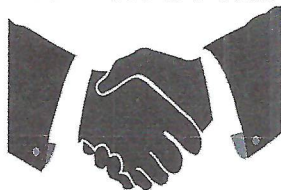




D&D Homecare, LLC

D&D HOMECARE, LLC
4495 Atlanta Hwy Ste 100C
Loganville Ga.30052
Phone: 706-349-1455
Fax: 888-390-6062



Welcome!

Dear Prospective Employee,

Thank you for considering D&D Homecare as your employer. The package that you received today includes documents that are require for hirer. All Aides (CNA, PCA) working within our client's homes providing support with daily living tasks, and personal care under the supervision of a Registered Nurse. Please fill out all documents and send all requested forms as soon as possible. Please include these following documents along with your completed application.

- Current CNA License
- Current TB/PPD Test Results /Chest X-Ray if positive
- Current Local Background Check
- CPR/ First Aid
- Color Copy of Your Driver's License
- Color Copy Social Security Card
- Two (2) References
- Reliable Transportation

Please be advised that if hired you will be classified as employee W-2. Please also be advised you will be able to start as an employee of D&D Homecare until we have received all your completed documents. If you have any question or concerns, please contact our office.

D&D Home Care, LLC

MISSION STATEMENT

It is the mission of D&D Home Care to provide its clients with the highest quality Private Home Care services.

It is the mission of D&D Home Care to respect the dignity of the client, and to respect the sanctity of their home while delivering high quality Private Home Care service.

It is the mission of D&D Home Care to provide services consisting of nursing services, personal care services, and to provide companion/ sitter services. The type of clients served will be the elderly, mentally frail or medically compromised, of which Private Home services can be provided in accordance with Rules of the Department of Community Health, Public Health Chapter 111-8-65.

It is the mission of D&D Homecare to assure that only the highest caliber staff be assigned to Private Home Care services and that D&D Home Care is committed to a program of quality improvement to assure that the level of care and services maintain the high standard to which D&D Home Care committed.

Employee Availability Sheet

Name _____

Phone Number _____

E-mail: _____

Date: _____

Please write the times you are available to work
(mornings, afternoons, evenings, specific hours,
etc.)

Monday _____

Tuesday _____

Wednesday _____

Thursday _____

Friday _____

Saturday _____

Sunday _____

D&D HOMECARE, LLC.
APPLICATION FOR EMPLOYMENT
 An Equal Opportunity Employer

This application cannot be accepted unless **both sides** have been completed and it is **signed and dated** by the applicant.

PERSONAL INFORMATION

NAME (LAST NAME, FIRST NAME, MI)				SOCIAL SECURITY NUMBER	
PRESENT ADDRESS		APT. NO.	CITY	STATE	ZIP
PERMANENT ADDRESS		APT. NO.	CITY	STATE	ZIP
ARE YOU 18 YEARS OF AGE OR OLDER?	D&D Homecare, LLC REQUIRES YOU TO MAINTAIN A WORKING TELEPHONE AT YOUR RESIDENCE. DO YOU HAVE A TELEPHONE? HOME PHONE NUMBER MOBILE PHONE PAGER NUMBER OTHER MEANS OF CONTACT				

DESIRED EMPLOYMENT

POSITION YOU ARE APPLYING FOR		DATE YOU CAN START	SALARY DESIRED
ARE YOU CURRENTLY EMPLOYED?		IF "YES," MAY WE INQUIRE OF YOUR PRESENT EMPLOYER?	
HAVE YOU EVER APPLIED TO THIS COMPANY BEFORE?	WHERE?	WHEN?	
HAVE YOU EVER WORKED FOR THIS COMPANY BEFORE?	WHERE?	WHEN?	
REASON FOR LEAVING			
NAME OF LAST SUPERVISOR AT THIS COMPANY			
WHO REFERRED YOU TO THIS COMPANY?			

EDUCATION

SCHOOL LEVEL	NAME AND ADDRESS OF SCHOOL	# YEARS ATTENDED	GRADUATE?	SUBJECTS STUDIED
GRAMMAR				
HIGH SCHOOL				
COLLEGE				
TRADE, BUSINESS, CORRESPONDENCE OR OTHER SCHOOL				

GENERAL INFORMATION

SUBJECTS OF SPECIAL STUDY OR RESEARCH WORK
SPECIAL TRAINING/SKILLS
LICENSES OR CERTIFICATIONS (include numbers)
AWARDS/RECOGNITION
COMMUNITY/CIVIC INVOLVEMENT

SERVICE RECORD

BRANCH OF SERVICE	DISCHARGE DATE/RANK
-------------------	---------------------

CRIMINAL BACKGROUND

HAVE YOU EVER BEEN CONVICTED OF A FELONY? YES NO IF "YES," WHEN? _____ IF "YES," EXPLAIN BELOW (WILL NOT NECESSARILY EXCLUDE YOU FROM CONSIDERATION)
--

PRESENT OR LAST EMPLOYER			
ADDRESS	CITY	STATE	ZIP
STARTING DATE	LEAVING DATE	JOB TITLE	
STARTING SALARY	ENDING SALARY	MAY WE CONTACT YOU SUPERVISOR? YES NO	
NAME OF SUPERVISOR		TITLE	PHONE
DESCRIPTION OF WORK			
REASON FOR LEAVING			

PRESENT OR LAST EMPLOYER			
ADDRESS	CITY	STATE	ZIP
STARTING DATE	LEAVING DATE	JOB TITLE	
STARTING SALARY	ENDING SALARY	MAY WE CONTACT YOUR SUPERVISOR? YES NO	
NAME OF SUPERVISOR		TITLE	PHONE
DESCRIPTION OF WORK			
REASON FOR LEAVING			

PRESENT OR LAST EMPLOYER			
ADDRESS	CITY	STATE	ZIP
STARTING DATE	LEAVING DATE	JOB TITLE	
STARTING SALARY	ENDING SALARY	MAY WE CONTACT YOUR SUPERVISOR? YES NO	
NAME OF SUPERVISOR		TITLE	PHONE
DESCRIPTION OF WORK			
REASON FOR LEAVING			

REFERENCES GIVE THE NAMES OF TWO PERSONS YOU ARE NOT RELATED TO, WHOM YOU HAVE KNOWN FOR AT LEAST ONE YEAR.

NAME	COMPLETE ADDRESS AND PHONE	BUSINESS	YEARS KNOWN

AUTHORIZATION: I CERTIFY THAT THE FACTS CONTAINED IN THIS APPLICATION ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND THAT, IF EMPLOYED, FALSIFIED STATEMENTS ON THIS APPLICATION SHALL BE GROUNDS FOR DISMISSAL.

I AUTHORIZE INVESTIGATION OF ALL STATEMENTS CONTAINED HEREIN (INCLUDING INFORMATION ON THE EXISTENCE OF ANY CRIMINAL RECORDS AS WELL AS THE REFERENCES AND EMPLOYERS LISTED ABOVE) TO GIVE YOU ANY AND ALL INFORMATION CONCERNING MY PREVIOUS EMPLOYMENT AND ANY PERTINENT INFORMATION THEY MAY HAVE, PERSONAL OR OTHERWISE. I RELEASE BOTH THE BUSINESS/PERSON GIVING THE INFORMATION AND THE BUSINESS/PERSON RECEIVING THE INFORMATION FROM ANY AND ALL LIABILITY FOR ANY DAMAGE THAT MAY RESULT FOR UTILIZATION OF SUCH INFORMATION, INCLUDING FAILURE TO SECURE EMPLOYMENT DUE TO AN UNSATISFACTORY REFERENCE.

I ALSO UNDERSTAND AND AGREE THAT NO REPRESENTATIVE OF THE COMPANY HAS ANY AUTHORITY TO ENTER INTO ANY AGREEMENT FOR EMPLOYMENT FOR ANY SPECIFIED PERIOD OF TIME, OR TO MAKE ANY AGREEMENT CONTRARY TO THE FOREGOING, UNLESS IT IS IN WRITING AND SIGNED BY AN AUTHORIZED COMPANY REPRESENTATIVE.

APPLICANT'S SIGNATURE

DATE



Personal Support Services (PSS) Guidelines

Employee Responsibilities & Limitations

Overview

Personal Support Services (PSS) are provided to individuals who require assistance with daily living activities. The goal of these services is to promote independence, safety, and overall well-being while supporting members in their home and community.

Scope of Services

PSS may include assistance with:

- Personal hygiene and grooming
- Household tasks
- Meal preparation
- Medication-related assistance (non-clinical)
- Mobility and daily living support

Services must always be delivered according to the member's authorized service plan.

Service Expectations

- Services must be delivered promptly, safely, and respectfully.
- Staff must follow the approved care plan at all times.
- Tasks should be completed within a reasonable timeframe (typically within Clients allotted Service hours unless otherwise specified).
- Any delays, concerns, or inability to complete services must be reported immediately.

Member Eligibility (Summary)

Members receiving PSS typically:

- Require assistance due to medical or functional limitations
- Need help with daily living activities
- Are able to remain safely in the community with support services

What Staff Are Allowed To Do

PSS staff may assist members with the following:

Personal Care

- Bathing, grooming, and hygiene
- Dressing and toileting
- Mobility assistance (walking, transferring, positioning)

Household Support

- Light housekeeping (laundry, dishes, tidying)
- Meal preparation and cleanup
- Grocery shopping and errands

Health-Related Support (Non-Clinical)

- Reminding members to take medications
- Assisting with self-administration (as permitted)
- Observing and reporting changes in condition

Community & Daily Living Support

- Transportation or accompaniment to appointments
- Encouraging participation in daily activities
- Assisting with communication and engagement

What Staff Are NOT Allowed To Do

PSS staff must NOT perform the following:

Medical or Skilled Nursing Tasks

- Administer medications (unless specifically authorized)
- Perform medical procedures
- Provide skilled nursing care

Restricted Activities

- Handle financial matters (banking, bill payments, etc.)
- Accept gifts, money, or personal favors
- Use the member's personal property for personal use

Safety & Compliance Violations

- Leave a member unattended if supervision is required
- Perform tasks outside of the authorized care plan
- Engage in any form of neglect, abuse, or exploitation

Documentation Requirements

- All services must be accurately documented
- Notes must reflect:
 - Tasks completed
 - Member condition
 - Any concerns or incidents
- Documentation must be completed in a timely and professional manner
- All **Accidents, Falls, and Complaints** must be reported to the office

IMMEDIATELY via phone call at (706) 349-1455.

- If you are unable to reach the office by phone, you may send a text message to the same number at any time to ensure timely communication and follow-up.

Professional Conduct

All staff are expected to:

- Maintain confidentiality at all times
- Treat members with dignity and respect
- Follow all company policies and state regulations
- Communicate effectively with supervisors and team members
- Maintain a high level of professionalism at all times while providing services
- Refrain from sharing personal information or engaging in inappropriate personal discussions with members

Important Notes

- Services must always align with the individual care plan
- Any uncertainty about tasks should be clarified with a supervisor
- The member's health, safety, and independence are always the top priority

Employee Signature : _____

Date: _____

Supervisor Signature: _____

Date: _____



D&D Homecare, LLC

JOB DESCRIPTION: Personal Care Assistant

PRIMARY FUNCTION: To increase the level of comfort for Private Home Care clients and to provide temporary relief to the family from total personal care responsibility by providing the client with personal aspects of care.

FIELD SUPERVISION Assigned Registered Nurse

QUALIFICATIONS

Successful completion of an approved Nurse Aide Training program and competency evaluation; or successful completion of a competency examination for Nurse Aides recognized by the Department; or successful completion of a health care or personal care credentialing program recognized by the Department; or be registered by the Georgia Nurse Aide Registry as a Certified Nurse Aide; or successful completion or progress in the completion of a 40 hour training program provided by a private Home Care provider which addresses at least the following:

1. Ambulation and transfer of clients, including positioning.
2. Assistance with bathing, toileting, grooming, shaving, dental care, dressing, and eating.
3. Caring for clients with special conditions and needs so long as the services provided are within the scope of the tasks authorized to be performed by the PCA by competency demonstration.
4. Home management and proper nutrition.
5. Home safety, sanitation, and infection control.
6. Medically related activities including taking vital signs. Observing and reporting changes in a client's condition, arranging trips to the doctor, picking up prescription drugs, accompanying clients on medical appointments, documenting client's food and/or liquid intake and output, and reminding clients to take medication and assisting with self-administration of medication.
7. Record keeping.
8. Understand the needs and characteristics of the elderly, the handicapped, or convalescing individuals.
9. Basic First Aid and CPR.



TRAINING

Orientation to Home Care services and any other training that may be necessary to complete the assigned duties effectively.

DUTIES

1. Provide personal hygiene aspects of care to clients, including bathing, oral hygiene, skin care and hair care.
2. Assist with transfer of client, e.g., bed to chair, bed to commode, chair/commode to bed.
3. Assist with ambulation and exercise of client as ordered and so assigned.
4. Assist with or provide meal preparation and related tasks.
5. Assist with feeding of client.
6. Maintain a clean, safe and comfortable environment for the client.
7. Have an awareness of the emotional status of client and be able to understand the emotional problems associated with the illness.
8. Coordinate care with primary nurse and/or the clinical manager.
9. Maintain accurate and up-to-date records of visits.
10. Attend regular meetings of the Private Home Care team and have direct involvement in developing, implementing and evaluating the plan of care.
11. Report client progress and problems to supervisory personnel and procedure for handling medical emergencies or other incidents that affect the delivery of services in accordance with the client's service plan.
12. Perform other duties as assigned by supervisor.

Signature of Employee

Date

Signature of Administrator

Date



D&D Homecare, LLC

**THE PRIVATE HOME AGENCY
PRIVATE HOMECARE-CAREGIVER STATEMENT**

I have never been shown by credible evidence evidence (e.g., court or jury, a department investigation or other reliable evidence) to have abused, neglected, sexually assaulted, exploited, or deprived any persona or to have subjected any person to serious injury as a result of intentional or grossly negligent misconduct an evident by an oral or written statement to this effect obtained at the time application.

Print Employee's Name _____

Employee Signature _____

Date _____



D&D Homecare, LLC

PAYROLL POLICY, PROCESS AND FORMS

Payroll Policy:

I acknowledge that all timesheet for missed punches must be submitted by Monday at 12:00pm. If the timesheets are not received by the deadline, a paycheck will not be issued until the timesheet is completed and accurate. I understand that I may submit the timesheets to D&D via fax or email; however, the original copy must be mailed or delivered to the office.

PAYCHECKS WILL NOT BE ISSUED IF A COMPLETED TIMESHEET HAS NOT BEEN RECEIVED.

Employee signature: _____ Date: _____

Supervisor signature: _____ Date: _____

D&D Private Home Care

PRIVATE HOME CARE PROVIDER CAREGIVER'S 8 HOUR ORIENTATION CHECKLIST

<u>AREA</u>	<u>DATE COMPLETED - HOURS</u>	
	Date	# of Hours
1. Mission Statement /Review of Services	_____	_____
2. Incident Reporting Policy/Form	_____	_____
3. Documentation of Services	_____	_____
4. HFR Client Rights	_____	_____
5. Service Agreement/ Policy	_____	_____
6. Review of Service Plan Policy, CCSP Nursing Care Plan, Aide documentation forms, and client goals. The importance of the Service Plan goals.	_____	_____
7. Procedures for Handling Emergencies	_____	_____
8. Employee policies/dress code	_____	_____
9. Confidentiality of Records/ Information	_____	_____
10. Home Safety/Fire Safety	_____	_____
11. Reporting Client Progress and problems to Supervisor	_____	_____
12. TB Exposure Reporting / infection Control	_____	_____
13. Privacy/Confidentiality (HIPPA)	_____	_____
14. Handling of Complaints	_____	_____
15. HIV/HEP-B - Precautions/Infection Control	_____	_____
16. Review of Employees' Job Responsibilities	_____	_____
17. CCSP Rights and Responsibilities	_____	_____
18. CCSP Policies and Procedures	_____	_____
19. Review of Company Policies and Procedures	_____	_____

My signature verifies that I have received orientation/training in the above areas.

Employee Signature: _____ Date: _____

My signature verifies that _____ meets the qualification of the job description _____ as outlined in the policy and procedure manual and has completed the required 8-hour orientation.

Trainer Signature: _____ Date: _____



D&D Homecare, LLC

CONFIDENTIALITY STATEMENT

I _____, understand that as an employee of D&D Homecare, LLC, I will routinely have access to documents containing sensitive client, employee, or agency information. I acknowledge that client records and other data are provided solely for the purpose of delivering services and that maintaining client trust depends on all D&D Homecare staff treating this information as strictly confidential and not disclosing any information without seeking guidance from the policies and procedures of D&D Homecare. I acknowledge that all client record and agency data are property of D&D Homecare.

By signing this statement, I agree to adhere to D&D Home Care's Policies and Procedures. I understand that federal and state laws govern certain types of information, and that violating agency policies and procedures may also result in violation of these laws. I take full responsibility for my own actions and understand that any breach of confidentiality may result in immediate termination of employment and/or legal action.

By signing below, I acknowledge that I have read, understand, and agree to comply with this confidentiality statement.

Employee _____ **Date** _____

Witness _____ **Date** _____



D&D Homecare, LLC

CODE OF ETHICS

Form to completed by all employees

I understand that while employed by **D&D Homecare, LLC** I agree to governed by this code of ethics. I further understand that failure to do so will result in disciplinary actions, up to and including termination.

D&D Homecare, LLC prohibits all employees from the following:

1. Documenting activities were completed that were not.
2. Performing activities not authorized in the Care Plan
3. Consuming client food
4. Using the client telephone for personal calls
5. Accepting gifts or financial gratuities (tips) from client/representative
6. Using client car for personal reasons
7. Lending money or other items to the client; borrowing money or other items from the client or client's representative.
8. Discussing political or religious beliefs, or personal problems with client
9. Selling foods, gifts other items to or for the client
10. Purchasing any items for the client not directed in the care plan.
11. Bringing other visitor's (i.e., employee relatives, friends, pets, etc.)
12. Smoking in the client's home, with/with out permission form the client or representative
13. Reporting for duty under the influence of alcohol or other illegal substance
14. Sleeping at the client's home at an inappropriate time that is not an overnight duty.
15. Remaining in client's home after services have been completed.

Employee's Signature

Date



D&D Homecare, LLC

NON-COMPETE AGREEMENT

It is against D&D Homecare's policy for a client to directly hire a D&D Homecare's employee. It is also against D&D Homecare's policy for an employee to solicit a client into hiring the employee directly.

1. This policy applies to all temporary and full-time employees.
2. A client cannot hire D&D Homecare's employee either directly or indirectly, if introduced to them by D&D Homecare will the employee is in the employ of D&D Homecare, or for a period of 1 year thereafter. If this agreement is broken, the employee will pay D&D Home care a placement fee of [\$3,000.00].

Employee Signature

Date



D&D Homecare, LLC

THINGS TO REPORT

All employees must report and of the following conditions:

- The client goes in the hospital (**Services cannot be provided is a client is in the hospital**)
- The client's condition is changes: Progress/Decline, abnormal observations.
- The client is involved in any type of accident.
- The client develops bruises, unusual swelling. Laceration or skin breaks
- The client does not receive services for any reason.
- You leave earlier or stay longer than the schedule time.
- The client has a new service added or deleted such as therapy, oxygen, or Home Delivered Meals.
- Any signs or suspected abuses or neglect
- You come in contact with or contact a communicable disease such as TB, Hepatitis, or AIDS

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____



D&D Homecare, LLC

TIME AND ATTENDANCE POLICY

Policy: All hourly employees will abide by the time and attendance policy.

Purpose: To ensure adequate time to allow the completion of job duties in a satisfactory manner.

Policy

- All employees shall report at the scheduled time.
- Tardiness will be documented for anytime any employee arrives after the scheduled time without the consent of the Nurse Manager or Administrative staff of D&D Homecare, LLC. Please follow the chain of command.
- Absence will be documented.
- Tardiness and absences will be tabulated in a six-month basis. Each tardiness and absence will be kept on file for six months.
- Unexcused absences will be removed when a doctor's excuse is brought into the office. The office manager will determine if an absence is excusable when there is no written doctor excuse. An inexcusable absence will be considered for all absences with less than 4 hour notice.

Guidelines for Absences		
# of Absences	Documentation	Correction Action
3	Verbal Counseling	In File (temporary)
6	Documented Verbal	Placed in file
7	Written Warning	3 months' probation
8	Documentation	TERMINATION
Guidelines for Tardiness		
# of Tardies	Documentation	Correction Action
4	Verbal Counseling	Placed in file
8	Documented Verbal	Placed in file
9	Written Warning	3 months' probation
10	Documentation	TERMINATION

I have read the above time and attendance policy. This policy has been verbally explained to me. I understand that I will be governed by the statement listed in this policy.

Employee signature: _____ Date: _____



D&D Homecare, LLC

EVV (Electronic Visit Verification) & Timekeeping Reporting Acknowledgement Form

Acknowledgement of Understanding

I, _____, acknowledge that I have read, understand, and agree to comply with the EVV* Timekeeping compliance policy of D&D Homecare, LLC. I understand that failure to adhere to this policy; to ensure federal and state regulations.

Initial _____ **Clocking In and Out Requirements**

- Employees must clock in and out at the client's location using the designated EVV system.
- Time adjustments for late clock-ins will only be permitted with a valid explanation and supporting documentation.
- If an employee forgets to clock in, they must immediately record the missed clock-in within the EVV app and submit a signed timesheet from the client as verification.

Initial _____ **Late Arrivals & Schedule Adjustments:**

- Employees who arrive late must make up the lost time by staying later, unless otherwise approved by the office.
- Any changes to a client's scheduled service time must be approved by the office prior to implementation.
- Employees are not permitted to clock in more than 5 to 10 minutes before their scheduled shift.

Initial _____ **Billing & Payment Compliance:**

- All EVV requirements must be met for services to be billed. This includes:
- Proper clock-in and clock-out at the client's location
- A valid client signature verifying services were provided
- Submission of all required documentation
- Failure to meet these requirements will result in non-payment, as incomplete or unverifiable services cannot be billed.

Initial _____ **Fraud Prevention & Legal Consequences:**

- Falsifying time records, clocking in or claiming hours for time not actually worked, or manipulating EVV data is a federal offense.
- Penalties for fraudulent timekeeping may include:
- Fines up to \$100,000 per violation
- Imprisonment of up to 10 years
- Employment termination and permanent disqualification from Medicaid-funded services

Employee Name: _____

Employee Signature: _____ **Date:** _____



D&D Homecare, LLC

HOURS OF WORK POLICY

D&D Homecare does not guarantee that CNA/PCA/PSA will receive 40 hours of work per week. The number of hours that an employee works depends entirely on client needs, scheduling availability, and the agency's operational requirement. Employee schedule-including days and hours of service- may be adjusted at any time based on the client requests, change in care plans or decisions made by the office manager in the best interest of the client. If you are assigned to a client who initially did not require weekend care but later has change in their schedule to include weekend hours, you are expected to adjust accordingly. This includes working every other weekend for that client as needed. While we strive to keep schedule changes to a minimum, flexibility is essential to ensure quality care.

I acknowledge that I have read and understand the Hours of Work Policy and agree to the terms as specified above.

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____



D&D Homecare, LLC

EMPLOYEE EMERGENCY INFORMATION

DATE COMPLETED: _____

NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

TELEPHONE: _____ **FAX:** _____

EMERGENCY CONTACTS:

1.	RELATIONSHIP:	HOME PHONE: WORK PHONE: OTHER:
2.	RELATIONSHIP:	HOME PHONE: WORK PHONE: OTHER:

REVIEW DATE: (Information must be reviewed for changes at least annually). Record date review or any time changes are made to the information.

Employee's Withholding Certificate

Department of the Treasury
Internal Revenue Service

**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.**

2026

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) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> 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.)		
Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.			

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(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): (a) Multiply the number of qualifying children under age 17 by \$2,200 3(a) \$ (b) Multiply the number of other dependents by \$500 3(b) \$ Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here 3 \$			
Step 4: 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. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here	4(b)	\$	
	(c) Extra withholding. Enter any additional tax you want withheld each pay period	4(c)	\$	

Exempt from withholding	I claim exemption from withholding for 2026, and I certify that I meet both of the conditions for exemption for 2026. See <i>Exemption from withholding</i> on page 2. I understand I will need to submit a new Form W-4 for 2027 <input type="checkbox"/>
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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)
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General Instructions

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

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2026 if you meet both of the following conditions: you had no federal income tax liability in 2025 and you expect to have no federal income tax liability in 2026. You had no federal income tax liability in 2025 if (1) your total tax on line 24 on your 2025 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2026 tax return. To claim exemption from withholding, certify that you meet both of the conditions by checking the box in the *Exempt from withholding* section. Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2027.

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

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

1. Are submitting this form after the beginning of the year;
2. Expect to work only part of the year;
3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;
4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or
5. Prefer the most accurate withholding for multiple job situations.

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

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

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

Specific Instructions

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

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

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

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



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

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

Step 4.

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 15, if you expect to claim deductions other than the basic standard deduction on your 2026 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for qualified tips, overtime compensation, and passenger vehicle loan interest; student loan interest; IRAs; and seniors. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain deductions. For additional eligibility requirements, see Pub. 501.

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

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



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

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

- 1 Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 5. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 **1** \$ _____
- 2 Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

 - a** Find the amount from the appropriate table on page 5 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a **2a** \$ _____
 - b** Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 5 and enter this amount on line 2b **2b** \$ _____
 - c** Add the amounts from lines 2a and 2b and enter the result on line 2c **2c** \$ _____
- 3** Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3** _____
- 4 Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (plus any other additional amount you want withheld) **4** \$ _____

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



See the Instructions for Schedule 1-A (Form 1040) for more information about whether you qualify for the deductions on lines 1a, 1b, 1c, 3a, and 3b.

1 Deductions for qualified tips, overtime compensation, and passenger vehicle loan interest.

a Qualified tips. If your total income is less than \$150,000 (\$300,000 if married filing jointly), enter an estimate of your qualified tips up to \$25,000 **1a** \$ _____

b Qualified overtime compensation. If your total income is less than \$150,000 (\$300,000 if married filing jointly), enter an estimate of your qualified overtime compensation up to \$12,500 (\$25,000 if married filing jointly) of the “and-a-half” portion of time-and-a-half compensation **1b** \$ _____

c Qualified passenger vehicle loan interest. If your total income is less than \$100,000 (\$200,000 if married filing jointly), enter an estimate of your qualified passenger vehicle loan interest up to \$10,000 **1c** \$ _____

2 Add lines 1a, 1b, and 1c. Enter the result here **2** \$ _____

3 Seniors age 65 or older. If your total income is less than \$75,000 (\$150,000 if married filing jointly):

a Enter \$6,000 if you are age 65 or older before the end of the year **3a** \$ _____

b Enter \$6,000 if your spouse is age 65 or older before the end of the year and has a social security number valid for employment **3b** \$ _____

4 Add lines 3a and 3b. Enter the result here **4** \$ _____

5 Enter an estimate of your student loan interest, deductible IRA contributions, educator expenses, alimony paid, and certain other adjustments from Schedule 1 (Form 1040), Part II. See Pub. 505 for more information **5** \$ _____

6 Itemized deductions. Enter an estimate of your 2026 itemized deductions from Schedule A (Form 1040). Such deductions may include qualifying:

a Medical and dental expenses. Enter expenses in excess of 7.5% (0.075) of your total income **6a** \$ _____

b State and local taxes. If your total income is less than \$505,000 (\$252,500 if married filing separately), enter state and local taxes paid up to \$40,400 (\$20,200 if married filing separately) **6b** \$ _____

c Home mortgage interest. If your home acquisition debt is less than \$750,000 (\$375,000 if married filing separately), enter your home mortgage interest expense (including mortgage insurance premiums) **6c** \$ _____

d Gifts to charities. Enter contributions in excess of 0.5% (0.005) of your total income **6d** \$ _____

e Other itemized deductions. Enter the amount for other itemized deductions **6e** \$ _____

7 Add lines 6a, 6b, 6c, 6d, and 6e. Enter the result here **7** \$ _____

8 Limitation on itemized deductions.

a Enter your total income **8a** \$ _____

b Subtract line 4 from line 8a. If line 4 is greater than line 8a, enter -0- here and on line 10. Skip line 9 **8b** \$ _____

9 Enter:

{	• \$768,700 if you’re married filing jointly or a qualifying surviving spouse	}	9	\$ _____
	• \$640,600 if you’re single or head of household				
	• \$384,350 if you’re married filing separately				

10 If line 9 is greater than line 8b, enter the amount from line 7. Otherwise, multiply line 7 by 94% (0.94) and enter the result here **10** \$ _____

11 Standard deduction.

Enter:

{	• \$32,200 if you’re married filing jointly or a qualifying surviving spouse	}	11	\$ _____
	• \$24,150 if you’re head of household				
	• \$16,100 if you’re single or married filing separately				

12 Cash gifts to charities. If you take the standard deduction, enter cash contributions up to \$1,000 (\$2,000 if married filing jointly) **12** \$ _____

13 Add lines 11 and 12. Enter the result here **13** \$ _____

14 If line 10 is greater than line 13, subtract line 11 from line 10 and enter the result here. If line 13 is greater than line 10, enter the amount from line 12 **14** \$ _____

15 Add lines 2, 4, 5, and 14. Enter the result here and in Step 4(b) of Form W-4 **15** \$ _____

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$0	\$480	\$850	\$850	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020
\$10,000 - 19,999	0	480	1,480	1,850	2,050	2,220	2,220	2,220	2,220	2,220	2,220	2,620
\$20,000 - 29,999	480	1,480	2,480	3,050	3,250	3,420	3,420	3,420	3,420	3,420	3,820	4,820
\$30,000 - 39,999	850	1,850	3,050	3,620	3,820	3,990	3,990	3,990	3,990	4,390	5,390	6,390
\$40,000 - 49,999	850	2,050	3,250	3,820	4,020	4,190	4,190	4,190	4,590	5,590	6,590	7,590
\$50,000 - 59,999	1,020	2,220	3,420	3,990	4,190	4,360	4,360	4,760	5,760	6,760	7,760	8,760
\$60,000 - 69,999	1,020	2,220	3,420	3,990	4,190	4,360	4,760	5,760	6,760	7,760	8,760	9,760
\$70,000 - 79,999	1,020	2,220	3,420	3,990	4,190	4,760	5,760	6,760	7,760	8,760	9,760	10,760
\$80,000 - 99,999	1,020	2,220	3,420	4,240	5,440	6,610	7,610	8,610	9,610	10,610	11,610	12,610
\$100,000 - 149,999	1,870	4,070	6,270	7,840	9,040	10,210	11,210	12,210	13,210	14,210	15,360	16,560
\$150,000 - 239,999	1,870	4,100	6,500	8,270	9,670	11,040	12,240	13,440	14,640	15,840	17,040	18,240
\$240,000 - 319,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,780	14,980	16,180	17,380	18,580
\$320,000 - 364,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,860	15,860	17,860	19,860	21,860
\$365,000 - 524,999	2,720	5,920	9,390	12,260	14,760	17,230	19,530	21,830	24,130	26,430	28,730	31,030
\$525,000 and over	3,140	6,840	10,540	13,610	16,310	18,980	21,480	23,980	26,480	28,980	31,480	33,990

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$90	\$850	\$1,020	\$1,020	\$1,020	\$1,070	\$1,870	\$1,870	\$1,870	\$1,870	\$1,870	\$1,970
\$10,000 - 19,999	850	1,780	1,980	1,980	2,030	3,030	3,830	3,830	3,830	3,830	3,930	4,130
\$20,000 - 29,999	1,020	1,980	2,180	2,230	3,230	4,230	5,030	5,030	5,030	5,130	5,330	5,530
\$30,000 - 39,999	1,020	1,980	2,230	3,230	4,230	5,230	6,030	6,030	6,130	6,330	6,530	6,730
\$40,000 - 59,999	1,020	2,880	4,080	5,080	6,080	7,080	7,950	8,150	8,350	8,550	8,750	8,950
\$60,000 - 79,999	1,870	3,830	5,030	6,030	7,100	8,300	9,300	9,500	9,700	9,900	10,100	10,300
\$80,000 - 99,999	1,870	3,830	5,100	6,300	7,500	8,700	9,700	9,900	10,100	10,300	10,500	10,700
\$100,000 - 124,999	2,030	4,190	5,590	6,790	7,990	9,190	10,190	10,390	10,590	10,940	11,940	12,940
\$125,000 - 149,999	2,040	4,200	5,600	6,800	8,000	9,200	10,200	10,950	11,950	12,950	13,950	14,950
\$150,000 - 174,999	2,040	4,200	5,600	6,800	8,150	10,150	11,950	12,950	13,950	14,950	16,170	17,470
\$175,000 - 199,999	2,040	4,200	6,150	8,150	10,150	12,150	13,950	15,020	16,320	17,620	18,920	20,220
\$200,000 - 249,999	2,720	5,680	7,880	10,140	12,440	14,740	16,840	18,140	19,440	20,740	22,040	23,340
\$250,000 - 449,999	2,970	6,230	8,730	11,030	13,330	15,630	17,730	19,030	20,330	21,630	22,930	24,240
\$450,000 and over	3,140	6,600	9,300	11,800	14,300	16,800	19,100	20,600	22,100	23,600	25,100	26,610

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$280	\$850	\$950	\$1,020	\$1,020	\$1,020	\$1,020	\$1,560	\$1,870	\$1,870	\$1,870
\$10,000 - 19,999	280	1,280	1,950	2,150	2,220	2,220	2,220	2,760	3,760	4,070	4,070	4,210
\$20,000 - 29,999	850	1,950	2,720	2,920	2,980	2,980	3,520	4,520	5,520	5,830	5,980	6,180
\$30,000 - 39,999	950	2,150	2,920	3,120	3,180	3,720	4,720	5,720	6,720	7,180	7,380	7,580
\$40,000 - 59,999	1,020	2,220	2,980	3,570	4,640	5,640	6,640	7,750	8,950	9,460	9,660	9,860
\$60,000 - 79,999	1,020	2,610	4,370	5,570	6,640	7,750	8,950	10,150	11,350	11,860	12,060	12,260
\$80,000 - 99,999	1,870	4,070	5,830	7,150	8,410	9,610	10,810	12,010	13,210	13,720	13,920	14,120
\$100,000 - 124,999	1,870	4,270	6,230	7,630	8,900	10,100	11,300	12,500	13,700	14,210	14,720	15,720
\$125,000 - 149,999	2,040	4,440	6,400	7,800	9,070	10,270	11,470	12,670	14,580	15,890	16,890	17,890
\$150,000 - 174,999	2,040	4,440	6,400	7,800	9,070	10,580	12,580	14,580	16,580	17,890	18,890	20,170
\$175,000 - 199,999	2,040	4,440	6,400	8,510	10,580	12,580	14,580	16,580	18,710	20,320	21,620	22,920
\$200,000 - 249,999	2,720	5,920	8,680	10,900	13,270	15,570	17,870	20,170	22,470	24,080	25,380	26,680
\$250,000 - 449,999	2,970	6,470	9,540	12,040	14,410	16,710	19,010	21,310	23,610	25,220	26,520	27,820
\$450,000 and over	3,140	6,840	10,110	12,810	15,380	17,880	20,380	22,880	25,380	27,190	28,690	30,190



2511004015

STATE OF GEORGIA EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

1a. YOUR FULL NAME	1b. YOUR SOCIAL SECURITY NUMBER
2a. HOME ADDRESS (Number, Street, or Rural Route)	2b. CITY, STATE AND ZIP CODE

PLEASE READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING LINES 3 - 8

3. MARITAL STATUS

Enter letter below on Line 7.

4. DEPENDENT ALLOWANCES []

- A. Single
- B. Married Filing Separate or Married Filing Joint, both spouses working
- C. Married Filing Joint, one spouse working
- D. Head of Household

5. GEORGIA ADJUSTMENTS ALLOWANCE []
(See instructions for details. Worksheet below must be completed)

6. ADDITIONAL WITHHOLDING \$ _____

WORKSHEET FOR CALCULATING ADDITIONAL ALLOWANCES
(Must be completed for step 5)

A. Federal Estimated Itemized Deductions (If Itemizing Deductions).....\$ _____

B. Georgia Standard Deduction (enter one):
 Single/Head of Household\$12,000
 Married Filing Joint\$24,000
 Married Filing Separate\$12,000

C. Subtract Line B from Line A (If zero or less, enter zero)\$ _____

D. Allowable Georgia Adjustments to Federal Adjusted Gross Income\$ _____

E. Add the Amounts on Lines C and D\$ _____

F. Estimate of Taxable Income not Subject to Withholding\$ _____

G. Subtract Line F from Line E (if zero or less, stop here).....\$ _____

H. Divide the Amount on Line G by \$4,000. Enter total here and on Line 5 above _____

(This is the number of Georgia Adjustments Allowances you can claim. If the remainder is over \$1,500 round up)

7. LETTER USED (Marital Status A, B, C or D) _____ TOTAL ALLOWANCES (Total of Lines 4 - 5) _____
(Employer: The letter indicates the tax tables in Employer's Tax Guide)

8. EXEMPT: (Do not complete Lines 4 - 7 if claiming exempt) Read the Line 8 instructions on page 2 before completing this section.

- a) I claim exemption from withholding because I incurred no Georgia income tax liability last year and I do not expect to have a Georgia income tax liability this year. **Check here**
- b) I certify that I am not subject to Georgia withholding because I meet the conditions set forth under the Servicemembers Civil Relief Act as provided on page 2. My state of residence is _____. My spouse's (servicemember) state of residence is _____. The states of residence must be the same to be exempt. **Check here**

I certify under penalty of perjury that I am entitled to the number of withholding allowances or the exemption from withholding status claimed on this Form G-4. Also, I authorize my employer to deduct per pay period the additional amount listed above.

Employee's Signature _____ Date _____

Employer: Complete Line 9 and mail entire form only if the employee claims over 14 allowances or exempt from withholding. If necessary, mail form to: Georgia Department of Revenue, Taxpayer Services Division, P.O. Box 105685, Atlanta, GA 30348-5685

9. EMPLOYER'S NAME AND ADDRESS: _____ EMPLOYER'S FEIN: _____

EMPLOYER'S WH#: _____

Do not accept forms claiming additional allowances unless the worksheet has been completed. Do not accept forms claiming exempt if numbers are written on Lines 4 - 7.

INSTRUCTIONS FOR COMPLETING FORM G-4

Enter your full name, address and social security number in boxes 1a through 2b.

Line 3: Write the letter on Line 7 according to your marital status.

- A. Single
- B. Married Filing Separate or Married Filing Joint, both spouses working
- C. Married Filing Joint, one spouse working
- D. Head of Household

Line 4: Enter the number of dependent allowances you are entitled to claim. The term "dependent" shall have the same meaning as in the Internal Revenue Code of 1986; provided, however, that any unborn child with a detectable human heartbeat, as such terms are defined in Code Section 1-2-1, shall qualify as a dependent minor.

Line 5: Complete the worksheet on Form G-4 if you claim Georgia adjustments Allowances. Enter the number from Line H here. **Failure to complete and submit the worksheet will result in automatic denial on your claim.**

Line 6: Enter a specific dollar amount that you authorize your employer to withhold in addition to the tax withheld based on your marital status and number of allowances.

Line 7: Enter the letter of your marital status from Line 3. Enter total of the numbers on Lines 4-5.

Line 8:

- a) Check the first box if you qualify to claim exempt from withholding. You can claim exempt if you filed a Georgia income tax return last year and the amount of Line 4 of Form 500EZ or Line 16 of Form 500 was zero, **and** you expect to file a Georgia tax return this year and will not have a tax liability. You cannot claim exempt if you did not file a Georgia income tax return for the previous tax year. **Receiving a refund in the previous tax year does not qualify you to claim exempt.**

EXAMPLES: Your employer withheld \$500 of Georgia income tax from your wages. The amount on Line 4 of Form 500EZ (or Line 16 of Form 500) was \$100. Your tax liability is the amount on Line 4 (or Line 16); therefore, you **do not qualify** to claim exempt.

Your employer withheld \$500 of Georgia income tax from your wages. The amount on Line 4 of Form 500EZ (or Line 16 of Form 500) was \$0 (zero). Your tax liability is the amount on Line 4 (or Line 16) and you filed a prior year income tax return; therefore you **qualify** to claim exempt.

- b) Check the second box if you are not subject to Georgia withholding and meet the conditions set forth under the Servicemembers Civil Relief Act. Under the Act, a spouse of a servicemember may be exempt from Georgia income tax on income from services performed in Georgia if:
 1. The servicemember is present in Georgia in compliance with military orders;
 2. The spouse is in Georgia solely to be with the servicemember;
 3. The servicemember maintains domicile in another state; and
 4. The domicile of the spouse is the same as the domicile of the servicemember or the spouse of the servicemember has elected to use the same residence for purposes of taxation as the servicemember.

Additional information for employers regarding the Military Spouses Residency Relief Act:

1. On the W-2 the employer should not report any of the wages as Georgia wages.
2. If the spouse of a servicemember is entitled to the protection of the Military Spouses Residency Relief Act in another state and files a withholding exemption form in such other state, the spouse is required to submit a Georgia Form G-4 so that withholding will occur as is required by Georgia Law when a Georgia domiciliary works in another state and withholding is not required by such other state. If the spouse does not fill out the form, the employer shall withhold Georgia income tax as if the spouse is single with zero allowances.

Worksheet for calculating additional allowances. Enter the information as requested by each line. For Line D, enter items such as Retirement Income Exclusion, U.S. Obligations, and other allowable deductions per Georgia Law, see the IT-511 booklet for more information.

Do not complete Lines 4-7 if claiming exempt.

O.C.G.A. § 48-7-102 requires you to complete and submit Form G-4 to your employer in order to have tax withheld from your wages. By correctly completing this form, you can adjust the amount of tax withheld to meet your tax liability. Failure to submit a properly completed Form G-4 will result in your employer withholding tax as though you are single with zero allowances.

Employers are required to mail any Form G-4 claiming more than 14 allowances or exempt from withholding to the Georgia Department of Revenue. Employers should honor the properly completed form as submitted unless otherwise notified by the Department. Such forms remain in effect until changed or until February 15 of the following year. Employers who know that a G-4 is erroneous should not honor the form and should withhold as if the employee is single claiming zero allowances until a corrected form has been received.



ACKNOWLEDGEMENT OF APPLICANT'S NON-CRIMINAL JUSTICE PRIVACY RIGHTS AND CONSENT TO BE INCLUDED IN THE CAREGIVER PORTAL

SECTION I - PRIVACY RIGHTS - TO BE COMPLETED BY INDIVIDUAL BEING FINGERPRINTED:

- APPLICANT TYPE: [] Owner (Facility) [] Applicant for Employment/Direct Access Employee (Facility) [] Non-Employee (Facility Volunteer) [] Contractor/Direct Access (Facility)

PRINT FULL NAME Last First Middle Date of Birth (mm/dd/yyyy)

Home Address Street City State Zip

Email Address Telephone No.

Name of Facility Street City State Zip

I hereby authorize the Georgia Department of Community Health (DCH), Office of Inspector General, to receive any criminal history record information pertaining to me which may be in the files of any state or local criminal justice agency in Georgia.

Applicant Signature Date

SECTION II - CAREGIVER PORTAL - TO BE COMPLETED ONLY BY AN APPLICANT OR EMPLOYEE BEING FINGERPRINTED AS PART OF FACILITY LICENSURE. DOES NOT INCLUDE OWNERS OR FAMILY EMPLOYERS.

- APPLICANT TYPE [] Applicant for Employment/Direct Access Employee (Licensed Facility) [] Non-Employee (Volunteer at Licensed Facility) [] Contractor/Direct Access Employee (Licensed Facility)

The Georgia Caregiver Portal only contains the eligibility status of applicants and employees who have successfully passed the background screening process. The Caregiver Portal does not contain the names of applicants and employees who are ineligible.

- [] I agree to the results of my background check determination being available to family employers in the Georgia Caregiver Portal. [] I am seeking employment only by licensed healthcare employers. I do not want or agree to the results of my background check determination being available to family employers.

Applicant Signature Date

Authorization for Direct Deposit - Employee Form

This authorizes D&D Homecare, LLC (the "Company") to send credit entries (and appropriate debit and adjustment entries), electronically or by any other commercially accepted method, to my (our) account(s) indicated below and to other accounts I (we) identify in the future (the "Account"). This authorizes the financial institution holding the Account to post all such entries.

Note: Enter your company name in the blank space above.

Account #1

Account #1 Type (check one): Checking Savings

Employee Bank Name

Bank Routing # (ABA#)

Account #

Percentage or Dollar Amount to be Deposited to This Account

Account #2 (remainder to be deposited to this account)

Account #2 Type (check one): Checking Savings

Employee Bank Name

Bank Routing # (ABA#)

Account #

Please attach a voided check for each account here.

This authorization will be in effect until the Company receives a written termination notice from myself and has a reasonable opportunity to act on it.

Signature

Printed Name

Employee ID #

Date

IMPORTANT: This document must be signed by employees requesting automatic deposit of paychecks and retained on file by the employer. Do not send this form to Intuit. Employees must attach a voided check for each of their accounts to help verify their account numbers and bank routing numbers.

D&D HOMECARE, LLC.

448 North Dr.
Cary, Ga 30512
Office: (770) 254-4217
Fax: (770) 254-7172

AUTHORITY FOR RELEASE OF INFORMATION

I, _____ hereby authorize D&D Homecare to conduct a Criminal history record information check in connection with my work. I authorize release and forever discharge said agency and person from any and all liability, which may be incurred as result of furnishing such information. I give consent to D&D Homecare to perform periodic criminal history background checks for the duration of my contract with this company.

_____ Last Name		_____ First Name	
_____ Middle Name		_____ Maiden Name	
_____ Social Security Number		_____ Date of Birth	
_____ Address			
_____ State (You live in)		_____ County	
_____ Sex		_____ Race	
_____ Driver's License#			
_____ Signature			_____ Date

Name of Person Taking Test: _____ SSAN _____ - _____ - _____

PERSONAL CARE ASSISTANT COMPETENCY EVALUATION Part 1

WRITTEN EXAMINATION PCA ANSWERS

Instructions: Circle the ONE correct Answer. Note: Each Question = 1 Point. Minimum of 80 Correct to Pass

I. ROLE OF THE PERSONAL CARE ASSISTANT

True or False

1. T F
2. T F
3. T F
4. T F
5. T F
6. T F
7. T F
8. T F
9. T F
10. T F

Questions

11. A B C D
12. A B C D
13. A B C D

II. COMMUNICATION

True or False

14. T F
15. T F
16. T F

Questions

17. A B C D
18. A B C D
19. A B C D
20. A B C D
21. A B C D

III. OBSERVATION, REPORTING AND DOCUMENTATION

True of False

22. T F
23. T F
24. T F

Questions

25. A B C D
26. A B C D
27. A B C D
28. A B C D
29. A B C D

Name of Person Taking Test: _____ SSAN _____ - _____ - _____

IV. READING AND RECORDING TEMPATURE, PULSE, AND RESPIRATIONS

True or False

- 30. T F
- 31. T F
- 32. T F

Questions

- 33. A B C D
- 34. A B C D
- 35. A B C D

V. INFECTION CONTROL

True or False

- 36. T F
- 37. T F
- 38. T F

Questions

- 39. A B C D
- 40. A B C D

VI. BODY FUNCTION AND CHANGES

True or False

- 41. T F
- 42. T F
- 43. T F

Questions

- 44. A B C D
- 45. A B C D
- 46. A B C D

VII. MAINTENANCE OF A CLEAN, SAFE ENVIRONMENT

True or False

- 47. T F
- 48. T F

Questions

- 49. A B C D
- 50. A B C D

VIII. EMERGENCY PROCEDURES

True or False

- 51. T F
- 52. T F
- 53. T F

Name of Person Taking Test: _____ SSAN _____ - _____ - _____

Questions

- 54. A B C D
- 55. A B C D
- 56. A B C D
- 57. A B C D

IX. HUMAN DEVELOPMENT

True or False

- 58. T F
- 59. T F
- 60. T F

Questions

- 61. A B C D
- 62. A B C D
- 63. A B C D
- 64. A B C D
- 65. A B C D

X. PERSONAL CARE

True or False

- 66. T F
- 67. T F
- 68. T F

Questions

- 69. A B C D
- 70. A B C D
- 71. A B C D
- 72. A B C D
- 73. A B C D

XI. SAFE TRANSFER TECHNIQUES AND AMBULATION

True or False

- 74. T F
- 75. T F
- 76. T F

Questions

- 77. A B C D
- 78. A B C D
- 79. A B C D
- 80. A B C D
- 81. A B C D
- 82. A B C D

Name of Person Taking Test: _____ SSAN _____ - _____ - _____

XII. NORMAL RANGE OF MOTION

True or False

- 83. T F
- 84. T F
- 85. T F

Questions

- 86. A B C D
- 87. A B C D
- 88. A B C D
- 89. A B C D

XIII. NUTRITION

True or False

- 90. T F
- 91. T F
- 92. T F

Questions

- 93. A B C D
- 94. A B C D
- 95. A B C D
- 96. A B C D
- 97. A B C D
- 98. A B C D
- 99. A B C D

XIV. CULTURAL DIFFERENCES IN FAMILIES

Question

- 100. A B C D

End

SIGNATURE of Person Taking Test: _____

_____ (Staff Use Only) _____

Examination Date: ____ / ____ / ____ (80 + Corrected Needed to Pass) Score ____ % = Pass (80 +%) Fail

Graded By Name: _____ Title: RN LPN

PHCP (Agency Name) _____ Phone: (____) ____ - _____ Fax: (____) ____ - _____

Address: _____ City _____ GA, Zip _____