WHEN THE CARE HAS TO BE GREAT ...
..."IT HAS TO BE IDEAL"

EMPLOYEE STATUS

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *State* *Zip Code.*

Home Phone: __(____)_____ Cell__(____)_____

Email Address: _____

Social Security Number: _____ Birthdate: _____

Hire Date: _____

Current Adopted Pay Rate: $ _____ $ _____ $ _____
Habilitation ***Respite*** ***ATC*** *[FAM] [NON-FAM]*

PROVIDER CURRENTLY WORKING WITH FOLLOWING CONSUMERS:

Date Completed: IDEAL CARE REP Initials:

IDEAL CARE LLC

NOTICE OF PROHIBITTED PRACTICES

The following are prohibited practices considered by DDD (Department of Development Disabilities) to be grounds for termination of a service agreement and/or the suspension, revocation, or nonrenewal of a HCBS Certification.

A Provider is Prohibited from:

1. Falsifying or forging an application, service agreement, or certification record (e.g., Training Documentation, Social Security Number, Criminal Background Information, etc.);
2. Getting anyone to sign a blank, or only partial completed billing form.
3. Altering or falsifying billings in any way after the responsible person has signed the form.
4. Claiming and reporting hours that were not actually worked by the/that Provider.
5. Actually working on a given day in billing those hours for a different day or for a different time.
6. Completing a billing form indicating the scheduled hours rather than the actual work hours.
7. Providing or billing for Respite Care for more than three clients at a time, unless prior written authorization has been given by a DDD District Program Manager or designee.
8. Providing or billing for more than one service category at a time (e.g., Attendant Care, Habilitation, Respite, etc.)
9. Providing a service or billing for more than one client at any given time, during the same time. The only exception is for respite services, as indicated in #7 above.
10. Respite, Attendant Care, Habilitation services are not to be provided while Consumer is in the Hospital, or receiving Therapies from a Professional. **(NO EXCEPTIONS)**

DCW/Provider's Signature: _____

Ideal Care Rep: _____

Date: _____

IDEAL CARE LLC
4135 N. 108TH Ave. Ste. #102
Phoenix, AZ 85037

Office: 623/266-0727
Fax: 623/266-0914
WWW.IDEALCARELLCAZ.COM

IDEAL CARE LLC

Provider/Proveedora:
Family Member? YES [ ] NO [ ]
Non-Family Member? YES [ ] NO [ ]
Re-Hire Date: _____ / _____ / _____

Employment Application

Applicant Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ E-mail Address: _____

Date Available: _____ Social Security No.: _____ Desired Salary: _____

Position Applied for: _____

Are you a citizen of the United States? YES ☐ NO ☐ If no, are you authorized to work in the U.S.? YES ☐ NO ☐

Have you ever worked for this company? YES ☐ NO ☐ How did you hear about us? _____

Have you ever been convicted of a felony? YES ☐ NO ☐

If yes, explain: _____

Education

High School: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____

College: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____

Other: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____

Professional Reference - *Referencia Profesional*

If Possible list 1 Professional Reference below: ***Si es posible*** *anota un Referencia Profesional abajo:*

Ref/Name: _____ Company: _____

Address: _____ Phone: _____

Work Type: _____

Job Experience: *Experiencia de Trabajo*

Professional Experience in the area of Disabilities: _____ Yrs. _____ Mos.
Experiencia Profesional en el Area de Discapacides: _____ Años _____ Meses

o

— *OR* — Voluntary Work: — *Ó* — *Trabajo Voluntario*

Voluntary Experience in the area of Disabilities: _____ Yrs. **What Type:** _____
Trabajo Voluntario en el Area de Discapacides: _____ Años **Qué Tipo:** _____

IDEAL CARE LLC

Employment Application

Previous Employment

Company: ______________________ Phone: ______________________

Address: ______________________ Supervisor: ______________________

Job Title: ____________ Starting Salary: ____________ Ending Salary: ____________

Responsibilities: ______________________

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: ____________

Responsibilities: ______________________

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: ____________

Responsibilities: ______________________

From: ________ To: ________ Reason for Leaving: ______________________

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Military Service

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: ____________

IDEAL CARE LLC

Additional Employee Information:

Additional Personal Information – *Informacion Personal Adicional*

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Alt Phone Number: ( ) _____

E-Mail Address: _____

Marital Status: _____

Spouse's Name: _____

Emergency Contact Information #1 - *Informacion de Contacto de Emergencia #1*

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Alt Phone Number: ( ) _____

Emergency Contact Information #2 - *Informacion de Contacto de Emergencia #2*

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Alt Phone Number: ( ) _____

IDEAL CARE LLC

Equal Opportunity Employer / Empleador de Igualdad de Oportunidades

CAREFULLY AND SIGN THAT YOU UNDERSTAND AND ACCEPT THIS INFORMATION:

I certify that the information in this application and its supporting documents are correct and complete. I understand and agree that failure to complete the form, or misrepresenting, or omitting facts, represents grounds for elimination from consideration of employment, or termination after employment if discovered at a later date. I authorize **IDEAL CARE LLC** to investigate, without liability, all statements contained in this application and supporting materials. I authorize references and former employers, without liability to make full responses to any inquiries in connection with this application for employment. If requested, I agree to submit to a physical exam, criminal and credit background investigation, and/or screening for illegal substances upon conditional offer of employment. I understand that this document is NOT an offer of employment, and that an offer of employment, tendered, does NOT constitute a contract for continued guaranteed employment. I understand that staff employees of **IDEAL CARE LLC** serve at will, and the employment relationship may be terminated at any time by either party, or any, or no reason, other than a reason prohibited by law. If employed, and will be required to furnish proof of eligibility to work in the United States, to file a state security questionnaire, and State Loyalty Oath, and to comply with company and departmental regulations. I understand that the first **SIX MONTHS** of regular employment represent a provisional period, during which I may be **TERMINATED** without a right to appeal.

LEE CUIDADOSMENTE Y FIRMA QUE ENTIENDES Y ACEPTAS TODA ESTA INFORMACION:

Yo certifico que la informacion en esta aplicacion y documentos estan correctos y completes. Yo entiendo y estoy de acuerdo que si y fallo en llenar completamente esta forma, si falsifico, o no reporto, o doy informacion erronea acerca de mi persona, puedo quedar eliminado/a de empleo, o se ser terminado/a de empleo si ya estoy empleado/a cuado se descubre estás dicrepancias a un tiempo despues, Yo uatorizo a **IDEAL CARE LLC** a investigar, sin resposabilidad legal, el investigar toda informacion proveida por mi en mi aplicacion. Autorizo a mis empleadores previos a responder qualquier pregunta sobre mi y mi persona en relacion a lo que you escribe en esta aplicacion. Si se me pedi, estoy dispuesto/a a pasar por un examen fisico, examen criminal, o de credito financiero, y de un examen para detectar drogas ilicitas en mi Sistema como condicion de empleo continuo. Tambien entiendo que este document NO es una oferta de empleo, y NO constituye un contrato de empleo. Entiendo que todo personal de **IDEAL CARE LLC** sirven a voluntad, y la relacion entre empleado y empleador puede ser terminada a cualquier tiempo, por cualquier razón, dentro de los esta contenido por Ley. Si soy empleado/a yo tengo la obligacion de mostrar puebas de eligibilidad de poder trabajar en los Estados Unidos. Yo entiendo que los primeros **SEIS MESES** de empleo regular representa un periodo de prueba, donde yo puedo ser **TERMINADO/A** sin derecho a una apelacion.

IDEAL CARE LLC DISCLAIMER: CARING COMPANION ASSITANCE LLC is an Equal Opportunity and EEO/Affirmative Action employer committed to excellence through diversity. Employment offers are made on the basis of qualifications, and without regard to race, sex, religion, nationality, or ethnic origin, or disability, or sexual orientation.

RECLAMACION DE IDEAL CARE LLC: IDEAL CARE LLC es un Empleador de Igualdad de Oportunidades y un Empleador de de Accion Afirmativa/EEO comprometido a la excelencia mediante la diversidad. Ofertasde empleo son hechas sobre la base de calificacion, y sin respect a raza, sexo, religion, nacionalidad, religion, origen etnico, discapacidad fisica, o orientacion sexual.

_____ _____

Applicant Signature/Firma de Aplicante: Date/Fecha:

REFERENCE REQUEST

This reference request should be provided to a person who has personal knowledge about your employment history, education, or character. References cannot come from family members. Please fill in your name below and give the form to the person making your REFERENCE. Make sure you bring in (3) Three References with you when you turn in your Completed Application

Applicant's Name: (Last, First, M.I.)

_____

PERSON PROVIDING REFERENCES: Please complete the questions listed below keeping in mind that Home and Community-Based Service (HCBS) may be performed unsupervised in the home of the person with Developmental Disabilities. Your time and effort in completing this form is appreciated, and will remain in strict confidence regarding all of your responses.

Print the Person's Name Providing the REFERENCE: (Last, First, M.I.)

_____

Address: **(Street)** **(City)** **(Zip Code)**

_____

Daytime Phone number: **Length of Time You Have Known Applicant**

_____

Type of Acquaintance: **(Check all that apply):**

☐ **Supervised Applicant** ☐ **Worked with Applicant** ☐ **Friend** ☐ **Neighbor**

_____

Indicate your feelings on how you believe the Applicant will relate to Individuals with Developmental Disabilities. Describe your knowledge of any characteristics and/or Special Trainings/ Education that the Applicant may have for working with these Individuals:

_____

_____

Additional Comments which will help us in evaluating this Applicant:

_____

_____

If you had a Sibling, Child, or Family Member with a Developmental Disability, or of Special Needs ------ Would you hire this Applicant? ☐ **YES** ☐ **NO**

_____

_____ _____

Ideal Care Representative ***Date:***

IDEAL CARE LLC: 4135 N. 108TH Avenue Suite #102 Phoenix AZ 85037 PHONE: (623) 266-0727 FAX: (623) 266-0914

REFERENCE REQUEST

This reference request should be provided to a person who has personal knowledge about your employment history, education, or character. References cannot come from family members. Please fill in your name below and give the form to the person making your REFERENCE. Make sure you bring in (3) Three References with you when you turn in your Completed Application

Applicant's Name: (Last, First, M.I.)

_____

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Print the Person's Name Providing the REFERENCE: (Last, First, M.I.)

_____

Address: **(Street)** **(City)** **(Zip Code)**

_____

Daytime Phone number: **Length of Time You Have Known Applicant**

_____

Type of Acquaintance: **(Check all that apply):**

☐ **Supervised Applicant** ☐ **Worked with Applicant** ☐ **Friend** ☐ **Neighbor**

_____

Indicate your feelings on how you believe the Applicant will relate to Individuals with Developmental Disabilities. Describe your knowledge of any characteristics and/or Special Trainings/ Education that the Applicant may have for working with these Individuals:

_____

_____

Additional Comments which will help us in evaluating this Applicant:

_____

_____

If you had a Sibling, Child, or Family Member with a Developmental Disability, or of Special Needs ------ Would you hire this Applicant? ☐ **YES** ☐ **NO**

_____

_____ _____

Ideal Care Representative ***Date:***

IDEAL CARE LLC: 4135 N. 108TH Avenue Suite #102 Phoenix AZ 85037 PHONE: (623) 266-0727 FAX: (623) 266-0914

REFERENCE REQUEST

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Applicant's Name: (Last, First, M.I.)

_____

PERSON PROVIDING REFERENCES: Please complete the questions listed below keeping in mind that Home and Community-Based Service (HCBS) may be performed unsupervised in the home of the person with Developmental Disabilities. Your time and effort in completing this form is appreciated, and will remain in strict confidence regarding all of your responses.

Print the Person's Name Providing the REFERENCE: (Last, First, M.I.)

_____

Address: **(Street)** **(City)** **(Zip Code)**

_____

Daytime Phone number: **Length of Time You Have Known Applicant**

_____

Type of Acquaintance: **(Check all that apply):**

☐ **Supervised Applicant** ☐ **Worked with Applicant** ☐ **Friend** ☐ **Neighbor**

_____

Indicate your feelings on how you believe the Applicant will relate to Individuals with Developmental Disabilities. Describe your knowledge of any characteristics and/or Special Trainings/ Education that the Applicant may have for working with these Individuals:

_____

_____

Additional Comments which will help us in evaluating this Applicant:

_____

_____

If you had a Sibling, Child, or Family Member with a Developmental Disability, or of Special Needs ------ Would you hire this Applicant? ☐ **YES** ☐ **NO**

_____

_____ _____

Ideal Care Representative ***Date:***

IDEAL CARE LLC: 4135 N. 108TH Avenue Suite #102 Phoenix AZ 85037 PHONE: (623) 266-0727 FAX: (623) 266-0914

IDEAL CARE LLC
Forma de Reconocimiento de Hepatitis B:

A QUIEN CONCIERNE,

Mi firma al final de este document certifica que he atendido a una sesion de entrenamiento en Patógenos Sanguíneos. Entiendo que mi empleo con Ideal Care LLC, carga un bajo riesgo de exposicion a Hepatitis B, y se me ha dado la oportunidad de ser vacunado/a con la vacuna de Hepatisis B sin cobro alguno a mi persona.

_____ Yo decline la vacuna de Hepatitis B a este tiempo

_____ Yo deseo proseguir y recibir las vacunas de Hepatitis B

Nombre: _____

Firma: _____

Fecha: _____

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WWW.IDEALCARELLCAZ.COM

IDEAL CARE LLC
Office 623/266-0727 Fax: 623/266-0914
Provider / Client Orientation Report

Provider / Client Orientation Form

Completed within 14 days of Hire:

By my signature below, I acknowledge that I have received formal training for the following Consumer, on the Subjects, and Dates indicated:

Consumer Name: _____

SUBJECT TRAINING:	DATE TRAINED:	SERVICES W/CONSUMER:
Client ISP Review		[ATC] [HAH] [RSP]
Client ISP Goals/Strategies Review		
Client Risk Assessment		
Client Orientation: ***See HAB Training:***		
Habilitation Training: Includes but not limited to: Allergies, Special Nutritional Needs, Seizure Activity, Adaptive Equipment, BT Plan, Health Care Routines, Characteristics of Developmental Disabilities, Positive Teaching Strategies, Creating Positive Behaviors, Common Terms and Special Education and Rehabilitation. And other information that may allow for sufficient knowledge to appropriately provide effective care to the members being served.		

_____ _____

Print Staff Name: Hire Date:

_____ _____

Ideal Care LLC Rep: Date:

IDEAL CARE LLC
4135 N. 108TH Ave. Ste. #102
Phoenix, AZ 85037

Office: 623/266-0727
Fax: 623/266-0914
WWW.IDEALCARELLCAZ.COM

CRIMINAL History Affidavit MUST be re-newed EVERY 12 MONTHS (EVERY 1 YEAR) _____ *Initials.*

ESTE Affidavit de Historial CRIMINAL DEBE ser renovado CADA 12 MESES (CADA 1 AÑO) _____ *Iniciales.*

CRIMINAL HISTORY SELF DISCLOSURE AFFIDAVIT

Your fingerprints will be submitted to the Arizona Department of Public Safety (DPS) and the Federal Bureau of Investigation (FBI) for a criminal history check. Your self-disclosure on this affidavit and the information provided by your criminal history check will be used, as authorized by Public Law and Arizona Revised Statues, to help us determine your fitness to have unsupervised access to vulnerable persons. **Your failure to disclose true and accurate information on this affidavit will be sufficient grounds to end your employment or to deny, suspend, or revoke your license and may be referred to the State Attorney General's Office for prosecution.**

Be sure that you go over all six (6) pages of the self-disclosure affidavit.

You have the right to obtain a copy of any background check report and challenge the accuracy or completeness of information contained in the report. If you challenge the information, you also have a right to prompt determination as to the validity of your challenge. To obtain a copy of your background check report, contact the DPS Records Unit, ACJIS Division at (602) 223-2222.

Name *(First, Middle, Last)*: _____ Date of Birth *(MM/DD/YY)*: _____

Address *(No., Street, Apt. No.)*: _____

City: _____ State: _____ ZIP Code: _____

Check one of the following and provide information as directed:

☐ I have not been convicted of nor am I under pending indictment for any crimes.

☐ I have been convicted of or I am under pending indictment for the following crime(s) *(Provide dates, location/ jurisdiction, circumstances and outcome. Attach additional pages as needed)*:

ALSO – Check one of the following:

☐ I am not subject to registration as a sex offender in Arizona or in any other jurisdiction.

☐ I am subject to registration as a sex offender in Arizona or in any other jurisdiction. *(If you are subject to registration as a sex offender in this state or any other jurisdiction, DPS will deny you a Level 1 Fingerprint Clearance Card and you **WILL NOT** be eligible to appeal the decision.)*

I certify that I understand this affidavit. My self-disclosure is true, accurate, and complete to the best of my knowledge.

Signature: _____ Date: _____

Notary Public

State of Arizona, County of _____

Subscribed and sworn or affirmed and acknowledged before me this _____ day of _____, 20____

Commission Expiration date: _____ Notary Public's Signature: _____

See page 6 for EOE/ADA disclosures

Non-Appealable Offenses

Are you awaiting trial for or have you ever been convicted of committing, attempting to commit, soliciting or facilitating or conspiring to commit one or more of these crimes in this state or a similar crime in another jurisdiction? Mark "Yes" or "No" as applicable.

If you are subject to registration as a sex offender in this state or any other jurisdiction, or awaiting trial on or been convicted of committing, attempting to commit, soliciting or facilitating, or conspiring to commit one or more of the crimes in this section DPS will deny you a Level 1 Fingerprint Clearance Card and you **WILL NOT** be eligible to appeal the decision.

Expunged convictions from any court other than juvenile court must be identified.

	YES	NO
1. Sexual abuse of vulnerable adult	☐	☐
2. Incest	☐	☐
3. Homicide, including first or second-degree murder, manslaughter and negligent homicide	☐	☐
4. Sexual assault	☐	☐
5. Sexual exploitation of a minor or vulnerable adult	☐	☐
6. Commercial sexual exploitation of a minor or vulnerable adult	☐	☐
7. Child prostitution as prescribed in A.R.S. § 13-3212	☐	☐
8. Child abuse	☐	☐
9. Felony child neglect	☐	☐
10. Sexual conduct with a minor	☐	☐
11. Molestation of a child or vulnerable adult	☐	☐
12. Dangerous crime against children as defined in A.R.S. § 13-705	☐	☐
13. Exploitation of minors involving drug offenses	☐	☐
14. Taking a child for the purposes of prostitution as defined in A.R.S. § 13-3206	☐	☐
15. Neglect or abuse of a vulnerable adult	☐	☐
16. Sex trafficking	☐	☐
17. Sexual abuse	☐	☐
18. Production, publication, sale, possession and presentation of obscene items as prescribed in A.R.S. § 13-3502	☐	☐
19. Furnishing harmful items to minors as prescribed in A.R.S. § 13-3506	☐	☐
20. Furnishing harmful items to minors by internet activity as prescribed in A.R.S. § 13-3506.01	☐	☐
21. Obscene or indecent telephone communications to minors for commercial purposes as prescribed in A.R.S. § 13-3512	☐	☐
22. Luring a minor for sexual exploitation	☐	☐
23. Enticement of persons for purposes of prostitution	☐	☐
24. Procurement by false pretenses of persons for purposes of prostitution	☐	☐
25. Procuring or placing persons in a house of prostitution	☐	☐
26. Receiving earnings of a prostitute	☐	☐
27. Causing one's spouse to become a prostitute	☐	☐
28. Detention of persons in a house of prostitution for debt	☐	☐
29. Keeping or residing in a house of prostitution or employment in prostitution	☐	☐
30. Pandering	☐	☐
31. Trafficking of persons for forced labor or services as defined in A.R.S. § 13-1308	☐	☐

	YES	NO
32. Transporting persons for the purpose of prostitution, polygamy and concubinage	☐	☐
33. Portraying adult as a minor as prescribed in A.R.S. § 13-3555	☐	☐
34. Admitting minors to public displays of sexual conduct as prescribed in A.R.S. § 13-3558	☐	☐
35. Any felony offense involving contributing to the delinquency of a minor	☐	☐
36. Unlawful sale or purchase of children	☐	☐
37. Child bigamy	☐	☐
38. Any felony offense involving domestic violence as defined in A.R.S. § 13-3601, except for a felony offense only involving criminal damage in an amount more than $250, but less than $1000 if the offense was committed before June 29, 2009	☐	☐
39. Felony indecent exposure	☐	☐
40. Felony public sexual indecency	☐	☐
41. Felony driving under the influence, driving under the extreme influence or aggravated driving under the influence if committed within 5 years of the date you apply for a Level 1 Clearance Card	☐	☐
42. Terrorism	☐	☐
43. Any offense involving a violent crime as defined in A.R.S. § 13-901.03	☐	☐

Appealable 5 Years After Conviction

The following **felony** offenses are non-appealable if committed within 5 years of the date you apply for a Level 1 Fingerprint Clearance Card. If you have been convicted of committing, attempting to commit, soliciting or facilitating or conspiring to commit one or more of the crimes in this section *within 5 years* of applying for a Level 1 Fingerprint Clearance Card, DPS will deny you a Level 1 Fingerprint Clearance Card and you **WILL NOT** be eligible to appeal the denial.

If the conviction was *more than 5 years* before you apply for a Level 1 Fingerprint Clearance Card, DPS will deny you a Level 1 Fingerprint Clearance Card, but you will be eligible to appeal the denial to the Arizona Board of Fingerprinting.

Mark "Within 5 Years," "Over 5 Years" or "No" as applicable.

	WITHIN 5 YEARS	OVER 5 YEARS	NO
1. Endangerment	☐	☐	☐
2. Threatening or intimidating	☐	☐	☐
3. Assault	☐	☐	☐
4. Aggravated assault	☐	☐	☐
5. Unlawfully administrating intoxicating liquors, narcotic drugs or dangerous drugs	☐	☐	☐
6. Dangerous or deadly assault by prisoner or juvenile	☐	☐	☐
7. Prisoners who commit assault with intent to incite to riot or participate in riot	☐	☐	☐
8. Assault by vicious animals	☐	☐	☐
9. Drive by shooting	☐	☐	☐
10. Assaults on public safety employees or volunteers and state hospital employees	☐	☐	☐
11. Discharging a firearm at a structure	☐	☐	☐
12. Prisoner assault with bodily fluids	☐	☐	☐
13. Aiming a laser pointer at a peace officer	☐	☐	☐
14. Possession and sale of peyote	☐	☐	☐
15. Possession and sale of a vapor-releasing substance containing a toxic substance	☐	☐	☐

	WITHIN 5 YEARS	OVER 5 YEARS	NO
16. Selling or giving nitrous oxide to underage persons	☐	☐	☐
17. Sale of regulated chemicals	☐	☐	☐
18. Sale of precursor chemicals	☐	☐	☐
19. Production or transportation of marijuana	☐	☐	☐
20. Possession, use or sale of marijuana, dangerous drugs or narcotic drugs	☐	☐	☐
21. Possession, use, administration, acquisition, sale, manufacture or transportation of prescription-only drugs	☐	☐	☐
22. Administration, acquisition, manufacture or transportation of dangerous drugs or narcotic drugs	☐	☐	☐
23. Manufacturing methamphetamine under circumstances that cause physical injury to a minor under the age of 15	☐	☐	☐
24. Involving or using minors in drug offenses	☐	☐	☐
25. Possession, use, sale or transfer of marijuana, peyote, prescription drugs, dangerous drugs, or narcotic drugs or manufacture of dangerous drugs in a drug-free school zone	☐	☐	☐
26. Possession, manufacture, delivery and advertisement of drug paraphernalia	☐	☐	☐
27. Use of wire communication or electronic communication in drug-related transactions	☐	☐	☐
28. Using a building for sale or manufacture of dangerous or narcotic drugs	☐	☐	☐
29. Manufacture or distribution of prescription-only drug	☐	☐	☐
30. Manufacture, distribution, possession or possession with intent to use imitation controlled substances, imitation prescription-only drugs or imitation over-the-counter drugs	☐	☐	☐
31. Manufacture of certain substances and drugs by certain means	☐	☐	☐

Appealable Offenses

Are you awaiting trial for or have you ever been convicted of committing, attempting to commit, soliciting or facilitating or conspiring to commit one or more of these crimes in this state or a similar crime in another jurisdiction? Mark "Yes" or "No" as applicable.

If you are awaiting trial on or been convicted of committing, attempting to commit, soliciting or facilitating or conspiring to commit one or more of these crimes, DPS will deny you a Level 1 Fingerprint Clearance Card, but you will be eligible to appeal the decision to the Arizona Board of Fingerprinting.

	YES	NO
1. Theft	☐	☐
2. Theft by extortion	☐	☐
3. Shoplifting	☐	☐
4. Forgery	☐	☐
5. Criminal possession of a forgery device	☐	☐
6. Obtaining a signature by deception	☐	☐
7. Criminal impersonation	☐	☐
8. Theft of a credit card or obtaining a credit card by fraudulent means	☐	☐
9. Receipt of anything of value obtained by fraudulent use of a credit card	☐	☐
10. Forgery of a credit card	☐	☐

	YES	NO
11. Fraudulent use of a credit card	☐	☐
12. Possession of any machinery, plate or other contrivance or incomplete credit card	☐	☐
13. False statements as to financial condition or identity to obtain a credit card	☐	☐
14. Fraud by persons authorized to provide goods or services	☐	☐
15. Credit card transaction record theft	☐	☐
16. Misconduct involving weapons	☐	☐
17. Misconduct involving explosives	☐	☐
18. Depositing explosives	☐	☐
19. Misconduct involving simulated explosives	☐	☐
20. Concealed weapon violation	☐	☐
21. Misdemeanor indecent exposure	☐	☐
22. Misdemeanor public sexual indecency	☐	☐
23. Aggravated criminal damage	☐	☐
24. Adding poison or other harmful substance to food, drink or medicine	☐	☐
25. A criminal offense involving criminal trespass under Title 13, Chapter 15	☐	☐
26. A criminal offense involving criminal burglary under Title 13, Chapter 15	☐	☐
27. A criminal offense involving organized crime or fraud as prescribed in Title 13, Chapter 23, except terrorism	☐	☐
28. Misdemeanor offenses involving child neglect	☐	☐
29. Misdemeanor offenses involving contributing to the delinquency of a minor	☐	☐
30. Misdemeanor offenses involving domestic violence as defined in A.R.S. § 13-3601	☐	☐
31. Felony offenses involving domestic violence if the offense only involved criminal damage in the amount of $250 but less than $1000 and the offense was committed before June 29, 2009	☐	☐
32. Arson	☐	☐
33. Criminal damage	☐	☐
34. Misappropriation of charter school monies as prescribed in A.R.S. § 13-1818	☐	☐
35. Taking identity of another person or entity	☐	☐
36. Aggravated taking identity of another person or entity	☐	☐
37. Trafficking in the identity of another person or entity	☐	☐
38. Cruelty to animals	☐	☐
39. Prostitution as described in A.R.S. § 13-3214	☐	☐
40. Sale or distribution of material harmful to minors through vending machines as prescribed in A.R.S. § 13-3513	☐	☐
41. Welfare fraud	☐	☐
42. Kidnapping	☐	☐
43. Robbery, aggravated robbery or armed robbery	☐	☐
44. Misdemeanor endangerment	☐	☐
45. Misdemeanor threatening or intimidating	☐	☐
46. Misdemeanor assault	☐	☐
47. Misdemeanor aggravated assault	☐	☐
48. Misdemeanor unlawfully administering intoxicating liquor, narcotic drugs or dangerous drugs	☐	☐

	YES	NO
49. Misdemeanor dangerous or deadly assault by prisoner or juvenile	☐	☐
50. Misdemeanor prisoners who commit assault with intent to incite riot or participate in riot	☐	☐
51. Misdemeanor assault by vicious animals	☐	☐
52. Misdemeanor drive-by shooting	☐	☐
53. Misdemeanor assaults on public safety employees or volunteers and state hospital employees	☐	☐
54. Misdemeanor discharging a firearm at a structure	☐	☐
55. Misdemeanor prisoner assault with bodily fluids	☐	☐
56. Misdemeanor aiming a laser pointer at a peace officer	☐	☐
57. Misdemeanor possession and sale of peyote	☐	☐
58. Misdemeanor possession and sale of a vapor-releasing substance containing a toxic substance	☐	☐
59. Misdemeanor selling or giving nitrous oxide to underage persons	☐	☐
60. Misdemeanor sale of regulated chemicals	☐	☐
61. Misdemeanor sale of precursor chemicals	☐	☐
62. Misdemeanor production or transportation of marijuana	☐	☐
63. Misdemeanor possession, use or sale of marijuana, dangerous drugs or narcotic drugs	☐	☐
64. Misdemeanor possession, use, administration, acquisition, sale, manufacture or transportation of prescription-only drugs	☐	☐
65. Misdemeanor administration, acquisition, manufacture or transportation of dangerous drugs or narcotic drugs	☐	☐
66. Misdemeanor manufacturing methamphetamine under circumstances that cause physical injury to a minor under the age of 15	☐	☐
67. Misdemeanor involving or using minors in drug offenses	☐	☐
68. Misdemeanor possession, use, sale or transfer of marijuana, peyote, prescription drugs, dangerous drugs, or narcotic drugs or manufacture of dangerous drugs in a drug-free school zone	☐	☐
69. Misdemeanor possession, manufacture, delivery and advertisement of drug paraphernalia	☐	☐
70. Misdemeanor use of wire communication or electronic communication in drug-related transactions	☐	☐
71. Misdemeanor using a building for sale or manufacture of dangerous or narcotic drugs	☐	☐
72. Misdemeanor manufacture or distribution of prescription-only drug	☐	☐
73. Misdemeanor manufacture, distribution, or possession with intent to use imitation controlled substances, imitation prescription-only drugs or imitation over-the-counter drugs	☐	☐
74. Misdemeanor manufacture of certain substances and drugs by certain means	☐	☐

IDEAL CARE LLC

OFFICE: 623/266-0727 FAX: 623/266-0914
4135 N. 108th Ave. Ste. #102 Phoenix, AZ. 85037

EMPLOYMENT VERIFICATION AUTHORIZATION FORM

By signing below, I authorize IDEAL CARE LLC to contact any and all - current and previous Employers noted on my Application/Resume. I also understand that any information provided by me to IDEAL CARE LLC is not only the most Updated Information - but also Truthful Information regarding my person and my past Employment.

Applicant Printed Name: _____

Applicant Signature: _____

Applicant Social Security: _____

Ideal Care LLC Administrative Notes:

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

DIRECT SERVICE POSITION

You have applied for a position that provides direct services to children or vulnerable adults. Arizona Revised Statutes (ARS § 8-804.I) require you to certify, under penalty of perjury, whether an allegation of abuse or neglect was made against you and was substantiated. If your certification does not indicate a current investigation or a substantiated report of abuse or neglect, your employer may permit you to provide direct services pending the findings of a Central Registry Background Check by the Division of Developmental Disabilities. Your employer is required to keep this form and all information provided on it as confidential.

Name *(Last, First, M.I.)* _____

SOC. SEC. NO. _____ Date of Birth _____

Aliases *(e.g.,maiden, nicknames)* _____

Address *(No., Street)* _____

City _____ State _____ ZIP Code _____

Are you currently the subject of an investigation of child abuse or neglect in Arizona, another state or jurisdiction?
☐ Yes ☐ No

Have you ever been the subject of an investigation of child abuse or neglect in Arizona, another state or jurisdiction that resulted in a substantiated *(determined to have occurred)* finding? ☐ Yes ☐ No

If Yes, to the question immediately above:

What was the allegation(s)?

When was the investigation(s) conducted? _____

Where was the investigation(s) conducted? _____

If you wish to provide additional information see Direct Service Position Supplement.

STATEMENT OF CERTIFICATION

By signing this form, I certify that the information provided is true, correct, and complete to the best of my knowledge and belief.

Signature _____ Date _____

Employers: Maintain this form as confidential.

IDEAL CARE LLC

OFFICE: 623/266-0727 FAX: 623/266-0914
4135 N. 108th Ave. Ste. #102 Phoenix, AZ. 85037

PAYROLL INFORMATION

Instructions: *Complete for all new employees and changes to existing employee records. This form should accompany the W-4 & A-4 --- completed and signed by the employee.*

Full Name _____

Home Phone (___)_____ Cell (___)_____

Address_____
Street Address *Apartment/unit #*

Mailing Address *(If Different)*_____ a Mrs. unilateral and the government will split the to settle

_____
(P.O. Box or alternative street address)

_____
City *State* *Zip*

Hire Date: _____

Adopted Pay Rate: $ _____ / $ _____ / $_____
Habilitation ***Respite*** ***ATC*** *[FAM] [NON-FAM]*

Date Completed: _____ / _____ / _____ IDEAL CARE LLC Initials: _____

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

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

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

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

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

STOP *Employer Completes Next Page* STOP

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

WHEN THE CARE HAS TO BE GREAT ...
...IT HAS TO BE IDEAL"

AUTHORIZATION FOR DIRECT DEPOSIT – Employee Form

This form authorizes **IDEAL CARE LLC** to send credit entries (and appropriate debit and adjustment entries) electronically, or by any other commercially accepted method, to my account indicated below. With this form I authorize the financial institution holding the Account to post all such entries.

Account #1

ACCOUNT TYPE (I.E. Checking or Savings): _____

EMPLOYEE BANK NAME: _____

BRANCH NAME: _____

CITY, STATE: _____

ACCOUNT NUMBER: _____

BANK ROUTING NUMBER: _____

This authorization will be in effect until **IDEAL CARE LLC** receives a written Termination Notice from me or a new Automatic Deposit Form from me stating that I am moving my Deposits to a New Bank.

_____

Provider Printed Name

_____

Provider Signature

_____

Date

Notes_____

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

2023

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.)

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, other details, and privacy.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Reserved for future use.

(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 . . . . . ☐

TIP: If you have self-employment income, see page 2.

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)

Arizona Form **A-4**

Employee's Arizona Withholding Election 2023

Arizona tax rates have decreased. As a result, we are revising withholding percentages and are requiring taxpayers to complete a new Form A-4 for 2023.

Type or print your Full Name		Your Social Security Number
Home Address – number and street or rural route		
City or Town	State	ZIP Code

Choose either box 1 or box 2:

☐ **1** Withhold from gross taxable wages at the percentage checked **(check only one percentage)**:

☐ 0.5% ☐ 1.0% ☐ 1.5% ☐ 2.0% ☐ 2.5% ☐ 3.0% ☐ 3.5%

☐ Check this box and enter an extra amount to be withheld from each paycheck ..... $

☐ **2** I elect an Arizona withholding percentage of zero, and I certify that I expect to have no Arizona tax liability for the current taxable year.

I certify that I have made the election marked above.

SIGNATURE DATE

Employee's Instructions

Arizona law requires your employer to withhold Arizona income tax from your wages for work done in Arizona. The amount withheld is applied to your Arizona income tax due when you file your tax return. The amount withheld is a percentage of your gross taxable wages from every paycheck. You may also have your employer withhold an extra amount from each paycheck. Complete this form to select a percentage and any extra amount to be withheld from each paycheck.

What are my "Gross Taxable Wages"?

For withholding purposes, your "gross taxable wages" are the wages that will generally be in box 1 of your federal Form W-2. It is your gross wages less any pretax deductions, such as your share of health insurance premiums.

New Employees

Complete this form within the first five days of your employment to select an Arizona withholding percentage. You may also have your employer withhold an extra amount from each paycheck. If you do not give this form to your employer the department requires your employer to withhold 2.0% of your gross taxable wages.

Current Employees

If you want to change your current amount withheld, you must file this form to change the Arizona withholding percentage or to change the extra amount withheld.

What Should I do With Form A-4?

Give your completed Form A-4 to your employer.

Electing a Withholding Percentage of Zero

You may elect an Arizona withholding percentage of zero if you expect to have no Arizona income tax liability for the current year. Arizona tax liability is gross tax liability less any tax credits, such as the family tax credit, school tax credits, or credits for taxes paid to other states. If you make this election, your employer will not withhold Arizona income tax from your wages for payroll periods beginning after the date you file the form. To keep this election for the next calendar year, you must give your employer an updated Form A-4. If you do not, your employer may withhold Arizona income tax from your wages and salary until you submit an updated Form A-4.

Zero withholding does not relieve you from paying Arizona income taxes that might be due at the time you file your Arizona income tax return. If you have an Arizona tax liability when you file your return or if at any time during the current year conditions change so that you expect to have a tax liability, you should promptly file a new Form A-4 and choose a withholding percentage that applies to you.

Voluntary Withholding Election by Certain Nonresident Employees

Compensation earned by nonresidents while physically working in Arizona for temporary periods is subject to Arizona income tax. However, under Arizona law, compensation paid to certain nonresident employees is not subject to Arizona income tax withholding. These nonresident employees need to review their situations and determine if they should elect to have Arizona income taxes withheld from their Arizona source compensation. Nonresident employees may request that their employer withhold Arizona income taxes by completing this form to elect Arizona income tax withholding.

IDEAL CARE LLC

OFFICE: 623/266-0727 FAX: 623/266-0914
4135 N. 108th Ave. Ste. #102 Phoenix, AZ. 85037

BILLING PROCEDURES ACHNOWLEDGEMENT FORM

As an HCBS Provider Employee for **Ideal Care LLC**, I agree to follow all the rules and regulations regarding Billing Procedures as established by **Ideal Care LLC** for all its HCBS Providers. I agree that I AM responsible for filling out, and completing **all of my TIMESHEETS** on time.

I agree to turn in any/all Timesheets, Documents, and/or Habilitation Reports and/or Attendant Care Reports (ATC) in a timely manner - or risk picking up my paycheck from the Ideal Care LLC office in exchange for any "Outstanding Reports" I may have failed to turn on time.

I understand that **Ideal Care LLC** needs to have all important Reports turned in to have them on file should they be needed during their regular **HCBS Audit** - and that turning such reports in on time is part of my Job Description and part of my responsibility as well.

Furthermore, I agree that I am responsible for completing all Billing Paperwork, Timesheets, and Forms accurately, and completely. I understand that it is also my responsibility to turn in all **ORIGINAL Timesheets** every two weeks in order for me to get paid on time.

Not turning in **MY TIMESHEETS** at all - will disqualify me from getting paid for hours worked that particular pay period - and delay my pay another pay period.

[ ] I agree to these terms as an HCBS Provider/DCW Employee

[ ] I **DO NOT** agree to these terms as an HCBS Provider/DCW Employee

Provider Name	*Provider Signature*	*Date*

Ideal Care LLC Rep	*Date*

IDEAL CARE LLC

OFFICE: 623/266-0727 FAX: 623/266-0914
4135 N. 108th Ave. Ste. #102 Phoenix, AZ. 85037

WHISTLEBLOWERS AGAINST FRAUD

FALSE CLAIMS ACT

READ the following statements, and write your initial insight each box provided, & at the bottom of this form to acknowledge that you know, and have been made aware of this False Claims Act Information.

Failure to initial or sign, or to adhere to the rules referenced in the ***False Claims Act Information*** *provided below may/will result in automatically not being hired for a Care Provider/DCW Position, and/or Termination of Employment by IDEAL CARE LLC.*

Knowingly presenting or causing to be presented to the Federal Government a false or fraudulent claim for payment. ***A ningun momento hare Fraude contra el Gobierno Federal.***	*Initials*
Knowingly using or causing to be used a false record statement to get a claim paid by the Federal Government. ***A ningun momento Falsificare Documentos contra el Gobierno Federal.***	*Initials*
Conspiring with others to get a false or fraudulent claim/s paid by the Federal Government. ***A ningun momento usare Documentos para Falsificar o Esconder Dineros contra el Gobierno Federal.***	*Initials*
Knowingly using or causing to be used a false record of statement to conceal, avoid, or decrease an obligation to pay money, or transit property to the Federal Government. ***A ningun momento usaqre Documentos para Falsificar mi Obligacion de pagar dinero debido al DDD/DES o al Gobierno Federal.***	*Initials*
The False Claims Act covers fraud involving any federal funded contractor program, with the exception of Tax Fraud. ***Este Acto cubre cualquier Fraude de cualquier Dinero Federal except Fraude de Impuestos Anuales.***	*Initials*
Liability for violating the FCA is equal to three times the dollar amount that the government is frauded (i.e. treble damages) in Civil Penalties of $5000-$11,000 for each False Claim. ***Este Acto de Fraude lleva penalidades de $5000-$11,000 por cada Acto de Fraude.***	*Initials*
An individual can receive an award for "Blowing the Whistle" under the FCA. ***Cualquier person que reporte algun Fraude puede recibir compensacion monetaria bajo el FCA.***	*Initials*
In order to receive the award, you must file a Qui Tam Lawsuit. ***Para recibir compensacion monetaria bajo el FCA – la persona debe sumitir a Corte una Demanda de Qui Tam.***	*Initials*
The whistleblower that files a false Claims Act suit receives an award only if, and after, the government recovers money from the defendant as a result of the lawsuit. ***La persona que meta esta demanda solo sera pagada si el Gobierno recibe dinero por medio de la demanda.***	*Initials*
The amount of the award depends, in part, if the government participates in the suit, and the extent to which the person substantially contributed to the prosecution of the action. ***La cantidad de las ganancias despues de la Corte dependeran de la contribucion y ayuda que la person brindo a la Corte.***	*Initials*
The whistleblower is protected under the FCA states as follows: Any employee who is discharged, demoted, or discriminated against because of lawful acts by the employer in furtherance of an action under the Act is entitled to any relief necessary to make the employee whole. ***No Habra contra-demanda de nadie contra la persona que reporto Fraude.***	*Initials*
Written policies and procedures for detecting and preventing fraud, waste, and abuse (such as a compliance program) are available should the employee request them. ***Si el empleado/a desea mas informacion se le proveera mas informacion.***	*Initials*

DCW/Provider's Signature: _____

Ideal Care Rep: _____

Date: _____

IDEAL CARE LLC

OFFICE: 623/266-0727 FAX: 623/266-0914
4135 N. 108th Ave. Ste. #102 Phoenix, AZ. 85037

TRANSPORTATION POLICY

I understand and agree to maintain my Driver's License, Vehicle Registration, and Automobile Insurance Valid and Current with Ideal Care LLC, and remove all Financial Liability form Ideal Care LLC when I Transport Members/Consumers.

So I _____ hereby **AGREE** to Ideal Care LLC's **Transportation Policy** stating that I must always maintain myself **Valid** and **Current** and **the decision to Transport a Consumer falls entirely on me**.

I **AGREE** to submit current Vehicle Registration and Proof of Insurance every six months, and agree to maintain the registration current on my vehicle.

I also understand that the decision to Transport any Consumer/s falls entirely on me as Direct Care Worker as well as showing Proof of Insurance should I get stopped by an Officer of the Law or should I be involved in an Accident, my Valid Vehicle Insurance will be the "Primary Vehicle Insurance Coverage."

I understand that failure to produce Vehicle Registration and Proof of Insurance may result in temporary, or permanent removal from my current Member Assignment, and/or Placement.

If I should encounter difficulty in abiding by this Transportation Policy, I will immediately contact my immediate IDEAL CARE LLC Supervisor.

DCW/Provider's Signature: _____

Ideal Care Supervisor: _____

Date: _____

VEHICLE INSPECTION REPORT

***** DCW DRIVER WAIVER ******

Inspection Completed By:			Date:
Provider Name:	Vehicle Make:	Model:	Year:
Mileage:		Next Inspection:	

Not OK	OK	BEFORE STARTING ENGINE:	VEHICLE ISSUES / WHEN FIXED:
		Headlights	
		Brake/head/tail/clearance lights	
		Direction signals/emergency flashers (4-way)	
		Mirrors (inside and outside)	
		Windows/windshield	
		Tires	
		Windshield wipers and washers	
		Horn	
		Seat Belts	
		CLIMATE CONTROL:	**AC - HEATER ISSUES / WHEN FIXED:**
		Properly working AC	
		Properly working Heater	

Condition of Vehicle is: ☐ Satisfactory ☐ Unsatisfactory

Provider Signature: _____

********** DCW DRIVER WAIVER: **********

DCW DOES NOT DRIVE CONSUMER IN COMMUNITY	DCW Name:	DCW *Signature*:

Ideal Care LLC Representative: _____ Date: _____

WHEN THE CARE HAS TO BE GREAT ...

..."IT HAS TO BE IDEAL"

AUTHORIZATION FOR DIRECT DEPOSIT – Employee Form

This form authorizes **IDEAL CARE LLC** to send credit entries (and appropriate debit and adjustment entries) electronically, or by any other commercially accepted method, to my account indicated below. With this form I authorize the financial institution holding the Account to post all such entries.

Account #1

ACCOUNT TYPE (I.E. Checking or Savings): _____

EMPLOYEE BANK NAME: _____

BRANCH NAME: _____

CITY, STATE: _____

ACCOUNT NUMBER: _____

BANK ROUTING NUMBER: _____

This authorization will be in effect until **IDEAL CARE LLC** receives a written Termination Notice from me or a new Automatic Deposit Form from me stating that I am moving my Deposits to a New Bank.

_____

Provider Printed Name

_____

Provider Signature

_____

Date

_____

Notes_____

Revised 1/23

Acceptance of Company Policies of:
Ideal Care LLC

The declarations to continue are part of the Policies of **Ideal Care LLC**. It is stipulated that not Accepting ***(with Initials)*** and NOT Initially signing off in Acceptance of our Company Written Policies may resulting Initially in NOT getting Employed, and should I break any Company Policies after being Hired/Employed I acknowledge that I will receive Disciplinary Actions as a result of breaking any Company Policies.

Please write your initials next to all Company Policies in acceptance of all Company Policies, and feel free to contact your Immediate Supervisor should you have any questions regarding any Company Policy, at any time.

CORRECTNESS OF TIMESHEET

Your time sheet should reflect the exact hours that you work. What should appear under timesheet is EXACTLY the times you worked, Failure to fill out your timesheet appropriately may result in disciplinary action. Filling out a timesheet with "fixed" times represents Fraud, and **Ideal Care LLC** will have no part of this.

Initials: _____

TAMPERING OF LEGAL TIMESHEET:

Ideal Care LLC will not tolerate any fraudulent activity. Fraudulent activity/behavior includes adding hours to any timesheet without the approval of the Member/Consumer or Family, as well as forging any Timesheets submitted to **Ideal Care LLC**, or submitting any Timesheet with "White-Out", Corrections, or Erasure Marks.

Initials: _____

40 HOUR WORK-WEEK POLICY

As of November 1, 2015, no employee of **Ideal Care LLC will be authorized to work more than 40 hours in a workweek (Sunday to Saturday)**, without prior approval from their Supervisor. All additional hours **HAVE TO BE** approved previously before being worked by your Supervisor. Not complying with this policy may be cause for disciplinary action. **Ideal Care LLC** will only pay a maximum of 40 hours per work week will be paid. **During any 5 week months, the 40 hour per week limit will apply as well. Furthermore,** it is strictly the responsibility of the Home Care Worker/Provider/DCW to always be aware of this Agency Policy from November 1, 2015, on.

Initials: _____

EMPLOYEE CHECKS:

If a Home Care Worker/Provider/DCW's payroll check should be lost because s/he did not notify us of a change of his/her new address, the Home Care Worker/Provider/DCW will be charged the **total fee** the check charges for a **Stop Payment** on the check. It is the obligation of the Home Care Worker/Provider/DCW to **always notify** employer of **ALL NEW personal information**. This includes new phone numbers, and new emails. All personal information changes have to be reported to **Ideal Care LLC** via phone or directly in the office **NO MORE** than 7 days of change.

Initials: _____

LATE TIMESHEET SUBMITTALS:
In addition to being paid correctly, it is very important that I Initiate and Complete my Timesheet on time through Vichra EVV every 2 weeks. (It is my duty to ALWAYS keep an eye on my Pay Calendar so that I am NOT LATE doing my Timesheet on **LINE**). As Employee – I understand that entering a "**LATE TIMESHEET**" will result in getting paid until "**Next**" Pay Period *(2 weeks later)*. There will be **NO EXCEPTIONS** because Payroll is controlled by the Program Vichra EVV as well.

Initials: _____

NEGLIGENCE TOWARDS A MEMBER/CONSUMER:
If the Home Care Worker/Provider stops working with their assigned Member/Consumer, then the Home Care Worker/Provider **must** notify employer **Ideal Care LLC immediately** of the sudden change. Any Home Care Worker/Provider/DCW who does not report to work with their assigned Member/Consumer, and who also does not call their Immediate Supervisor to report this sudden change may be placing their Member/Consumer **AT RISK** and may be subject to disciplinary action (especially if given Member/ Consumer suffers harm as a result of this negligence).

Initials: _____

MAINTAINING CERTIFICATIONS CURRENT:
Ideal Care LLC is required per Contract with DDD, that **all of its employees maintain all of their certifications current**. As a courtesy you will receive letters, emails, or phone calls from Ideal Care LLC, **but it is strictly the responsibility of the Home Care Worker/Provider themselves to view expirations and their certificates.** The Home Care Worker/Provider should always plan on **RE-CERTIFYING** themselves at least 2 months before actual expiration of certificates.

Initials: _____

SERVICES TO NON-CLIENTS:
It is a violation to the policies of Ideal Care LLC to take care of "other children" who are not Members/Consumers of **Ideal Care LLC**. More clearly, the Home Care Worker/Provider cannot take care of the brothers or sisters of the Member/Consumers, or their family members, etc.

Initials: _____

WORKING WITH OTHER AGENCIES:
Ideal Care LLC does not prohibit its employees from working with other agencies, but if you are submitting hours with another Provider Agency, **you have to** inform your immediate supervisor about this. **If the Home Care Worker/Provider wishes to take any certificates from one Provider Agency to another, then the Testing Agency has the right to charge for its Certificates before releasing them to Home Care Worker.**

Initials: _____

CHARGING HOURS WHILE MEMBER/CONSUMER IS IN HOSPITALIZATION/THERAPIES:
AHCCCS Rules and Regulations do not permit that any Home Care Worker/Provider turn in hours while their Member/Consumer is in the **Hospital**, or while receiving **Therapies**. Should an AHCCCS Audit occur and any Home Care Worker/Providers be found to have worked, and submitted hours while their Member/ Consumer was in the hospital, or receiving therapies, then the **Home Care Worker/Provider will be held responsible to pay back all the hours submitted while the Member/Consumer was in the hospital, or receiving therapies from a Professional Caregiver.**

 Initials: _____

MEMBER/CONSUMER TRAVELLING OUT OF STATE/OUT OF THE COUNTRY:
Be aware that if a Member/Consumer wishes to receive services while they travel outside of the state of Arizona, the Service Coordinator needs to approve this before-hand. Submitting hours while the Member/Consumer is out of the country is **NOT** permitted.

Initials: _____

DO NOT WORK ANY "VOLUNTARY HOURS":
Due to the rules and regulations of the Department Of Labor, we do not allow our employees to be voluntary workers (employees without pay) with the Members/Consumers of **Ideal Care LLC**. The Home Care Worker/Provider will not be paid beyond the allotted workweek hours authorized by the Division. **Ideal Care LLC** does not make itself responsible for payment of any additional hours, **but only *of* those legally written on their Ideal Care LLC Timesheet, signed an initialed by the Responsible Party.**

Initials: _____

FMLA:
If an employee of **Ideal Care LLC** wishes to exercise the rights of FMLA, to be absent two or more weeks from their assignment with a Member/Consumer, due to an illness, family emergency, or pregnancy, then the Home Care Worker/Provider must notify their immediate supervisor, as soon as possible to acquire more information.

Initials: _____

CONFIDENTIALITY/HIPAA:
It is a violation of the rules of DDD and HIPAA that any employee disclose any information regarding the clients who they work with at **Ideal Care LLC**. This includes, but is not limited to sharing the names, photographs, etc. in any format; spoken, or written through Facebook, Twitter, etc. It is forbidden that any employee of **Ideal Care LLC** upload photos, or names of Members/Consumers **WHO ARE MINORS, or to put in writing that they work with persons of Special Needs, and include their names.**

Initials: _____

HOME CARE WORKER/PROVIDER WORK PROFESSIONALSIM:
You are obligated to behave in a professional manner, and always have a good attitude, at all times. This includes your tone of voice, your selection of words, your facial expressions, and your physical posture. This also includes not bringing other people, or children to the place of work, which is the home of the Member /Consumer.

Initials: _____

HARASSMENT:
All forms of harassment are prohibited. These include, but are not limited to, conduct that may humiliate anyone based on race, religion, nationality, sexual preference, age, condition, or sex, which may result in a hostile environment. You may not harass your consumers, families, or fellow workers. If you feel you have been harassed in any manner, you need to notify your Immediate Supervisor.

Initials: _____

PORNOGRAPHY:

You are not permitted to use pornography, introduce others to pornography, utilize pornography as a "friendly topic" of conversation with any Member/Consumer, or fellow worker. Such un-tolerated activities will be grounds for immediate discharge from employment from **Ideal Care LLC**, and possible Civil and/ or Criminal Action may follow.

Initials: _____

INCIDENT REPORTING:

All employees of **Ideal Care LLC** have are obligated to report Abuse and Negligence. This means that you as an employee are obligated to report any instance, or suspicion of Abuse or Negligence to your Immediate Supervisor as soon as you are consciously aware of such a situation. Should the Member/ Consumer suffer an injury, or should an incident occur while in your care, **you are to make an Incident Report with/to your Immediate Supervisor within 24 hours of incident - Who will in turn report/FAX over report to the Division within these same 24 hours.**

Initials: _____

HOME CARE WORKER/PROVIDER DRESS CODE:

All employees of **Ideal Care LLC** will be conscious of the way they are dressed when they go to work and represent **Ideal Care LLC. It is required by Ideal Care LLC that all employee be dressed modestly, and appropriately every day they work.** Clothing shall not be too transparent, too tight or too revealing.

Initials: _____

USE OF CELLULAR PHONE:

It is **Prohibited** for the **Ideal Care LLC** Employee/Home Care Worker/Provider to use their cellular telephone, tablet, iPad, or computer while they are working, and in the care of one of our **Ideal Care LLC** Member/Consumer. The only reason to be on the cell phone is if the employee has a legitimate emergency, then it is only to notify the Member/Consumer or Family of what the emergency is. **It is also Prohibited for any and all of Ideal Care LLC Employees to text and drive at the same time.** The Employee ***must*** pull over to the side of the road completely before using their cell phone for texting, **or making a phone call.**

Initials: _____

VALUABLES AND/OR MONEY:

It is **Prohibited** for the **Ideal Care LLC** Employee/Home Care Worker/Provider to take any valuables and/or money found within the homes of the **Ideal Care LLC** Member/Consumer/s they serve. The **Ideal Care LLC** Employee must immediately notify the Consumer or Family that they have found given Valuables and/or Money and return **ALL** such valuables. Employees accused of taking Valuables after an Investigation and found to be at fault/guilty will be **Terminated**.

Initials: _____

VEHICLE REGISTRATION AND PROOF OF INSURANCE ***(Every 6 months)***

It is mandatory that **ALL** Employees/Home Care Workers/Providers of **Ideal Care LLC** submit **Valid Vehicle Registration and Proof of Insurance every six months** to maintain employment with **Ideal Care LLC.** Should **Ideal Care LLC** not have current **Proof of Insurance** and **Vehicle Registration,** after courtesy phone call has gone out to give an employee, then employee will ceased to submit hours with **any and all Consumers** until current **Proof of Insurance** and **Vehicle Registration** has been to submitted to **Ideal Care LLC.**

 Initials: _____

ACKNOWLEDGEMENT THAT EMPLOYMENT WITH IDEAL CARE LLC INVOLVES TAKING AND SUCCESSFULLY PASSING REQUIRED TESTS AND D.C.W. TRAINING TEST: LEVELS 1 & 2:

Ideal Care LLC always encourages **ALL** of its Employees **to** taking needed Exams/Tests and passing them with at least an 80% is required for employment. **This Policy includes First Aid & CPR, Article 9 Test, Habilitation Training, and highly encourages ALL its Employees taking D.C.W. Training and Testing so that in the case a "Back Up" position in the area of ATC opens – I have already received the DCW Training in advance.**

As an **Ideal Care LLC** Employee/Care Provider I hereby understand and agree to taking the D.C.W. Training and Testing **(2-DAY TRAINING)** within 90 days of Actual Hire.

Initials: _____

ACKNOWLEDGEMENT THAT EMPLOYMENT WITH IDEAL CARE LLC IS PART-TIME:

Ideal Care LLC always stipulates and makes it clear to **ALL** prospective employees before actually being hired that employment with **Ideal Care LLC** is **Part-Time**. As an **Ideal Care LLC** Employee/Care Provider I hereby understand that I am hired Part-Time throughout my employment with **Ideal Care LLC.** I also understand that if my assignment with a particular Consumer stops because of Family Choice/Consumer Choice then it is **my Obligation and Responsibility** to contact the office of **Ideal Care LLC** to ask for another **Part-Time** position with another Consumer/Family whereby **Ideal Care LLC** will give me a Job Lead and who to **contact** to continue being employed with **Ideal Care LLC.** as I am never fired, but simply transferred to another Consumer/Family to work with.

Initials: _____

ACKNOWLEDGEMENT FOR ALL IDEAL CARE LLC EMPLOYEES NOT TO BUY FOOD OR ITEMS/GIFTS WITH CARE PROVIDER/DCW's OWN MONEY:

Ideal Care LLC always stipulates and explains to ALL its Employees not to spend out of pocket and spend out of own Money to buy Gifts or Food for Consumer – but if purchases are made – because Parents direct Employee to so – that the Money come from Parents of Consumer. Ideal Care LLC reminds Employee DO NOT get Consumer and/or Parents used to Employee expecting Gifts/Food – REMEMBER that **IDEAL CARE LLC** and **THE STATE WILL NOT REFUND EMPLOYEE FOR MONEY SPENT due to this inappropriate practice.** So – to maintain good relations with everyone and to keep your Job – DO NOT engage in this practice! REMEMBER – if this practice brings you problems – Don't say we didn't warn you!

Initials: _____

ACKNOWLEDGEMENT THAT EVERY IDEAL CARE LLC EMPLOYEES MUST PASS ALL BACKGROUND CHECKS TO HOLD EMPLOYMENT WITH IDEAL CARE LLC:

Ideal Care LLC stipulates and makes it clear to ALL prospective employees that **ALL** employees must pass all Background Checks before probationary period ends. **Ideal Care LLC** will not hire anyone not passing ALL Background Checks as we serve vulnerable Children and Adult Members/Clients who need to be protected at all times. Should a perspective employee not pass ALL Background Checks - then s/he will be notified immediately - and will not be hired. In hiring all employees with **Ideal Care LLC** - all prospective employees will be looked up on the APS Registry (**Arizona Adult Protective Services Registry**) as an added precaution. Ideal Care LLC recognizes that anyone found guilty of taking advantage of/or abusing Vulnerable Adults and Children will be banned for 25 years from providing Home Care Services to any Adults and Children.

Initials: _____

ACKNOWLEDGEMENT THAT IF AN IDEAL CARE LLC DIRECT CARE WORKERS (DCW) IS CHARGED WITH A CRIME – S/HE IS REQUIRED TO SUBMIT TO LOCAL AUTHORITES IMMEDIATELY.

Ideal Care LLC stipulates and makes it clear to **ALL** prospective employees that in the event that an employee of this agency gets charged with a Misdemeanor or Felony - the employee or DCW must turn himself/herself into local authorities Immediately - and it is understood by this Employee that His/Her employment also stops on this date.

Initials: _____

ACKNOWLEDGEMENT THAT ALL IDEAL CARE LLC DIRECT CARE WORKERS (DCW) ARE TO OBSERVE ALLCOVID-19 GUIDELINES – AS OUTLINED BY THE CENTER FOR CONTROL DISEASE (CDC) GOING FORTH:

Ideal Care LLC stipulates and makes it clear to **ALL** prospective employees need to observe all rules and guidelines that the Center for Disease Control (CDC) has set forth - such as: Washing one's hands for 20 seconds often – If Employee feels sick - and feverish - not to show up to work at the Consumer's Home - but remain home and self-monitor - until there are no more illness symptoms.

Initials: _____

ON THE ONSET OF BEING EMPLOYED AT IDEAL CARE LLC – I UNDERSTAND AND ACCEPT THAT IDEAL CARE LLC DOES NOT OFFER MEDICAL/HEALTH INSURANCE TO ANY OF ITS CARE PROVIDERS (DCWs):

Ideal Care LLC- In accordance with Arizona USA Law, "As a Small Business – has NO Legal Obligation to offer Medical/Health Insurance to any of its Employees".

Initials: _____

ON THE ONSET OF BEING EMPLOYED AT IDEAL CARE LLC – I UNDERSTAND AND ACCEPT THAT IDEAL CARE LLC WILL CONTINOUSLY COMMUNICATE WITH VIA MASS TEXT MESSAGES:

Whenever IDEAL CARE LLC has the need to Communicate anything NECESSARY and/or IMPORTANT, regarding COMPANY POLICIES, COMPANY PROCEDURES, or EMERGENCY MESSAGES regarding Daily Business of IDEAL CARE LLC to me while holding Employment with IDEAL CARE LLC.

Initials: _____

ACKNOWLEDGEMENT BY DIRECT CARE WORKERS (DCWs) THAT IDEAL CARE PAYS ITS EMPLOYEES "PAID SICK TIME" AT A RATIO OF 30:1 ***(30 HOURS WORKED = 1 HOUR PAID SICK TIME)*** **FOR A MAXIMUM TOTAL OF 40 HOURS YEARLY – AND PAYABLE FROM EACH OCT 1 – SEPT 30 OF EACH SUBSEQUENT YEAR (WITH CHECK ON ACCUMULATION AND/OR REMAINING OF 40 HRS P.S.T. ON EACH SUBSEQUENT 1ST PAYCHECK ON THE MONTH OF OCTOBER RESPECTIVELY.**

And in accordance to Arizona Department of Labor - Ideal Care LLC holds the Legal Right to **ALWAYS Pay** its Employees at/or above Arizona Minimum Rate Wage Pay for "**Paid Sick Time" as** allowed and stipulated on D.O.L. Website [**https://www.azica.gov/labor-frequently-asked-questions-english**]. **Ideal Care LLC also holds the right through Company Policy to ALWAYS pay out ALL P.S.T to ALL Employees ALL owed P.S.T. by ALL Octobers, Yearly – on the 1st Paycheck of Every October – and** NOT Roll Over **any P.S.T.** into any subsequent Year.

"WHEN THE CARE HAS TO BE GREAT ....
... IT HAS TO BE IDEAL"

DECLARATION OF UNDERSTANDING OF COMPANY POLICIES:

By sign below, affirming that I have read and understood **Ideal Care LLC's** Company Policies and Procedures contained within these 7 pages. I accept to act in accordance with these Company Policies. I further recognize that I have communicated with my Immediate Supervisor, and that I have asked any and all questions that I had in respect to these Company Policies, and agree to all Company Policies that I am hereby signing.

_____ _____

Care Provider Name *Care Provider Signature*

_____ _____

IDEAL CARE LLC Representative Signature *Date*

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_____ _____

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_____ _____

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_____ _____

Care Provider Name *Care Provider Signature*

_____ _____

IDEAL CARE LLC Representative Signature *Date*

Aceptanción de Polizas de Empresa de:
Ideal Care LLC

Las declaraciones a continuación son parte de las Polizas de **Ideal Care LLC**. Está estipulado que el no Aceptar ***(con Iniciales)*** y el de NO Inicialmente firmar en aceptación de nuestras Polizas Escritas puede resultar en Inicialmente NO ser Empleados/as, y/o de despues de ser Empleados/as de recibir Acciones Disciplinarias como respuestas al quebrar una/s de nuestras Polizas de Empresa Escritas.
Favor de escribir tus iniciales al lado de todas las Polizas de Empresa como acceptación de ellas, y se les recomienda que se pongan en contacto con su Supervisor si tuviesen alguna pregunta de cualquier Poliza, a cualquier momento.

EXACTITUD DE TIMESHEET – DOCUMENTO LEGAL
Tu Timesheet debe reflejar horas trabajadas "Exactas" que has trabajado. Lo que debe aparacer en tu Timesheet son las horas **EXACTAS** que has trabajado. El Fallar en llenartu Timesheet apropiadamente puede resultar en accion disciplinarian.Llenando un Timesheet con "Tiempo Acomodado" representa **FRAUDE**, y Ideal Care LLC no tendra parte de este acto.

Iniciales: _____

MANIPULACION DE TIMESHEET:
Ideal Care LLC no va a tolerar ninguna activida fradulenta. Actividad o Comportamiento Fadulento incluye agregando horas al Timesheet sin el permiso de/ Miembro/Consumidor, of Familia, al igual de forgar cualquier Timesheet presentado a Ideal Care LLC, o entregando cualquier Timesheet con "White-Out", Correctiones, o Marcas como Borrones.

Iniciales: _____

POLIZA DE 40 HORAS POR SEMANA
Desde Noviembre 1, 2015, ningun empleado con **Ideal Care LLC será autorizado/a a trababjarmás de 40 horas en unasemana/por semana**(Domingo a Sabado), sin aprovamiento previo de del Supervisor. Cualquier horas adicionales**TIENEN que** ser aprovadas por el Supervisor. El no cumplir con estas Nuevas Polizas pueden ser causa de accion disciplinaria. Ideal Care LLC solo pagara por un maximo de 40 horas de trabajo por semana. Durante cualquier mes conteniendo 5 semanas, tambien aplicara el limite de 40 horas porsemana. Aun mas, es estrictamente la responsabilidad de la/el Proveedor/a DCW de siempre tener esta poliza revisada en mente y saber que este cambio/poliza comienza desde Noviembre 1, 2015, enadelante.

Iniciales: _____

POLIZA DE CHEQUES DE EMPLEO:
Si un Cheque de Trabajo de un/a Trabajador de Cuidado de Casa/Proveedor/a/DCW se llegase a perder debido a que el Empleado/a no notifico a la Agencia Ideal Care LLC del cambio de sudireccion, el/la Trabajador/a de Cuidado de Casa/Proveedor/a/DCW sera cobrado/a por la **CUOTA TOTAL** por el Cheque el Empleado que se tenga que ser **CANCELLADO.** Es la obligacion complete de la/el Trabajador/a de Cuidado de Casa/Proveedor/a/DCW de **SIEMPRE NOTIFICAR** a la agencia de cualquier cambio personal; y esto incluye Nuevo numero de telefono, y Nuevo correo electronico e-mail, en NO MAS de 7 diasdespues del cambio.

Iniciales: _____

IDEAL CARE LLC

OFFICE: 623/266-0727 FAX: 623/266-0914
4135 N. 108th Ave. Ste. #102 Phoenix, AZ. 85037

Overtime Policy Agreement
40 Hour per Week Work Limit/NO Overtime

To whom it may concern,

Please be advised that I _____ have been informed that due to the recent US Court of Appeals decision regarding the US Department of Labor's Home Care Final Rule, that I will be limited to working for, in invoicing to Ideal Care LLC a Maximum of 40 Hours per Week.

Each Workweek is determined by Sunday morning at 12:00 AM through Saturday night at 11:59 PM. These hours will include any, and all hours of service provided to, and on behalf of Ideal Care LLC.

I further understand that any overtime from November 1, 2015 on, must be authorized by Ideal Care LLC, HCBS Director in writing, prior to being worked. I understand that violation of this agreement will result in disciplinary action/s which may result in my suspension and/or my termination of employment.

_____ _____

Employee Signature Date

_____ _____

Ideal Care LLC Rep Signature Date

Receipt of: Providers, Ball v Betlach Lawsuit

Ball v Betlach Lawsuit

A recent decision from the Court in the Ball v Betlach (formerly Ball v Biedess) lawsuit required Arizona Health Care Cost Containment System (AHCCCS) to make changes to current contract and policy regarding back-up workers. This has resulted in changes to the Division's policies and procedures.

The Division will begin verifying that each provider agency **contracted** to provide attendant care, housekeeping or respite is available after normal business hours, including weekends. This needs to be verified at a minimum quarterly until the Division can demonstrate 100% compliance for two consecutive quarters. The Division will complete a test of all agencies contracted to provide a critical service (attendant care, housekeeping and respite). Your agency is required to return any calls received after hours within 15 minutes from the time a message is left.

Additionally, all providers of attendant care, housekeeping or respite are required to have processes in place to ensure there are back-up caregivers available on-call to substitute for those times when an unforeseeable gap in critical service occurs and to fill those gaps within two hours of being reported. Agencies are required to work with the family to follow the steps in the back-up plan when the scheduled provider becomes unavailable. Agencies must offer a replacement each time a gap occurs, regardless of the consumer/family's preference. When a replacement is offered, consumers/families have the right to decline the replacement. If your agency is unable to offer a replacement you are required to contact the Support Coordinator. The Support Coordinator will work with family to follow the back-up plan and find a replacement, if needed. It is the responsibility of the agency to follow up with the support coordinator to identify how the gap was resolved and report on the monthly Non-Provision of Service report. Continued inability of the agency to offer replacements may result in the family choosing another agency to provide the service on an ongoing basis.

Consumers/Families authorized to receive a critical service will be mailed a letter identifying the steps they should take when a provider is unavailable for a scheduled work time. This letter directs the family to contact the authorized agency when a provider is unavailable or does not show for a scheduled time. Families will also be given a 24-hour phone number to AHCCCS for families to report when a provider is unavailable to work. If AHCCCS, receives a call from a consumer/family reporting the scheduled provider did not show, AHCCCS will contact the authorized agency. Your agency is required to return any call from AHCCCS within 15 minutes. When an agency receives a call from AHCCCS reporting the gap, the agency will be required to call the hotline back to report how the gap was resolved.

Provider Name:	*Provider Signature*	*Date:*

Ideal Care Rep: Signature: Name:	*Date:*

IDEAL CARE LLC
4135 N. 108TH Ave. Ste. #102
Phoenix, AZ 85037

Office: 623/266-0727
Fax: 623/266-0914
WWW.IDEALCARELLCAZ.COM