever been convicted of a felony?	Yes No

Please provide dates and times you are available to work:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

EDUCATION

High School: From: To:

Address: Did you graduate? Yes No

College: From: To:

Address: Did you graduate? Yes No

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PROFESSIONAL REFERENCES

Please list three professional references:

Name: Relationship:

Company: Phone:

Address:

Name: Relationship:

Company: Phone:

Address:

Name: Relationship:

Company: Phone:

Address:

PREVIOUS EMPLOYMENT

Company: Phone:

Address: Supervisor:

Job Title: Starting Salary: Ending Salary:

From: To: Reason for Leaving:

May we contact your previous supervisor for a reference? Yes No

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Company: Phone:

Address: Supervisor:

Job Title: Starting Salary: Ending Salary:

From: To: Reason for Leaving:

May we contact your previous supervisor for a reference? Yes No

Company: Phone:

Address: Supervisor:

Job Title: Starting Salary: Ending Salary:

From: To: Reason for Leaving:

May we contact your previous supervisor for a reference? Yes No

MILITARY SERVICES

Branch: From: To:

Rank at Discharge: Type of Discharge:

If other than honorable, explain:

DISCLAIMER AND SIGNATURE

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

Signature:

Date:

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Background Check Authorization

Confidential

Printed Name:

(First Name) (Middle Name) (Last Name)

Former Name(s) and Dates Used:

Current Address Since:

(MM/YYYY) (Street) (City) (State/Zip)

Previous Address Since:

(MM/YYYY) (Street) (City) (State/Zip)

Previous Address Since:

(MM/YYYY) (Street) (City) (State/Zip)

Social Security Number: Date of Birth:

Driver's License Number/State: Telephone Number:

The information contained in this application is correct to the best of my knowledge. I hereby authorize Sunbridge Home Healthcare, Inc and its designated agents and representatives to conduct a comprehensive review of my background causing a consumer report and/or investigative consumer report may include, but is not limited, to the following areas: verification of social security number, current and previous residences, employment history, educational background, character references, civil and criminal records from any criminal justice agency in any or all federal, state, country jurisdictions, driving records, birth records and any other public records.

I further authorize any individual, company, firm, corporation or public agency (including the Social Security Administration and law enforcement agencies) to divulge any and all information, verbal or written, pertaining to me to Sunbridge Home Healthcare, Inc or its agents. I further authorize the complete release of any records or data pertaining to me from other source.

By my signature below, I certify the information I provided on and in connection with, this form is true, accurate and complete.

Signature: Date:

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Application for Background Pre-Screen

Please check the appropriate space below for which you would fall under.

BE AWARE THAT YOUR BACKGROUND WILL BE CHECKED AND INTENTIONALLY FALSIFYING THIS DOCUMENT WILL RESULT IN A NO-HIRE NOW AND WILL NEGATIVELY AFFECT FUTURE CONSIDERATION.

If you have issues that may result in a failed background check in one or more of the items listed, it does not necessarily mean that you cannot be hired; it just means that there are certain facilities that you cannot work.

Name:

PLEASE CHECK ALL THAT APPLY:

I have been convicted of a felony or have been convicted as a Sexual Offender ☐

I have been convicted of any misdemeanor involving drug use or possession or any violence in the last 4 years. ☐

If so, when?

I have had a series of vehicular convictions (DUI, DWI, or driving with a revoked or expired license)

2 in the last year ☐

2 in the last 5 years ☐

5 in your lifetime ☐

I have been convicted of check fraud within the last 4 years ☐

I have special circumstances, questions or would like to discuss my situation with a company representative ☐

I have none of the above ☐

Signature:

Date:

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2025

Step 1: Enter Personal Information

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

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

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if: you are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

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

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

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

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 **and** you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2025 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 17, 2026.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Are submitting this form after the beginning of the year;

2. Expect to work only part of the year;

3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;

4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

5. Prefer the most accurate withholding for multiple job situations.

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

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

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work. Submit a separate Form W-4 for each job.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

Instead, if you (and your spouse) have a total of only two jobs, you may check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2025 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . **2b** $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3**

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . **4** $

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2025 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $30,000 if you're married filing jointly or a qualifying surviving spouse
- $22,500 if you're head of household
- $15,000 if you're single or married filing separately

. . . . . **2** $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . **3** $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . **4** $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . **5** $

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 with no other entries on the form; 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 territories 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.

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$700	$850	$910	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	700	1,700	1,910	2,110	2,220	2,220	2,220	2,220	2,220	2,220	3,220
$20,000 - 29,999	700	1,700	2,760	3,110	3,310	3,420	3,420	3,420	3,420	3,420	4,420	5,420
$30,000 - 39,999	850	1,910	3,110	3,460	3,660	3,770	3,770	3,770	3,770	4,770	5,770	6,770
$40,000 - 49,999	910	2,110	3,310	3,660	3,860	3,970	3,970	3,970	4,970	5,970	6,970	7,970
$50,000 - 59,999	1,020	2,220	3,420	3,770	3,970	4,080	4,080	5,080	6,080	7,080	8,080	9,080
$60,000 - 69,999	1,020	2,220	3,420	3,770	3,970	4,080	5,080	6,080	7,080	8,080	9,080	10,080
$70,000 - 79,999	1,020	2,220	3,420	3,770	3,970	5,080	6,080	7,080	8,080	9,080	10,080	11,080
$80,000 - 99,999	1,020	2,220	3,420	4,620	5,820	6,930	7,930	8,930	9,930	10,930	11,930	12,930
$100,000 - 149,999	1,870	4,070	6,270	7,620	8,820	9,930	10,930	11,930	12,930	14,010	15,210	16,410
$150,000 - 239,999	1,870	4,240	6,640	8,190	9,590	10,890	12,090	13,290	14,490	15,690	16,890	18,090
$240,000 - 259,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$260,000 - 279,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$280,000 - 299,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$300,000 - 319,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,170	19,170
$320,000 - 364,999	2,040	4,440	6,840	8,390	9,790	11,100	12,470	14,470	16,470	18,470	20,470	22,470
$365,000 - 524,999	2,790	6,290	9,790	12,440	14,940	17,350	19,650	21,950	24,250	26,550	28,850	31,150
$525,000 and over	3,140	6,840	10,540	13,390	16,090	18,700	21,200	23,700	26,200	28,700	31,200	33,700

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$200	$850	$1,020	$1,020	$1,020	$1,370	$1,870	$1,870	$1,870	$1,870	$1,870	$2,040
$10,000 - 19,999	850	1,700	1,870	1,870	2,220	3,220	3,720	3,720	3,720	3,720	3,890	4,090
$20,000 - 29,999	1,020	1,870	2,040	2,390	3,390	4,390	4,890	4,890	4,890	5,060	5,260	5,460
$30,000 - 39,999	1,020	1,870	2,390	3,390	4,390	5,390	5,890	5,890	6,060	6,260	6,460	6,660
$40,000 - 59,999	1,220	3,070	4,240	5,240	6,240	7,240	7,880	8,080	8,280	8,480	8,680	8,880
$60,000 - 79,999	1,870	3,720	4,890	5,890	7,030	8,230	8,930	9,130	9,330	9,530	9,730	9,930
$80,000 - 99,999	1,870	3,720	5,030	6,230	7,430	8,630	9,330	9,530	9,730	9,930	10,130	10,580
$100,000 - 124,999	2,040	4,090	5,460	6,660	7,860	9,060	9,760	9,960	10,160	10,950	11,950	12,950
$125,000 - 149,999	2,040	4,090	5,460	6,660	7,860	9,060	9,950	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,090	5,460	6,660	8,450	10,450	11,950	12,950	13,950	15,080	16,380	17,680
$175,000 - 199,999	2,040	4,290	6,450	8,450	10,450	12,450	13,950	15,230	16,530	17,830	19,130	20,430
$200,000 - 249,999	2,720	5,570	7,900	10,200	12,500	14,800	16,600	17,900	19,200	20,500	21,800	23,100
$250,000 - 399,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$400,000 - 449,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$450,000 and over	3,140	6,490	9,160	11,660	14,160	16,660	18,660	20,160	21,660	23,160	24,660	26,160

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$450	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,870	$1,870	$1,870	$1,890
$10,000 - 19,999	450	1,450	2,000	2,200	2,220	2,220	2,220	3,180	4,070	4,070	4,090	4,290
$20,000 - 29,999	850	2,000	2,600	2,800	2,820	2,820	3,780	4,780	5,670	5,690	5,890	6,090
$30,000 - 39,999	1,000	2,200	2,800	3,000	3,020	3,980	4,980	5,980	6,890	7,090	7,290	7,490
$40,000 - 59,999	1,020	2,220	2,820	3,830	4,850	5,850	6,850	8,050	9,130	9,330	9,530	9,730
$60,000 - 79,999	1,020	3,030	4,630	5,830	6,850	8,050	9,250	10,450	11,530	11,730	11,930	12,130
$80,000 - 99,999	1,870	4,070	5,670	7,060	8,280	9,480	10,680	11,880	12,970	13,170	13,370	13,570
$100,000 - 124,999	1,950	4,350	6,150	7,550	8,770	9,970	11,170	12,370	13,450	13,650	14,650	15,650
$125,000 - 149,999	2,040	4,440	6,240	7,640	8,860	10,060	11,260	12,860	14,740	15,740	16,740	17,740
$150,000 - 174,999	2,040	4,440	6,240	7,640	8,860	10,860	12,860	14,860	16,740	17,740	18,940	20,240
$175,000 - 199,999	2,040	4,440	6,640	8,840	10,860	12,860	14,860	16,910	19,090	20,390	21,690	22,990
$200,000 - 249,999	2,720	5,920	8,520	10,960	13,280	15,580	17,880	20,180	22,360	23,660	24,960	26,260
$250,000 - 449,999	2,970	6,470	9,370	11,870	14,190	16,490	18,790	21,090	23,280	24,580	25,880	27,180
$450,000 and over	3,140	6,840	9,940	12,640	15,160	17,660	20,160	22,660	25,050	26,550	28,050	29,550

FORM
A4
(REV. 3/2014)

ALABAMA DEPARTMENT OF REVENUE
50 North Ripley Street • Montgomery, AL 36104 • InfoLine (334) 242-1300
www.revenue.alabama.gov

Employee's Withholding Tax Exemption Certificate

Every employee, on or before the date of commencement of employment, shall furnish his or her employer with a signed Alabama withholding exemption certificate relating to the number of withholding exemptions which he or she claims, which in no event shall exceed the number to which the employee is entitled. In the event the employee inflates the number of exemptions allowed by this Chapter on Form A4, the employee shall pay a penalty of five hundred dollars ($500) for such action pursuant to Section 40-29-75.

Part I – To be completed by the employee

Reset Form

EMPLOYEE NAME | EMPLOYEE SOCIAL SECURITY NUMBER

STREET ADDRESS | CITY | STATE | ZIP CODE

HOW TO CLAIM YOUR WITHHOLDING EXEMPTIONS

1. If you claim no personal exemption for yourself and wish to withhold at the highest rate, write the figure "0", sign and date Form A4 and file it with your employer. . . . . _____
2. If you are SINGLE or MARRIED FILING SEPARATELY, a $1,500 personal exemption is allowed. Write the letter "S" if claiming the SINGLE exemption or "MS" if claiming the MARRIED FILING SEPARATELY exemption . . . . . _____
3. If you are MARRIED or SINGLE CLAIMING HEAD OF FAMILY, a $3,000 personal exemption is allowed. Write the letter "M" if you are claiming an exemption for both yourself and your spouse or "H" if you are single with qualifying dependents and are claiming the HEAD OF FAMILY exemption. . . . . _____
4. Number of dependents (other than spouse) that you will provide more than one-half of the support for during the year. *See dependent qualification below.* . . . . . _____

5. Additional amount, if any, you want deducted each pay period . . . . . $ _____
6. **This line to be completed by your employer:** Total exemptions (example: employee claims "M" on line 3 and "2" on line 4. Employer should use column M-2 (married with 2 dependents) in the withholding tables) . . . . . _____

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

Employee's Signature _____ **Date** _____

Part II – To be completed by the employer

EMPLOYER NAME | EMPLOYER IDENTIFICATION NUMBER (EIN)

ADDRESS | CITY | STATE | ZIP CODE

Employers are required to keep this certificate on file. If the employee is believed to have claimed more exemption than legally entitled or claims 8 or more dependent exemptions, the employer should contact the Department at the following address or phone number for verification: Alabama Department of Revenue, Withholding Tax Section, P.O. Box 327480, Montgomery, AL 36132-7480, by phone at (334) 242-1300, or by fax at (334) 242-0112. If the employee does not qualify for the exemptions claimed upon verification, the employer is required to withhold at the highest rate until the employee submits a corrected Form A4 reflecting the proper exemption they are entitled to claim.

DEPENDENTS: To qualify as your dependent (Line 4 above), a person must receive more than one-half of his or her support from you for the year and must be related to you as follows:

Your son or daughter (including legally adopted children), grandchild, stepson, stepdaughter, son-in-law, or daughter-in-law;
Your father, mother, grandparent, stepfather, stepmother, father-in-law, or mother-in-law;
Your brother, sister, stepbrother, stepsister, half-brother, half-sister, brother-in-law, or sister-in-law;
Your uncle, aunt, nephew, or niece (but only if related by blood).

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 05/31/2027

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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

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

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

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

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

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

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 an individual temporarily authorized to work for a specific employer because of his or her status or parole: **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 individual's status or parole 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 For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		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				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	**OR**	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

Alabama Medicaid Agency

TB Baseline Screening Assessment

Attachment A to WAV-37

Symptoms	Yes	No	Comments
History of positive TB Skin Test			
Have you ever had TB disease?			
Coughed up blood			
Unplanned weight loss			
Night Sweats			
Shortness of breath			
Fatigue			
Loss of appetite			
Chest pain			
Hoarseness			
Close contact with someone who has had infectious TB disease since the last TB test.			
Temporary or permanent residence of one month or less in a country with a high TB rate. (Any country other than the U.S., Canada, Australia, New Zealand, and those in Northern Europe or Western Europe.			
Current or planned immunosuppression. Including HIV, organ transplant, treatment with a TNF-alpha antagonist, chronic steroids (equivalent of prednisone less than 15mg/day for 1 month or less) or other immunosuppressive medication			
Fever > 2 weeks duration			
Productive cough			**If yes,** **Color**_____ **Consistency**_____ **Blood in sputum?** **Yes** **No**

_____ _____

Date Clinician Signature & Title

_____ _____

Date Signature of Applicant

Sunbridge
home health care

1313 13th Avenue Decatur, AL 35601
Office: 256-580-5800
Fax: 256-580-5801

4.18 CONFIDENTIALITY OF CLIENT INFORMATION

Policy:

The agency personnel must read and sign their acknowledgment of the following statement:

By accepting employment with the agency, I agree to carefully refrain from discussing any client's condition or personal affairs with anyone outside of the agency, unless expressly authorized to do so.

I will not share my medical information with other clients or visitors without clear instructions provided to the agency. I acknowledge that all information seen or heard regarding clients, directly or indirectly, is completely confidential and is not to be discussed, even with my family of coworkers.

My job as an employee requires that I govern myself by high ethical standards. Failure to recognize the importance of confidentiality is not only a breach of professional ethics, but can also involve an employee in legal proceedings. I will not share any information about clients or the agency with the media.

The employee will protect all electronic records, including passwords, as outlined in the HIPPA manual. This is essential for protection of both the client and agency.

I further understand that at no time am I allowed a client to endorse a check over to the home care agency or myself.

I have read and understood the above statement and agree to abide by these policies. I understand that a breach of policy may result in disciplinary action and possible dismissal of employment.

Employee Signature:

Date:

Witness Signature:

Date:

Tuberculosis (TB) Facts

TB Can Be Treated

What is TB?

"TB" is short for a disease called tuberculosis. TB is spread through the air from one person to another. TB germs are passed through the air when someone who is sick with **TB disease** of the lungs or throat coughs, speaks, laughs, sings, or sneezes. Anyone near the sick person with **TB disease** can breathe TB germs into their lungs.

TB germs can live in your body without making you sick. This is called **latent TB infection**. This means you have only inactive (sleeping) TB germs in your body. The inactive germs cannot be passed on to anyone else. However, if these germs wake up or become active in your body and multiply, you will get sick with **TB disease**.

When TB germs are active (multiplying in your body), this is called **TB disease**. These germs usually attack the lungs. They can also attack other parts of the body, such as, the kidneys, brain, or spine. **TB disease** will make you sick. People with **TB disease** may spread the germs to people they spend time with every day.

If the **TB disease** is in your lungs, you may:

- cough a lot,
- cough up mucus or phlegm ("flem"),
- cough up blood, or
- have chest pain when you cough.

You should ALWAYS COVER YOUR MOUTH when you cough!

If you have **TB disease**, you may also:

- feel weak,
- lose your appetite,
- lose weight,
- have a fever, or
- sweat a lot at night.

These are symptoms of **TB disease**. These symptoms may last for several weeks. Without treatment, they usually get worse.

If you get **TB disease** in another part of the body, the symptoms will be different. Only a doctor can tell you if you have **TB disease**.

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of Tuberculosis Elimination

CS232274_A

Signature: _____ Date: _____

BLOODBORNE PATHOGENS

UNIVERSAL PRECAUTIONS FOR THOSE EXPOSED TO BLOOD OR OTHER POTENTIALLY INFECTIOUS MATERIALS IN THEIR OCCUPATION

PROTECT YOURSELF

ALL BLOOD AND BODILY FLUID MUST BE TREATED AS IF THEY WERE INFECTED WITH:

- HUMAN IMMUNODEFICIENCY VIRUS (HIV) WHICH FREQUENTLY LEADS TO AIDS.
- HEPATITIS B VIRUS (HBV).
- OTHER BLOODBORNE PATHOGENS (MICROORGANISMS FOUND IN HUMAN BLOOD WHICH CAN CAUSE DISEASE).

KNOW THE RULES

BE FAMILIAR WITH YOUR ORGANIZATION'S EXPOSURE CONTROL PLAN.

MAKE SURE YOU KNOW:

- VACCINATION REQUIREMENTS
- PROCEDURES
- PRACTICES
- PROPER REPORTING REQUIREMENTS FOR INCIDENTS OF EXPOSURE.

KNOW YOUR COLORS

- RED BAGS OR CONTAINERS DON'T NEED TO BE LABELED - THEIR COLOR INDICATES THEY MAY CONTAIN BIOHAZARDS.
- FLUORESCENT ORANGE-RED LABELS AND SIGNS WITH CONTRASTING LETTERING OR SYMBOLS ARE APPROPRIATE

READ ALL LABELS AND SIGNS

WEAR THE RIGHT EQUIPMENT

PROPER PROCEDURE CAN REDUCE YOUR RISK OF INFECTION TO ZERO

WASH HANDS

AND FOLLOW SAFE HYGIENE AND WORK PRACTICES.

DISPOSE OF NEEDLES IN APPROPRIATE CONTAINERS.

NEVER

RECAP, BEND, OR BREAK NEEDLES.

FOLLOW PROPER DISPOSAL PROCEDURES.

CONTAMINATED LAUNDRY AND PERSONAL PROTECTIVE EQUIPMENT SHOULD BE DISPOSED OF IN PROPERLY DESIGNATED AREAS.

KEEP IT CLEAN

CLEAN WORKSITE AND DECONTAMINATE EQUIPMENT. FOLLOW ALL SAFE HANDLING PROCEDURES.

DON'T FORGET

ALL BODY FLUIDS SHOULD BE HANDLED AS IF POTENTIALLY INFECTIOUS.

Signature:

Date:

Supervisor:

Date:

Sunbridge
home health care

RECEIPT OF EMPLOYEE HANDBOOK

This is to acknowledge that I have received a copy of the Agency Employee Handbook and understand that it sets forth the terms and conditions of my employment as well as the duties, responsibilities, and obligations of employment with the company. I understand and agree that it is my responsibility to read the Employee Handbook and abide by the rules, policies, and standards set forth in the Employee Handbook.

I acknowledge that my employment with the Agency is not for a specified period of time and I can be terminated at any time for any reason, with or without cause or notice, by me or the company. I acknowledge that no oral or written statements or representations regarding my employment can alter the foregoing, I also acknowledge that no employee has the authority or enter into an employment agreement-express or Implied-providing for employment other than at-will.

I acknowledge that except for the policy of at-will employment, the company reserves the right to revise, delete, and add to the provisions of this Employment Handbook. All such revisions, deletions, or additions must be in writing and must be signed by the President of the company, No oral statements or representations can change the provisions of this Employee Handbook. I also acknowledge that, except for the policy of at-will employment, terms and conditions of employment with the company may be modified at the sole discretion of the company with or without cause or notice at any time. No implied contact concerning any employment-related decision, term of employment, or condition of employment can be established by any other.statement, conduct, policy, or practice.

I understand that the foregoing agreement concerning my at-will employment.status and the company's right to determine and modify the terms and conditions of employment is the sole and entire agreement between me and our Agency concerning the duration of my employment, the circumstances under which my employment may be terminated, and the circumstances under which the terms and conditions of my employment may change. I further understand that this agreement supersedes all prior agreements, understandings, and representations concerning my employment with the company.

If I have questions regarding the content or Interpretation of this handbook, I will bring them to the attention of my supervisor.

Name

Date:

Signature:

Sunbridge
home health care

1313 13th Avenue Decatur, AL 35601
Office: 256-580-5800
Fax: 256-580-5801

Sunbridge Home Health Care, Inc.

Direct Deposit Agreement Form

Authorization Agreement

I hereby authorize Sunbridge Home Health Care, Inc. to initiate automatic deposits to my account at the financial Institution named below. Further, I agree not to hold Sunbridge Home Health Care, Inc, responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial Institution or due to an error on the part of my financial institution in depositing funds to my account. This agreement will remain in effect until Sunbridge Horne Health Care, Inc, receives a written notice of cancellation from me or my financial Institution, or until I submit a new direct deposit form to the Payroll Department.

Account Information

Employee Name:

Name of Financial Institution:

Routing Number:

Account Number: ☐ Checking | ☐ Savings

Signature

Authorized Signature: Date:

Please attach a voided check or deposit slip and return this form to the Payroll Department.

If you do not have a bank account and wish to receive payment via Bank Card, check this box: ☐

Sunbridge
home health care

1313 13th Avenue Decatur, AL 35601
Office: 256-580-5800
Fax: 256-580-5801

Paystub Policy:

If you are requesting paystubs, you need to give us a week to get them. Payroll is unable to print them out in a day due to being extremely busy at times.

By signing this form, you are acknowledging that you understand you must fill out the paystub request form and it must be turned in 1 week before you need them.

Worker Signature:

Date:

Supervisor Signature:

Date:

Sunbridge
home health care

Nurses Job Description

QUALIFICATIONS

- Must be an active, licensed nurse with a LPN or RN
- Must respect clients- including ethics and the confidentiality of care
- A certificate of where you graduated nursing school from
- Be free from health problems that may be injurious to the client or other employees
- Meet standards for training hours on a yearly basis
- Be experienced in the areas of skilled care: feeding tube, changing bandages of blisters and bed sores, trachs, etc.

DUTIES OF POSITION

- To perform skilled services for clients while adhering to the care plan
- Provide all patient care and skilled services according to The Nurse Practice Act and agency policy which includes systematic data gathering, assessment, appropriate nursing judgment, and evaluation of human response to actual and potential health problems
- Adhere to the Care Plan and follow physician's orders to provide safe and competent care to the client'
- Report abnormal findings to the physiclan and provide appropriate follow up documentation on abnormal findings
- Completed documentation to accurately reflect patient status
- Complete all patient care documentation and departmental documentation In a timely and accurate manner, according to policy
- Communicate professionally and appropriately with all internal and external customers so that the information Is shared accurately, timely, and appropriately ensuring compliance with agency policy
- Perform correct clock in/out time In the ClearCare system. Promptly notify staff of any changes in the assigned schedule.
- Execute a medical care plan to the benefit of the client

JOB CONDITIONS

- Have the ability to drive to each of the client's homes
- Must be able to communicate clearly whether it be verbally or written
- Organization skills to perform and communicate the care plans
- Risk to bloodborne pathogens - HIGH

Sunbridge
home health care

DRESS CODE POLICY

- Scrubs of any color, unless directed by the client's family not to wear
- Closed toe shoes
- Sunbridge badge

Report to immediate supervisor/director of private duty nursing:

Felicia Flannigan, RN

We look forward to having you become a part of our company. If you have any questions or concerns, please do not hesitate to contact us.

ACKNOWLEDGMENT:

Employee Signature: _____ Date: _____

Sunbridge
home health care

Nursing Skills Profile

Nurse: RN LPN Date:

Trainer: Date:

Instructions: Review the skills list and indicate your current competence with each skill by checking the appropriate response. Any skills you have never performed, which you cannot perform accurately should be identified. Those skilled procedures will be reviewed and learning experiences provided as available. You will be checked off on any skills required for your assignments.

**Please Note: Any nurse may be asked to demonstrate any skill regardless of competency indicated.

Skill	Never Done	Need Review	Competence	Demo/ Training Done	Comments
Vital Signs					
ASSESSMENT					
Cardiovascular					
Respiratory					
Neurological					
Integumentary					
Musculoskeletal					
Endocrine, Immune					
Neonatal assessment					
Pediatric assessment					
INFECTION CONTROL					
Aseptic Technique					
Biohazard Waste Disposal					
Universal Precautions					
Personal Protective Equipment					
URINARY CATHETER					
Foley insertion - male					

Sunbridge
home health care

Nursing Skills Profile

Skill	Never Done	Need Review	Competence	Demo/ Training Done	Comments
Foley insertion-female					
Foley care					
Supra-pubic catheter care					
In and out catheter care					
External catheter care					
Bladder instillation/irrigation					
MEDICATION MANAGEMENT					
First Dosing					
History of Allergies					
Physician's orders					
PULMONARY					
COPD					
CPAP / BIPAP					
Oral/Nasotracheal Suction					
Ventilator Management					
Oxygen Safety					
Portable Oxygen					
Tracheostomy Care					
NEUROLOGICAL					
Alzheimer's Dementia					
Traumatic Brain Injury					
CVA/TIA					

Sunbridge
home health care

Nursing Skills Profile

Skill	Never Done	Need Review	Competence	Demo/ Training Done	Comments
Degenerative Neurological Disorders (ALS, MS etc)					
Para / Quadriplegia					
Parkinson's					
Seizure Disorder					
GASTROINTESTINAL					
Bowel Obstruction					
Colostomy/Ileostomy Management					
Drainage devices					
Feeding pumps					
Gastric Juice Maintenance (NG,GJ,J,PEG,DOBHOFF)					
GI Bleed					
Hepatitis Liver Failure					
ENDOCRINE / METABOLIC					
Cushing's / Addison's Disease					
Diabetes					
Hyper / Hypoglycemia					
Indwelling Insulin Pumps					
Thyroid Disease					
WOUND / SKIN CARE					
Braden Scale					
Pressure Ulcer Prevention/ Staging and Management					

Sunbridge
home health care

Nursing Skills Profile

Skill	Never Done	Need Review	Competence	Demo/ Training Done	Comments
Wound Care					
IV THERAPY					
Infusion pump setup and management					
IV fluid management					
Peripheral IVs					
PICC/CVP Lines					
Start IVs					
Venous Access Ports					
PSYCHIATRIC					
Cognitive Disorders					
Management of Aggressive Disorders					
Medication Compliance					
Mood Disorders					
Schizophrenia, Psychotic Disorders					
PEDIATRIC					
Cystic Fibrosis					
Growth and Development					
Muscle Dystrophy					
Respiratory Distress Syndrome					
Sickle Cell Disease					
Spina Bifida					

Sunbridge
home health care

Nursing Skills Profile

Skill	Never Done	Need Review	Competence	Demo/ Training Done	Comments
DOCUMENTATION					
Nurse Notes					
Narrative					
Medication Administration Syndrome (MARS)					
Seizure Record					
Ventilatory Check Sheet					
REPORTING					
Incidents					
Complaints					
New Change Physician's Orders					
Verbal Orders					
Adult Protective Services					
Child Protective Services					
EMERGENCY MANAGEMENT					
Contact 911					
Patient Injury / Death					
SAFETY					
Falls Risk Assessment and Prevention					
Fire Safety and Prevention					
Severe Weather Precaution					

Sunbridge
home health care

Nursing Skills Profile

Skill	Never Done	Need Review	Competence	Demo/ Training Done	Comments
ERGONOMICS					
Back Safety					
Proper Lifting Technique					
Proper Use of Equipment					

Sunbridge
home health care

Job Title/Position: Registered Nurse / Licensed Practical Nurse

PHYSICAL REQUIREMENTS

The frequency of each activity will be identified by the following codes:
R - Rarely (less than .5 hr per day) O - Occasionally (.5 to 2.5 hr. per day) F - Frequently (2.5 to 5.5 hr. per day) C - Continually (5.5 to 8 hr per day) NA - Not Applicable

PHYSICAL ACTIVITIES	Code	Describe any repetition or a unique application of activity, which may be associated with this position.
Sitting	F	
Stationary Standing	F	
Walking	F	
Ability to be Mobile	C	
Crouching (bend at knees)	F	
Kneeling/Crawling	R	
Stooping (bend at waist)	F	
Twisting (knees/waist/neck)	R	
Turning / Pivoting	O	During patient transfer
Climbing	O	Office / client location may require climbing steps
Balancing	F	
Reaching Overhead	R	
Reaching Extension	R	
Grasping	O	
Pinching	R	
Pushing/Pulling/Lifting/Carrying	F	During patient transfer
Weight ranges	F	
Other	Universal precautions and infection control standards must be maintained; there may be unsafe environments in a patient's home (.e.g pets). May be exposed to blood & bodily fluids, household dust, cigarette smoke, needles, and other sharp instruments, may need to use mask, goggles,or gowns.	

Sunbridge
home health care

Job Title/Position: Registered Nurse / Licensed Practical Nurse

PHYSICAL REQUIREMENTS

The frequency of each activity will be identified by the following codes:
R - Rarely (less than .5 hr per day) O - Occasionally (.5 to 2.5 hr. per day) F - Frequently (2.5 to 5.5 hr. per day) C - Continually (5.5 to 8 hr per day) NA - Not Applicable

SENSORY / COGNITIVE ACTIVITIES	Code	Describe any repetition or a unique application of activity, which may be associated with this position.
Talking in person using the English language	C	
Writing using the English language	F	
Talking on the telephone	C	
Hearing in person & on telephone	C	
Vision for close work	C	
Works independently; makes individual decisions	C	
Prioritizes multiple tasks	C	

I have read and understand the position description and physical requirements for this position:

Employee Signature:

Date:

Supervisor Signature:

Date:

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Office: 256-580-5800
Fax: 256-580-5801

Welcome to the Sunbridge Home Health Care Team! We look forward to working with you and below we have provided new hire instructions to help acclimate you to your new position and hopefully answer some questions that you may have:

1) **Dawn Kreps, RN** is our Nursing Supervisor and handles all staffing, scheduling, clock-ins/outs, payroll questions.

Dawn's work number is **256-580-0544** and she can receive calls or texts Monday through Friday 8am-5pm. We prefer texts when it comes to schedule changes or clock-ins/outs so we have a record of the change we can reference back to when fixing the schedules online.

After 5pm on weekdays and on weekends/holidays, there isn't anyone answering calls or responding to text messages. You can send any clock in/out issues to this number via text and Dawn will make the corrections the next business day.
Email: dawn@sunbridgehhc.org

2) **Felicia Flannigan, RN** is our Director of Nursing

Feel free to contact Felicia at **256-309-7263** after hours, weekdays 5p-8a and on weekends/holidays if you have an emergency with your client, or major complaint. IF it is not an emergency and it is after hours, please make sure to text the phone and not call. Felicia will get back to you promptly.

If you are needing to schedule a shift, or make changes to an assigned shift after hours or on the weekend/holiday, please text the above number. All scheduling should be handled during business hours if possible.
Email: felicia@sunbridgehhc.org

3) Payday is bi-weekly on Friday via direct deposit. Our work week is Monday-Sunday.

4) If you have any payroll related questions, such as a tax question, paycheck question, or needing paystubs, please contact Dawn and she will try to help you or she will contact our finance department to get it resolved.

5) We offer a pay stub portal (Intuit) where you can view all your pay stubs/W2 forms. If you would like to be on the portal, please email: paystubs.sunbridge@gmail.com or braden@sunbridgehhc.org.

If you are unable to sign up for the portal, please keep in mind that if you request a pay stub, it may take a few days for you to receive it. Please do not wait until the last minute to ask for a pay stub. If you know you are going to need it for a loan or other reason, please contact Dawn well before you need it to ensure you have it on time.

6) We do offer health, dental and vision insurance to new employees that have been

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employed 90 days and are working full time hours (30+ hours a week). If you are a current employee, open enrollment is June 1 of every year. If you terminate employment with us and are covered under our health insurance; please contact Madison to ask when your insurance will be stopped. AFLAC accident, disability, cancer and hospital policies are available without being a full time employee. We utilize United Benefits for all insurance related questions and setting employees up on insurance. Charnett Willis is the contact person: 256- 415-3500

7) This is a 365 day a year employment. Although you may be working full-time or part-time, these clients need care on weekends and holidays. If you are scheduled to work on a holiday, please notify Dawn in advance if you can't work that day. Many of the families are flexible on holidays and will work with you on the schedule. Again, please keep Dawn updated with your schedule changes. We do not offer holiday pay, PTO, Sick pay or Bereavement pay. We do offer overtime throughout the year if you work more than 40 hours in a week. If you are interested in working overtime, please contact Dawn to discuss your options.

8) We do ask for at least a two weeks' written notice if you are planning to terminate employment with us. We care for very critical patients and it is vital we have coverage for them. So, it is very important to give us notice so we can find a replacement. A notice of less than two weeks will result in being labeled as non- rehirable. Please inform your client/client's Cg if you are resigning and inform them when your last day of work will be.

9) We utilize Therap for clocking in and out.

- Download the Therap App from the App store on your phone (Orange square with Therap across it)
- Login name - **Your first name.Your last name** (notice the **.** between first and last name)
  Code - **SUNPDN-AL**
  Password - **Homehealth1!** (You will have to contact the office to get your password rest if/when you need to)

  ** If you are not clocking in/out from the address in the system, you must add a comment with the reason.
  *** If you are clocking in or out late, you must enter a comment with the correct time.
  ****Your payroll is pulled from Therap, very important that you clock in and out correctly and notify the office immediately with schedule changes. We asked that you submit your schedule for the next week by noon on Friday.

  If you are not able to work an assigned shift, notify your client first then Dawn. Do not go to the client's home and work an unassigned shift and then notify Dawn afterwards, you will not be paid. We have an unlimited overtime pay rate, we will discuss it if interested.

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10) Medicaid approves the hours that the client receives 90 days at a time. If the client or client's family ask you to pick up an extra shift, please contact Dawn and she will confirm that the client has the available hours and she will assign the extra shift if the hours are available.

11) Please email any changes in the client's orders to alisha@sunbridgehhc.org. Alisha works with the Physician and Medicaid to get the client approved and recertified for services. Alisha's telephone number is 256-602-6191

12) If your client is admitted to the hospital, please notify Dawn immediately and complete the "Client Hospitalization Form". This form is not for Emergency Room visits. Email the form to Dawn at dawn@sunbridgehhc.org.

If you do not have access to email, contact Dawn and she will discuss other options in getting the form submitted to her. **The Nurse is not allowed to be on the clock with Sunbridge Home Health if the client is admitted to the hospital.

Upon your first scheduled shift to the client's home, ask the client/client's Cg for the "**Emergency Plan form"**. All clients should have a completed ER plan in the home.

13) Documentation: A very important part of your job responsibilities is to complete your nursing notes during your assigned shift. Please document in blue ink and do not staple your nursing notes. Nursing notes are due in the office at least every 2 weeks. The following is your options in getting your notes to the office:

- Email to braden@sunbridgehhc.org

If you have an iPhone, you are able to scan documents in your "notes" section

If you email your notes, we still need the original notes sent to the office. You can hold the original notes and give them to the Supervising Nurse when she comes to the client's home for her visit.

- Drop notes at the office in your area
- Mail notes to **Sunbridge Home Health P.O Box 2597 Decatur, AL 35602**.

It is vital to get your nursing notes in because without them, we are not able to get the clients recertified to continue services. If you get more than one month behind in turning your notes in, you will be subject to disciplinary action starting with a verbal warning, then a written disciplinary form, and last resort (which we do not want to do) would be contacting the board of nursing.

14) Each month your clients will be visited by one of our Supervisory Nurses to check on the client and evaluate your job performance. The Supervisory Nurse will have Nursing notes and other forms that you may use in the home with them. Please ask for the forms if you are in the home. Please notify Dawn if you are running low on forms/gloves so she can contact the Supervising Nurse and make arrangements to get the needed supplies to you. Please do not wait until you are completely out or

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using your last form to contact Dawn, as the Supervising Nurse may not be in your area for a while. Reminder: The Supervising Nurse can always pick up completed Nursing notes and bring them into the office for you.

15) Uniforms/Lunch/Breaks

16) Please report any client or employee incidents/accidents immediately during work hours: 256-580-0544; After Hours/Weekends: 256-309-7263

We are happy to have you on our team and we know the clients are grateful for you. The information covered above are the main topics we receive questions about, but it does not cover everything. Please feel free to contact Dawn if you have any further questions. She will be happy to assist you.

Welcome Letter Acknowledgment Form

Please sign and date below acknowledging that you understand each of these points and will follow them. Please return signed copy to Dawn Kreps and please keep a copy for your records.

Employee's Printed Name:

Employee Signature: Date:

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Employee Emergency Contact Form

Employee Name:

Phone:

CONTACT #1

Name:

Phone:

Relationship:

CONTACT #2

Name:

Phone:

Relationship:

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April 1, 2024

Sunbridge Home Health Care, Inc.
Effective: April 1, 2024

Alabama False Claims and Whistleblower Protection Policy

Scope: Applies to all Sunbridge employees and management

Purpose: To comply with certain requirements set forth in the Deficit Reduction Act of 2005 with regard to federal and state false claims laws.

False Claims Law: One of the primary purposes of false claims laws is to combat fraud and abuse in government health care programs.

Federal False Claims Law: Under the Federal False Claims Act, any person or entity that knowingly submits a false or fraudulent claim for payment of United States Government funds, or knowingly retains an overpayment of such funds more than 60 days, is liable for significant penalties and fines.

One of the unique aspects of the federal False Claims Act is the "qui tam" provision, commonly referred to as the "whistleblower" provision. This provision allows a private person with knowledge of a false claim to bring a civil action on behalf of the United States Government to recover the funds paid by the Government as a result of the false claim.

Alabama Anti-Fraud Statute: Under Alabama law, it unlawful for any person to, with the intent to defraud or deceive, make or cause to be made or assist in the preparation of any false statement, representation, or omission of a material fact in any claim or application for any payment, regardless of amount, from the Medicaid Agency, knowing the same to be false; or with the intent to defraud or deceive, make, or cause to be made, or assist in the preparation of any false statement, representation, or omission of a material fact in any claim or application for medical benefits from the Medicaid Agency, knowing the same to be false. Violations of this law are criminal offenses, and the violator shall be guilty of a Class C felony. See Ala. Code §§ 22-1- 11, 13A-5-6 & 13A-5-11.

Reporting Concerns Regarding Fraud, Abuse and False Claims: The Company takes issues regarding false claims and fraud and abuse seriously. The Company encourages all employees, management, and contractors or agents of the Company's affiliated facilities to be aware of the laws regarding fraud and abuse and false claims, and to identify and resolve any issues immediately.

Therefore, the Company encourages its employees, managers, and contractors to report concerns to their immediate supervisor, when appropriate. If the supervisor is not deemed to be the appropriate contact or if the supervisor fails to respond quickly and appropriately to the concern, then the individual with the concern should be encouraged to discuss the situation with the Company's Chief Operating Officer and/or another member of management.

* This is a reduced version of the full policy. If you would like a copy of the full policy, please contact your immediate supervisor. *