Employment Eligibility Verification

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

USCIS
Form I-9
OMB No.1615-0047
Expires 05/31/2027

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

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

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

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

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

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

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

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

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

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

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

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

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

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

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)			**Additional Information**		
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)			☐ Check here if you used an alternative procedure authorized by DHS to examine documents.		

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

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

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

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

RMT2 HEALTHCARE SERVICES LLC

4601 LOCUST LANE, HARRISBURG PA 17109 SUITE 306

EMPLOYMENT APPLICATION FORM

PLEASE FILL OUT ALL INFORMATION REQUESTED	
Email Address:	**Date:**
Full name:	
Last First Middle Maiden	
Present address:	
Number Street City Province Postal	
How long have you lived at this address: YES☐ NO☐	**Social Security #:**
Date of Birth:	
Have you lived in Pennsylvania longer than 2 years?	**YES☐ NO☐**
Telephone:	
Position applied for:	**Days available to work:**
Salary desired:	**Flexible** ☐ **Thu** ☐ **Monday** ☐ **Fri** ☐ **Tuesday** ☐ **Sat** ☐ **Wednesday**☐ **Sun** ☐
Do you have CPR training YES☐ NO☐ **List below** **Do you have Nursing Training** YES☐ NO☐ **List below** **Do you have Assistant Nursing Training** YES ☐ NO ☐ **List below**	
How many hours can you work weekly?	**Can you work nights?** YES☐ NO☐ **Can you work weekends?** YES☐ NO☐
Type of employment desired: FULL-TIME ONLY LIVE OUT ☐ PART-TIME LIVE OUT ☐ LIVE IN ☐	
What date are you available to start work?	

EDUCATION

LEVEL OF EDUCATION	NAME OF SCHOOL	PROGRAM OF STUDY	COMPLETED YES/NO	MAJOR/ DEGREE
High School				
College				
University				
Trade/Vocation				

info@rmt2hs.com

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Have you ever been convicted of a crime? YES☐ NO☐	
Do you have a driver's license? YES☐ NO☐	
What is your means of transportation to work?	
Driver's license number:	**Location of issue:**
Expiration Date:	
Have you had any accidents during the past three years? YES ☐ NO☐ If yes please explain:	**How many?**
Have you had any driving violations during the past three years? YES ☐ NO☐ If yes please explain:	**How Many?**
Access to Communication Technology	
Do you have any of the following? **Cell phone** YES☐ NO☐ **Computer** YES☐ NO☐ **Tablet** YES☐ NO☐	
DATA PLAN ON PHONE YES☐ NO☐ **(We need to know you able to be reached while on the job)**	**List other IT Skills:**
Please list two references other than relatives or previous employers.	
Name:	**Name:**
Position:	**Position:**
Company:	**Company:**
Address:	**Address:**
Telephone:	**Telephone:**
Additional Information:	

info@rmt2hs.com

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Work Experience	Please list your work experience for the **past three years** beginning with your most recent job held. If you were self-employed, give firm name. **Attach additional sheets if necessary.**		
Job One			
Name of Employer:	**Name of Last Supervisor**	**Employment Dates**	**Salary**
Complete Address:		**From:**	**Start:**
		To:	**Final:**
Phone Number:	**Your Last Job Title:**		
Reason for Leaving (be specific):			
Job Two			
Name of Employer:	**Name of Last Supervisor:**	**Employment Dates**	**Salary**
Complete Address:		**From:**	**Start:**
		To:	**Final:**
Phone Number:	**Your Last Job Title:**		
Reason for Leaving (be specific):			
Job Three			
Name of Employer:	**Name of Last Supervisor:**	**Employment Dates**	**Salary**
Complete Address:		**From:**	**Start:**
		To:	**Final:**
Phone Number:	**Your Last Job Title:**		
Reason for Leaving (be specific):			
May we contact your present employer? YES☐ NO☐			
Did you complete this application yourself? YES☐ NO☐			
If not, who did?			

info@rmt2hs.com

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PLEASE READ CAREFULLY

APPLICATION FORM WAIVER

I authorize investigation of all statements contained in this application. I understand that the misrepresentation or omission of facts called for is cause for dismissal at any time without any previous notice. I hereby give the employer permission to contact schools, previous employers (unless otherwise indicated), references, and others.

I further understand that my employment shall be probationary for (30) days, and further that at any time during the probationary period or thereafter, my employment is terminable at will for any reason by either party.

PRINT FULL NAME:

Signature of Applicant: **Date:**

This is an equal employment opportunity employer. We adhere to a policy of making employment decisions without regard to race, color, religion, sex, sexual orientation, national origin, citizenship, or age. We assure you that your opportunity for this employment position depends solely on your qualifications.

Thank you for completing this application form and for your interest in the position

info@rmt2hs.com

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

2024

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number

Address

City or town, state, and ZIP code

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*.

(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, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

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

Step 3: Claim Dependent and Other Credits

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

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

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

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

HIPAA Confidentiality Agreement

Employees and partners of RMT2 Healthcare Services LLC will have access to confidential information, both written and oral, in the course of their employment and job responsibilities. It is imperative that this information is not disclosed to any unauthorized individuals to maintain the integrity of the patient information. An unauthorized individual would be any person that is not currently an employee Services and/or any information. Any other disclosures may only occur at the direction of the Privacy Office or by patient authorization.

I have read and understand RMT2 HS LLC policies with regards to privacy and security of personal health information. I agree to maintain confidentiality of all information obtained in the course of my employment including, but not limited to, financial, technical, or propriety information of the organization and personal and sensitive information regarding patients, employees, and vendors. I understand that inappropriate disclosure or release of patient information is grounds for termination.

Signature: _____ Date: _____

Print Name: _____

RMT2 HEALTHCARE SERVICES LLC

Face To Face Interview and Authorization for Pre-employment clearance/screening

I, _____, understand that as part of the employment process, needs to complete a background check, my employment with the agency may be temporary based on the outcome of my screenings, which may include but not limited to:

1. Criminal record;
2. Sex and Violent Offenders Record;
3. Employment Verification;
4. Education Verification;
5. License Verification;
6. Motor Vehicle Records;
7. Personal/Professional Reference Verification;
8. Medical Suitability
9. Drugs/Alcohol

- I authorize all federal and state agencies, persons and organizations that may have information relevant to this research to disclose such information to **RMT2 Healthcare Services LLC** or its authorized agent(s).
- I understand that this authorization is to be part of the written and signed employment application and verification that I have received a Face–to-face interview from an agency Rep.
- I also understand that I do not have to give authorization for a background check but if I don't give permission, my employment application will not be processed further.
- I understand that I have specific rights under the federal Fair Credit Reporting Act (FCRA) and may have additional rights under relevant State law.
- I further authorize that a photocopy of this authorization may be considered as valid as the original.
- I hereby certify that all statements on this form are true and correct to the best of my knowledge and belief. I understand that employment with **RMT2 Healthcare Services LLC** is contingent upon successful completion of a background check.
- During that interview I was told that this agency requires a criminal background check to be performed by the State Police in this state and a possible negative drug screen as conditions for employment for all employees. If I will be assigned to transport a homecare client, the Agency will obtain a driver's record in accordance with the state's Department of Transportation.

_____ _____

Signature Date

Full Name _____Telephone No. _____

Former Name(s) and Date(s) used: _____

Current Address_____

Date of Birth_____ SS#: _____ Sex: _____Race:_____

Current Driver's License: _____ State: _____

RMT2 HEALTHCARE SERVICES LLC

Probationary/Temporary Status

This letter is to verify that I, _____understand that my employment with **RMT2 Healthcare Services LLC** is temporary until my pre-employment screening results come back with a satisfactory result that is conducive with state regulations. In the event that my pre-employment screening is not favorable in accordance with state regulations I will be released from my employment immediately with **RMT2 Healthcare Services LLC** and ineligible for rehire.

Staff Signature: _____ Date: _____

Agency Rep. Signature: _____ Date: _____

CLGS-32-6 (6-13)

RESIDENCY CERTIFICATION FORM
Local Earned Income Tax Withholding

TO EMPLOYERS/TAXPAYERS:

This form is to be used by employers and/or taxpayers to report essential information for the collection and distribution of Local Earned Income Taxes to the local EIT collector. This form must be utilized by employers when a new employee is hired or when a current employee notifies employer of a name and/or address change. Use the Address Search Application at www.newPA.com/Act32 to determine PSD codes, EIT rates and tax collector contact information.

EMPLOYEE INFORMATION – RESIDENCE LOCATION

NAME (Last Name, First Name, Middle Initial)			SOCIAL SECURITY NUMBER
STREET ADDRESS **(No PO Box, RD or RR)**			
ADDRESS LINE 2			
CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER
MUNICIPALITY (City, Borough or Township)			
COUNTY	RESIDENT PSD CODE		TOTAL RESIDENT EIT RATE

EMPLOYER INFORMATION – EMPLOYMENT LOCATION

EMPLOYER BUSINESS NAME (Use Federal ID Name)			EMPLOYER FEIN
STREET ADDRESS WHERE ABOVE EMPLOYEE REPORTS TO WORK **(No PO Box, RD or RR)**			
ADDRESS LINE 2			
CITY	STATE	ZIP CODE	PHONE NUMBER
MUNICIPALITY (City, Borough or Township)			
COUNTY	WORK LOCATION PSD CODE		WORK LOCATION NON-RESIDENT EIT RATE

CERTIFICATION

Under penalties of perjury, I (we) declare that I (we) have examined this information, including all accompanying schedules and statements and to the best of my (our) belief, they are true, correct and complete.

SIGNATURE OF EMPLOYEE		DATE (MM/DD/YYYY)
PHONE NUMBER	EMAIL ADDRESS	

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

www.newPA.com/Act32

RMT2 HEALTHCARE SERVICES LLC

4601 LOCUST LANE HARRISBURG PA 17109, SUITE 306
(717) 350-5108 INFO@RMT2HS@GMAIL.COM

Face to Face Interview Questions

Applicant Name: _____

Date: _____

Position Applied for: _____

Did applicant read the job description? Yes / No _____

How did you hear about us?

Tell me about yourself (Job Experience)?

Have you ever worked in this field?

What skills do you think you can bring to this position?

Are you open to learning new things/skills?

How do you handle pressure/stressful situations/difficult behavior?

How do you feel about consumer choice?

What are your strengths and weaknesses?

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JOB DESCRIPTION

The following Services shall be provided by **RMT2 Healthcare Services LLC** under Home Care;

☐ Assistance with self-administered medications;

☐ Personal care (i.e., assistance with personal hygiene, dressing and feeding)

☐ Homemaking (i.e., assistance with household tasks, housekeeping, shopping, meal

Planning and preparation, and transportation);

☐ Companionship;

☐ Respite care (i.e., assistance and support provided to the family); and

☐ Other non-skilled services

Caregiver Signature:_____

Date:_____

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Caregiver Care Plan Training

I _____ have been giving all necessary information concerning the participant's care plan, to ensure that proper care is provided at all times.

Caregiver Signature: _____

Date: _____

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OLTL/ODP STAFF TRAINING RECORD

Staff Name:_____ Position:_____

Training	Signature	Date
APS Law Training Prevention of abuse and exploitation		
Incident Management/Reporting		
Complaint/Grievance Procedure		
Department-Issued Policies and Procedures		
Quality Managemant Plan		
Fraud/Financial Abuse Prevention		

kotapay

EMPLOYEE EMAIL FOR PAYSTUBS:_____

A Division of First International Bank & Trust

Employer/Company Information (required):		***KOTAPAY***
Name:		*1700 42nd St. S, Suite 2000*
Street Address:		*Fargo, ND 58103*
City, State, Zip:		*(800) 378-3328*
Telephone:		

Authorization for Debit and Credit Electronic Funds Transfers

On this _____ day of _____, _____, I hereby authorize Kotapay, a division of First International Bank & Trust ("KP") as well as the employer or compa described above, and its agents (collectively, "Company/Employer"), to initiate electronic withdrawals and/or deposits from/to the bank account provided below, and a subsequent bank accounts identified by me in writing. I understand that adjustment and/or reversing entries may be made to these accounts to ensure an accurate and balanc accounting of all transactions. This authorization will remain in effect until:

a) **I notify the financial institution provided below ("Bank") and KP in writing to terminate this authorization and the Bank and KP have been afforded reasonable time to comply, or**
b) **The Bank, Company/Employer, and/or KP have provided me with five (5) business days advance written notice of their decision not to initiate electronic withdrawals and/or deposits from/to the bank account provided below.**

Notwithstanding the foregoing authorization termination provisions, I understand that any written termination of this authorization will become effective no earlier than five (business days after the day the last transaction has cleared and there are no outstanding balances to the account.

I UNDERSTAND THAT KP PROVIDES ELECTRONIC FUND TRANSFER SERVICES TO THE COMPANY/EMPLOYER DESCRIBED ABOVE AND THEIR AGENT: INCLUDING PAYMENT AND PAYROLL PROCESSORS, IF USED. THE FUNDS TO BE TRANSFERRED MUST BE COLLATERALLY FUNDED AND ARE FULL GUARANTEED BY THE EMPLOYER/COMPANY LISTED ABOVE, THEIR AGENTS, INCLUDING ANY PAYROLL OR PAYMENT PROCESSOR, IF USED, AND/OR MYSEL IN THE EVENT THAT THE FUNDING FOR A TRANSFER IS RETURNED FOR ANY REASON, KP HAS BEEN PROVIDED WITH INCORRECT INFORMATION, AND/OR K HAS ERRONEOUSLY TRANSFERRED FUNDS TO MY ACCOUNT, I AUTHORIZE KP TO CORRECT/WITHDRAW FROM MY ACCOUNT THE AMOUNT OF FUND TRANSFERRED IN ERROR. I ALSO UNDERSTAND THAT KP MAY WITHDRAW AND/OR DEPOSIT TO MY ACCOUNT VARIOUS FUNDS RELATING TO M PARTICIPATION IN A FLEXIBLE BENEFIT/CAFETERIA PLAN/ERISA PLAN. I HEREBY HOLD IC HARMLESS FROM ALL CLAIMS AND CAUSES OF ACTION RESULTIN FROM KP'S TRANSFER OF SUCH FUNDS UPON THE DIRECTION OF MY EMPLOYER OR ITS PROCESSOR, AGREE THAT MY REMEDY FOR ANY ERRONEOU TRANSFERS IS SOLELY AGAINST THE PROCESSOR AND/OR MY EMPLOYER, AND FURTHER AGREE THAT I WILL HOLD KP HARMLESS FROM ANY LIABILITY AN DAMAGES RESULTING THEREFROM, INCLUDING COURT COSTS AND REASONABLE ATTORNEY'S FEES.

Electronic Funds Transfer (15 U.S.C. § 1693): I hereby acknowledge receipt of notice from my Bank of my responsibilities under the Electronic Funds Transfer Act ("Act"), my potential liability for certain unauthorized electronic fund transfers, my duty to promptly report unauthorized transfers, any charges for electronic fund transfers, if applicable, the right to stop payment of pre-authorized electronic fund transfers, the procedure to initiate such stop payment orders, my right to receive documentation of electronic fund transfers, and the Bank's liability pursuant to the Act.

Limitation of Action: I acknowledge that I will have 60 days from the date of a withdrawal or deposit to my Bank account to dispute the withdrawal or deposit. I furth acknowledge that I shall dispute a withdrawal or deposit by providing the Company/Employer and IC with written notification of any discrepancies, errors or disputes concernin any transfer of funds to or from any account processed by KP. I acknowledge that all written notices must include the following information:

a) The name of the Company/Employer authorized to make the transaction;
b) The federal taxpayer ID number of the Company/Employer;
c) My full name;
d) My contact information;
e) The name, account number and ABA number of the transaction in question;
f) The dollar amount of the transaction in question; and
g) A description and explanation of the error.

I acknowledge that, if possible, the Company/Employer , its agent, or KP will inform me of the results of their investigation into the disputed transaction within ten (10) days the receipt of my complaint, and will attempt to correct any identified error promptly. However, if my employer, its agent, and/or KP need additional time, I understand that the may take up to 45 days to investigate my complaint. For transfers initiated outside the United States or transfers resulting from point of sale or debit/access cards, I understan that the time periods for investigating and resolving errors will be 45/90 days, respectively.

Undersigned's Name (printed) _____ Date _____

Financial Institution _____ Branch name _____

City _____ Branch Phone Number _____

Routing (ABA) Number _____ Account Number _____

Account Type: Checking ☐ Savings ☐

Please designate if you wish a specific dollar amount or percentage deposited: $_____ / _____%

Routing (ABA) Number _____ Account Number _____

Account Type: Checking ☐ Savings ☐

Please designate if you wish a specific dollar amount or percentage deposited: $_____ / _____%

Undersigned's Signature _____ Employee ID # *(if applicable)* _____

Created 4/