ACTION PAGES

(FAX OR SHAREFILE BEFORE YOUR FIRST VISIT PLEASE)

- EMPLOYMENT APPLICATION WHICH INCLUDES THE FOLL REQUESTS:
  - DIPLOMA REQUEST
  - RESUME (CV) REQUEST
  - PROF'L LICENSE REQUEST
  - PROF'L REGISTRATION REQUEST
  - PROF'L LIABILITY INSURANCE REQUEST
- SIGNATURE PG OF HIPAA HANDOUT
- SIGNATURE PG OF FRAUD INSERVICE
- SIGNATURE PG OF INCIDENT PROTOCOLS
- SIGNATURE PG OF SCIP PROTOCOLS
- SIGNATURE PG OF CODE OF CONDUCT
- I-9 IMMIGRATION FORM WHICH INCLUDES THE FOLLOWING REQUESTS:
  - PASSPORT OR SSN CARD
  - DRIVER LICENSE REQUEST
- DIRECT DEPOSIT FORM
- W9 OR W4 TAX FORM + GUIDESHEET
- SAMPLE PAYROLL INVOICE
- SIGNATURE PG OF CONTRACT

FAX: 844-800-1470
SHAREFILE PLATFORM (PLS SET UP YOUR PROFILE😊

Caring Therapy Services, PLLC

17 North Plank Road, Suite 10, Newburgh, NY 12550. Phone: 845-800-9305. Fax: 844-800-1470

EMPLOYMENT APPLICATION: CONTRACTUAL PROFESSIONAL

Date____________________________

Name:____

D.O.B.___________________________ SSN__________________________________

Home Address: ____

____

(Include area code with telephone numbers)
(h):____________________________________cell:_______________________________
(w)_____________________________________fax_______________________________
E-mail: ____

Contractual/ Self Employed Position desired: __________________________________
(attach CV; attach professional liability certificate, if you don't currently have ins pls call 800-503-9230 or 800-982-9491 or 800-421-6694)

Education/Credentials (pertaining to your discipline – attach copies)

Educational Institution____

Years attended ______ Degree awarded in: __________________________________

Date degree awarded:(attach copy of ***diploma***)________/__________/______________

Prof ***License*** # (attach copy of ***license)***____

Current professional NY ***registration*** valid to (attach signed copy) ______/_________/_______

Alternate/Emergency Contact
Name & Relationship____
Address: ____
Include area code with telephone numbers
(h):___________________________________cell:_____________________________
E-mail:____

Please return pages 4 and 5. Keep pages 1-3 for your records, reference and use.

PROTECTED HEALTH INFORMATION RELEASE
Therapist's Blanket Release.

NAME OF THERAPIST:	
Signature of Therapist:	
Nature of request:	Current PPD to be faxed to Residence Manager at assigned sites
	Current PPD to be faxed to Article 16 Clinic or referring Hospital
Requested by:	Residence Manager at assigned sites or Article 16 Clinic
Request approved by:	Yvonne Pasqualicchio Title: Privacy Officer
Signature:	
DATE:	

Confidentiality notice: By my signature I hereby agree to the release of protected health information only to the parties listed above. Caring Therapy Services will not be held responsible for re-disclosure of said information.

Please return pages 4 and 5. Keep pages 1-3 for your records, reference and use.

I have read and fully understand the contents of the information contained in **CTS HIPAA Compliance Overview**

Date : ____

Name: ____

Title: ____

Signature: ____

License #: ____

Inservice: **What is Fraud**

****

Return this page for Inservice Attendance.
Keep pages 1-3 for your records and reference.

I have read and fully understand the contents of the information contained in the Inservice**: What is Fraud?**

Date Read: ____

Your Name: ____

Title: ____

Signature: ____

License #: ____

***** Please remember that this page with your original signature is required in order to process and approve your next paycheck.**

Thank You

**Sign and return this page.
Keep pages 1-10 for your records and reference.

I have reviewed and understand the procedures as outlined above regarding: **REPORTABLE INCIDENTS, SERIOUS REPORTABLE INCIDENTS, ABUSE: PROTOCOLS**

Name of Clinician: ______________________________________

Title:____

License #: ____

Signature: ____

Date Signed: ____

Sign and return this page.
Keep page 1 for your records and reference.

Policy and Procedures relative to SCIP (Strategies for Crisis Intervention Prevention)

I have reviewed and understand the procedures as outlined above.

Name of Clinician: ______________________________________

Title:____

Signature: ____

License #: ____

Date Signed: ____

PLEDGE TO ABIDE BY THE CODE OF CONDUCT FOR CUSTODIANS OF PEOPLE WITH SPECIAL NEEDS

I pledge to prevent abuse, neglect, or harm toward any person with special needs. If I learn of, or witness, any incident of abuse, neglect or harm toward any person with special needs, I will offer immediate assistance and then notify emergency personnel, including 9-1-1 where appropriate, and inform the management of this organization. I pledge also to report the incident to the Justice Center for the Protection of People with Special Needs.

I acknowledge that I have read and that I understand the Code of Conduct.

I agree to abide by this Code of Conduct.

______________________	________________	___________
Signature	Print Name	Date

Program: IPSIDD AND INDEPENDENT CLINIC SERVICES

Department: LONG TERM OUTPATIENT REHAB

Facility/Provider Organization: CARING SLP, PSYCHOLOGY, OT & NUTRITION SERVICES, PLLC

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: ____________

OR

2. Form I-94 Admission Number: ____________

OR

3. Foreign Passport Number: ____________

Country of Issuance: ____________

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

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

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

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

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

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

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

Section 2. Employer or Authorized Representative Review and Verification

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

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

List A Identity and Employment Authorization — **OR** — **List B** Identity — **AND** — **List C** Employment Authorization

List A	List B	List C
Document Title: US PASSPORT	Document Title: DRIVER LICENSE	Document Title: SOCIAL SECURITY CARD
Issuing Authority: US INS	Issuing Authority: DMV	Issuing Authority: SSA
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)*:

List A (continued)
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
YPasqual		ADMINISTRATIVE DIRECTOR

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
PASQUALICCHIO	YVONNE	CARING SLP, PSYCHOLOGY, OT & NUTRITION SERVICES, PLLC

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code
17 NORTH PLANK RD, SUITE 10	NEWBURGH	NY	12550

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

This page left intentionally blank. Affix your current Driver license and social security card.
Or just the first page of current valid US Passport.

Instructions for Completing the
OPWDD Form 159
OPWDD Registered Provider Request for
Statewide Central Register Database Check Form

ALL information must be neatly and clearly written.

Clearly write in all information(your addresses for the last 30 years)
Print
Sign once
Sign again
Return to Makayla by fax or scan and email
Fax – 844-800-1470
Email: makayla.select@gmail.com

Each SCR Database Check submitted should be reviewed for completeness. Please don't skip dates.

Justice Center for the Protection of People with Special Needs	**Applicant Consent Form for Fingerprinting for Justice Center Criminal Background Check (CBC)**	**NYS Justice Center for the Protection of People with Special Needs (Justice Center) Criminal Background Check Unit**

Part 1. Applicant Information (Please Print)

Last Name:	First Name:	MI:
Date of Birth:	Applicant type: Employee Indep contractor Volunteer Family Care___Operator_______	
Applicant address, city state:	Social Security Number:	
Facility/Provider Name: CARING SLP, PSYCHOLOGY, OT, & NUTRITION SERVICES, PLLC		

Part 2. Attestation

1. I have been advised that as part of the application process, the facility or provider agency listed above must request a background check with the NYS Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI) and the Justice Center must review and evaluate the results received from DCJS and the FBI. A conviction for certain crimes may affect my suitability for employment in this position.
2. I consent to having my fingerprints taken and submitted to DCJS and the FBI and consent to the Justice Center sharing with the facility or provider agency listed above a summary of the NYS criminal history information, if any, returned by DCJS, as part of its background investigation of my suitability for employment or volunteer service, or for certification as a natural person operator.
3. I have been advised that procedures exist for me to obtain, review and, if necessary, seek correction of my criminal history information pursuant to regulations established by DCJS in 9 NYCRR Part 6050, and the FBI, as applicable.
4. I have been advised that I have the right to withdraw my application for employment or volunteer service, or certification as a natural person operator, without prejudice, any time before employment, volunteer service, or certification as a natural person operator is offered or declined, regardless of whether the authorized person of the facility or provider agency has reviewed the summary of any criminal history information.
5. I have been advised that the results of the criminal background check forwarded to the Justice Center shall be confidential pursuant to the applicable federal and state laws, rules and regulations, and shall only be disclosed to persons authorized by law. Criminal history information will be considered pursuant to Article 23-A of the NYS Correction Law in making hiring determinations.
6. I affirm that the fingerprints submitted will be my own and that the information I have provided is true, complete and accurate.
7. I certify to the best of my knowledge that I: (check as appropriate)
   (a) ____have not been convicted of a crime.
   (b) ____have been convicted of a crime in NY or other jurisdiction.
   (c) ____ have pending arrest charges.
   If (b) or (c) is checked, provide details:______________________
   ____
   ____
   ____

You have not been convicted of a crime if:
a. Your conviction was sealed; dismissed; reversed; resulted in a youthful offender (YO) or juvenile delinquency (JD) adjudication; resulted in a conviction for a non-criminal violation offense; or if you were acquitted;
b. you received an Adjournment in Contemplation of Dismissal (ACD) and the adjournment period has elapsed; or
c. you withdrew your plea after completing a treatment program, and were not convicted of a felony or misdemeanor.

8. I have been advised that my social security number is being requested so that the Justice Center may check whether I am on the Staff Exclusion List as required by Social Services Law and will be performed prior to the criminal history information check.

Applicant Signature		Date:
Guardian signature if under 18	N/A	Date: N/A
Part 3	**Facility or Provider Agency Authorized Person Information**	
Authorized Person Name:	MAKAYLA DORNACHER	Title: Human Resources Coordinator
Signature:	[signature]	Email: makayla.select@gmail.com

OPWDD Form 159 (1/2/2014) FRONT

OPWDD Use Only
Date Submitted
Reference ID #

OPWDD Registered Provider Request for STATEWIDE CENTRAL REGISTER DATABASE CHECK

ALL INFORMATION MUST BE COMPLETE AND TYPED

REGISTERED PROVIDER NAME:	CARING SLP, PSYCHOLOGY, OT, & NUTRITION SERVICES, PLLC	**AUTHORIZED PERSON'S NAME:** MAKAYLA DORNACHER
AGENCY NAME: (if applicable)	-same-	**AUTHORIZED PERSON'S PHONE NUMBER:** (540) 903-9429
STREET ADDRESS:	17 NORTH PLANK ROAD, SUITE 10	**AUTHORIZED PERSON'S EMAIL ADDRESS:** makayla.select@gmail.com
CITY:	NEWBURGH	
STATE & ZIP CODE:	NY 12550	

Complete the following for yourself, your spouse, your children and any other person(s) in your home at the present time. MAKE SURE YOU COMPLETE ALL MAIDEN NAME/ALIAS SECTIONS THAT APPLY. IF NONE, STATE "NONE" List RELATIONSHIP in the fields below

Attach additional page(OPWDD Form 159a or 159b) if necessary.

The purpose of collecting the demographic data on *other persons in your household* who are not screened pursuant to Section 424-a of the Social Services Law is to enable the N.Y.S. Office of Children and Family Services to identify with the greatest degree of certainty whether the person(s) being screened is the subject of an indicated child abuse or maltreatment report. The utilization of this information in a discriminatory manner is contrary to the Human Rights Law.

APPLICANT/HOUSEHOLD MEMBER AREA

RELATIONSHIP TO APPLICANT	LAST NAME	FIRST NAME	SEX M/F	DATE OF BIRTH		
APPLICANT						
MAIDEN/ALIAS						

Please provide your current address and any other addresses at which you have resided for the last 28 years, including street, city, state and zip code.

CURRENT STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO

I affirm that all the information provided on this form is true to the best of my knowledge. I understand that if I knowingly give false statements, such action could be grounds for denial or dismissal from employment or denial or revocation of a license, certificate, permit, registration or approval.

APPLICANT'S SIGNATURE (therapist)	DATE

I authorize the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) and the Office for People with Developmental Disabilities to furnish all information which may be contained within the SCR to the above named registered provider. If there is an indicated report as a result of the SCR check, I authorize the above named registered provider to contact the appropriate investigating entity to receive further information with regard to the incident indicated in the report.

APPLICANT'S SIGNATURE (therapist)	DATE

I certify that I am an authorized person at the above named registered provider and am authorized to receive the information pertaining to criminal background checks. I understand that the information must be kept confidential in accordance with 14 NYCRR 633.24(c)(6).

AUTHORIZED PERSON'S SIGNATURE (yp)	DATE

* Required Fields

Please enter your information below. Then click ‘Next’ to continue or ‘Cancel’ to exit.

Citizenship

* **Country of Birth**

-- Choose One -- pls write in:

City of Birth

pls write in

* **Country of Citizenship**

-- Choose One -- pls write in, if not the US

OPWDD Form 159a

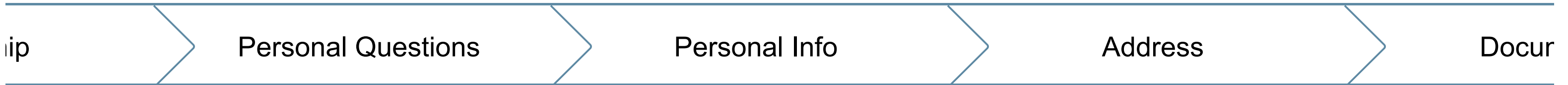
STATEWIDE CENTRAL REGISTER DATABASE CHECK FORM ADDITIONAL PAGE

(Use only if the space on the OPWDD Form 159 is not sufficient)

APPLICANT NAME: ____________________

All dates must be consecutive.

Previous Street Address	City	State	Zip	From	To



* Required Fields

Please enter your information below (letters, spaces, hyphens (-), and apostrophes (’) are allowed in name fields). Then click ‘Next’ to continue or ‘Cancel’ to exit.

Personal Information

pls write in the answers. your weight, you can be creative with :)

US | Metric

*** Height**

[ ] ft [ ] in

*** Weight**

[ ] lbs

*** Hair Color**

-- Choose One --

*** Eye Color**

-- Choose One --

*** Preferred Language (Receipts & other communication)**

English

*** Gender**

-- Choose One --

*** Race**

-- Choose One --

*** Ethnicity**

-- Choose One --

Dear Supervised Therapist – if you have an LLC, you may choose to get paid as an Independent Contractor with no taxes taken out. (use the W9, not the W4)

However, if you do not have an LLC, then just return the W4. Ignore the W9

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

2020

Step 1: Enter Personal Information

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

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Step 3: Claim Dependents

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

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

Multiply the number of other dependents by $500 . . . . ▶ $ ________

Add the amounts above and enter the total here . . . . **3** $

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

▶ ________________
Date

Employers Only

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

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

Print or type.
See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ ________

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) ________

Exemption from FATCA reporting code (if any) ________

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

☐☐☐ – ☐☐ – ☐☐☐☐

or

Employer identification number

☐☐ – ☐☐☐☐☐☐☐

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

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-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

Direct Deposit Enrollment/Change Form*

Company Name and/or Client Number CARING SLP,PSYCHOLOGY , OT & NUTRITION SERVICES, PLLC CLIENT# 1809-8863

Employee/Worker Name ____________ **Employee/Worker Number** ________

EMPLOYEE/WORKER: Retain a copy of this form for your records. Return the original to your employer/company.

EMPLOYER/COMPANY: Return this form to your local Paychex office. For clients using on-line services, please retain a copy of this document for your records.

COMPLETE TO ENROLL / ADD / CHANGE BANK ACCOUNTS – *PLEASE PRINT CLEARLY IN BLACK/BLUE INK ONLY*

Type of Account: ☐ Checking ☐ Savings	Accountholder's Name:
Routing/Transit Number	
Checking/Savings Account Number**	
Financial Institution ("Bank") Name	
I wish to deposit (check one): ☐ ____ % of Net	☐ Specific Dollar Amount $ ________ .00 ☐ Remainder of Net Pay
Type of Account: ☐ Checking ☐ Savings	Accountholder's Name:
Routing/Transit Number	
Checking/Savings Account Number**	
Financial Institution ("Bank") Name	
I wish to deposit (check one): ☐ ____ % of Net	☐ Specific Dollar Amount $ ________ .00 ☐ Remainder of Net Pay

COMPLETE IF CHANGING EXISTING DEPOSIT AMOUNTS – *PLEASE PRINT CLEARLY IN BLACK/BLUE INK ONLY*

Type of Account: ☐ Checking ☐ Savings	Accountholder's Name:
Routing/Transit Number	
Checking/Savings Account Number**	
Financial Institution ("Bank") Name	
I wish to change my deposit amount to (check one):	☐ From ____% to____% of Net ☐ From $______ .00 To $______.00 ☐ Remainder of Net Pay

EMPLOYEE/WORKER CONFIRMATION STATEMENT

PLEASE SIGN IN BLACK/BLUE INK ONLY

I authorize my employer/company to deposit my earnings into the bank account(s) specified above and, if necessary, to electronically debit my account to correct erroneous entries. I certify my account(s) allow these transactions. Furthermore, I certify that the above listed account number accurately reflects my intended receiving account. I agree that direct deposit transactions I authorize comply with all applicable laws. My signature below indicates that I am agreeing that I am either the accountholder or have the authority of the accountholder to authorize my employer/company to make direct deposits into the named account.

Employee/Worker Signature ____________________ **Date** ____________

Note: Digital or Electronic Signatures are **not** acceptable.

I confirm that the above named employee/worker has added or changed a bank account for direct deposit transactions processed by Paychex, Inc. I have reviewed the information provided and it is accurate to the best of my knowledge. My signature below indicates that I have the authority to execute this document on behalf of the Client.

Employer/Company Representative Printed Name: YVONNE PASQUALICCHIO

Employer/Company Representative Signature: YPasqual **Date:** ____________

* **All fields are required except Employee/Worker Number.**

** **Certain accounts may have restrictions on deposits and withdrawals. Check with your bank for more information specific to your account.**

DP0002 10/17

Form Expires 10/31/20

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Affix your voided check. It must show CLEARLY your routing and account number. If funds are to be deposited in your savings, indicate CLEARLY your routing and account number