OTSAR FAMILY SERVICE INC
EMPLOYMENT APPLICATION
2334 WEST 13TH STREET
BROOKLYN, NY 11223
TEL # 718-946-7301

Date: _____ Social Security #: _____

OTSAR Family Services Inc. is an equal opportunity employer. Applicants are considered without regard to race, creed, color, national origin, sex, age, disability, marital status, sexual orientation, veterans' status, citizenship status, or any other protected characteristic or status in all employment decisions, including but not limited to recruitment, hiring, compensation, training, promotion, transfers, termination, and all other terms and conditions of employment.

Please be aware that, if the position for which you are applying requires regular and substantial unsupervised or unrestricted physical contact with people being served by Otsar Family Services, you will need to provide information, statements, and fingerprints according to the requirements of OPWDD (Office of People with Developmental Disabilities) and The Justice Center regulations in order for a criminal background check to be conducted.

PERSONAL INFORMATION

_____
Applicant's Last Name First Middle

_____
Present Mailing Address Apt# City State Zip Code

Home Phone ( ) _____- _____Work Phone ( ) _____-_____Ext ____

If under 18 years old please indicate age _____ Cell ( ) _____ -_____

Email address:_____

Please check the job that you are applying for:_____ Sunday Program _____Community Habilitation

( ) F/T ( ) P/T_____ ( ) Other: _____

Hours Available_____Date Available for Work_____

- ❑ Are you legally employable under U.S. Immigration Laws? ( ) No ( ) Yes
- ❑ Are you in the USA on a visa? ( ) No ( ) Yes If Yes, indicate visa expiration date:_____ Please provide copy of visa to the Human Resources Office.
- ❑ A NYS driver's license is required for some positions.
  Do you possess a valid driver's license? ( ) No ( ) Yes – State:_____
- ❑ Have you ever been convicted of a DWI? ( ) No ( ) Yes – indicate date:_____
- ❑ Do you have any moving violations? ( ) No ( ) Yes - indicate date:_____
- ❑ Are you presently employed? ( ) No ( ) Yes
- ❑ May we contact your present employer? ( ) No ( ) Yes
- ❑ Are you on layoff or subject to recall? ( ) No ( ) Yes
- ❑ Can you travel if required? ( ) No ( ) Yes
- ❑ Are you currently attending school? ( ) No ( ) Yes

- ❑ Have you ever been convicted of a misdemeanor or a felony?( ) No ( ) Yes indicate date:_____

Provide a description of all convictions:

_____

_____

❑ Is there a pending criminal charge against you? ( ) No ( ) Yes indicate date _____
Provide a description of all pending criminal charges:

_____

_____

EDUCATIONAL INFORMATION

Do you possess a high school degree or equivalency diploma? ( ) Yes ( ) No

High School Name:_____City/State: _____

Date of Graduation or Expected Date of Graduation:_____

College/University:_____ City/State:_____

Years Completed:_____ Graduated: ( ) Yes ( ) No Expected Date of Graduation: _____

Degree Received: _____ Major:_____

Second Major:_____ Minor:_____

College/University:_____ City/State:_____

Years Completed:_____ Graduated: ( ) Yes ( ) No Expected Date of Graduation: _____

Other Degrees and/or Certifications (Specify NYS Licenses where appropriate)

_____

_____

What languages are you proficient in:_____

Do you have any special skills or hobbies:_____

Have you ever worked with the developmentally disabled population? ( ) Yes ( ) No
(If yes give specific details)

_____

_____

Is there any other information you would like to tell us? _____

_____

(Ii.e. client preference, etc)_____

Do you have any medical conditions which may affect your attendance or functioning on the job?_____

_____

EMPLOYMENT EXPERIENCE:
List below your employment history starting with the most recent employer. Include any period in which you were not employed and explain what you were doing during that time.

Employer: _____ Dates Employed: From_____ To_____

Salary Start: _____ Salary Final:_____

Address:_____

Position Held:_____ Reason for Leaving: _____

Supervisor:_____ Telephone Number: _____

Describe Duties: _____

_____

Employer: _____ Dates Employed: From_____ To_____

Salary Start: _____ Salary Final:_____

Address:_____

Position Held:_____ Reason for Leaving: _____

Supervisor:_____ Telephone Number: _____

Describe Duties: _____

_____

Employer: _____ Dates Employed: From_____ To_____

Salary Start: _____ Salary Final:_____

Address:_____

Position Held:_____ Reason for Leaving: _____

Supervisor:_____ Telephone Number: _____

Describe Duties: _____

_____

PROFESSIONAL REFERENCES

OTSAR requires 2 professional and 2 personal references. Please include 2 individuals who have had direct supervisory responsibility for your position as well as two individuals who are not related to you for personal references.

1 Name _____ Employment Relationship _____

Employer _____ Phone:_____

2 Name _____ Employment Relationship _____

Employer: _____ Phone :_____

3 Name _____ Personal Relationship _____

Occupation: _____ Phone _____

4 Name _____ Personal Relationship_____

Occupation_____ Phone _____

APPLICANT'S STATEMENT

I certify that the information contained in this application is true and correct to the best of my knowledge and understand that falsification or omission of information is grounds for refusal to hire or, if hired, immediate termination.

I further authorize the investigation of all information in this application for employment as may be necessary in arriving at an employment decision.

I further understand that if employed, I am employed at-will and that my employment can be terminated at my option or the option of the agency at any time and that no employee or representative of the agency, other than the Executive Director has any authority to enter into any agreement or contract contrary to the above.

I also agree that I am required to conform to the policies, procedures, rules and regulations of the agency and that all offers of employment are conditioned on the satisfactory proof of my identity and legal authority to work in the United States.

Print Name:_____ Signature: _____ Date:_____

Interviewer: _____ **Date Interviewed:** _____

Comments: _____

_____

_____

_____

_____

CODE OF CONDUCT FOR CUSTODIANS OF PEOPLE WITH SPECIAL NEEDS

June 10, 2013

Introduction

The Protection of People with Special Needs Act ("the Act") establishes the Justice Center for the Protection of People with Special Needs ("Justice Center") and requires that this Code of Conduct be read and signed by anyone who will have regular and substantial contact with any person who is receiving services or supports from facilities or providers covered by the Act.

The Code of Conduct is not intended to provide a detailed list of what to do in every aspect of your work. Instead it represents a framework that will help custodians determine how to help people with special needs live self-directed, meaningful lives in their communities, free from abuse and neglect, and protected from harm.

You must abide by the following Code of Conduct provisions:

1. **Person-Centered Approach**

   My primary duty is to the people who receive supports and services from this organization. I acknowledge that each person of suitable age must have the opportunity to direct his or her own life, honoring, where appropriate, their right to assume risk in a safe manner, and recognizing each person's potential for lifelong learning and growth. I understand that my job will require flexibility, creativity and commitment. Whenever appropriate, I will work to support the individual's preferences and interests.

2. **Physical, Emotional and Personal Well-being**

   I will promote the physical, emotional and personal well-being of any person who receives services and supports from this organization, including their protection from abuse and neglect and reducing their risk of harm. I will immediately report any situation in which any person receiving services or supports is experiencing, or is at risk of experiencing abuse or neglect.

3. **Respect, Dignity and Choice**

   I will respect the dignity and individuality of any person who receives services and supports from this organization and honor their choices and preferences whenever possible and appropriate. I will help people receiving supports and services use the opportunities and resources available to all in the community, whenever possible and appropriate.

4. **Self-Determination**

   I will help people receiving supports and services realize their rights and responsibilities, and, as appropriate, make informed decisions and understand their options related to their physical health and emotional well-being.

5. **Relationships**

I will help people who receive services and supports from this organization maintain or develop healthy relationships with family and friends. I will support them in making informed choices about safely expressing their sexuality and other preferences, whenever possible and appropriate.

6. **Advocacy**

I will advocate for justice, inclusion and community participation with, or on behalf of, any person who receives services and supports from this organization, as appropriate. I will promote justice, fairness and equality, and respect their human, civil and legal rights.

7. **Personal Health Information and Confidentiality**

I understand that persons served by my organization have the right to privacy and confidentiality with respect to their personal health information and I will protect this information from unauthorized use or disclosure, except as required or permitted by law.

8. **Non-Discrimination**

I will not discriminate against people receiving services and supports or colleagues based on race, religion, national origin, sex, age, sexual orientation, economic condition or disability.

9. **Integrity, Responsibility and Professional Competency**

I will reinforce the values of this organization when it does not compromise the well-being of any person who receives services and supports. I will maintain my skills and competency through continued learning, including all training provided by this organization. I will actively seek advice and guidance of others whenever I am uncertain about an appropriate course of action. I will not misrepresent my professional qualifications or affiliations. I will demonstrate model behavior to all, including persons receiving services and supports.

10. **Reporting Requirement**

As a mandated reporter, I acknowledge my legal obligation to report all allegations of reportable incidents immediately upon discovery to the Justice Center's Vulnerable Persons' Central Register by calling 1-855-373-2122.

_____

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: ☐ Respite ☐ Community Habilitation ☐ Other: _____

Department: **Medicaid**

Facility/Provider Organization: **Otsar Family Services, Inc.**

NYS Justice Center
For the Protection of People with Special Needs

Andrew M. Cuomo, *Governor*
Jeff Wise, *Acting Executive Director*

161 Delaware Avenue, Delmar, New York 12054
TEL: 518-549-0200

N.Y.S. PROTECTION OF PEOPLE WITH SPECIAL NEEDS ACT

NOTICE TO MANDATED REPORTERS

Justice Center Guidance – June 11, 2013

This Notice provides Mandated Reporters with an overview of their legal duties under the New York State Protection of People with Special Needs Act (the Act) to report Abuse, Neglect and Significant Incidents involving vulnerable persons to the Vulnerable Persons' Central Register (VPCR), a 24/7 hotline operated by the Justice Center for the Protection of People with Special Needs (Justice Center). The effective date of this new reporting requirement is June 30, 2013.

WHAT ARE MANDATED REPORTERS REQUIRED TO REPORT?

Effective June 30, 2013, Mandated Reporters have a legal duty to:

- Report to the Justice Center, by calling the VPCR at 1-855-373-2122, if they have reasonable cause to suspect abuse or neglect of a Vulnerable Person, including a child receiving residential services in a facility or provider listed below. Certain Mandated Reporters may also submit reports by completing a form available on the Justice Center website.

- Report all Significant Incidents to the Justice Center by calling the VPCR at 1-855-373-2122 or by completing the form on the Justice Center website.

- Call the Statewide Central Register of Child Abuse and Maltreatment if they have reasonable cause to suspect abuse or maltreatment of children in family and foster homes, and day care settings. Suspicion of child abuse or neglect in a day care setting, foster family boarding homes, or within a family home must continue to be reported to the Statewide Central Register of Child Abuse and Maltreatment at 1-800-635-1522.

WHO ARE MANDATED REPORTERS?

Mandated Reporters are (1) Custodians and (2) Human Service Professionals.

1. **Custodians:**

- Employees, volunteers, directors and operators of covered facilities and programs (please see list on Page 3), and
- External staff who have regular and substantial contact with the people being served.

2. **Human Service Professionals:**

Child Care or Foster Care Worker; Chiropractor; Christian Science Practitioner; Coroner; Dental Hygienist; Dentist; District Attorney or Assistant District Attorney; Emergency Medical Technician; Hospital Personnel engaged in the admission, examination, care, or treatment of persons; Intern; Investigator employed in the office of the district attorney; any other Law Enforcement Official; Licensed Creative Arts Therapist; Licensed Marriage and Family Therapist; Licensed Mental Health Counselor; Licensed Occupational Therapist; Licensed Physical Therapist; Licensed Practical Nurse; Licensed Psychoanalyst; Licensed Speech/Language Pathologist/Audiologist; Medical Examiner; Mental Health Professional; Nurse Practitioner; NYS Office of Alcoholism and Substance Abuse - all persons credentialed by OASAS; Optometrist; Osteopath; Peace Officer; Physician; Podiatrist; Police Officer; Psychologist; Registered Nurse; Registered Physician's Assistant; Resident (medical); Social Services Worker; Social Worker; Surgeon, and School Official, including but not limited to: School Teacher, School Guidance Counselor; School Psychologist; School Social Worker; School Nurse; School Administrator; or other school personnel required to hold teaching or administrative license or certificate.

WHAT TYPE OF INFORMATION SHOULD A MANDATED REPORTER BE PREPARED TO PROVIDE TO THE JUSTICE CENTER?

- Details regarding the victim(s), suspect(s) and witnesses(s).
- Details of the incident, including the date and time, location, description of incident and injury/impact to the victim.
- State agency responsible for oversight of the agency, facility and/or program.
- Name and address of the agency, facility and/or program.
- Confirmation that immediate protections are in place for the victim(s), if applicable.
- Any other information that may assist with the investigation or review of the incident.

Note: Mandated Reporters are required to report to the VPCR even if they may not have all the information outlined above.

WHEN IS REPORTING REQUIRED?

Whenever a Mandated Reporter has reasonable cause to suspect a Reportable Incident involving a vulnerable person, he or she is required to make a report to the VPCR immediately upon discovery.

- Reasonable Cause means that, based on your observations, training and experience, you have a suspicion that a vulnerable person has been subject to abuse or neglect as described below. Significant incidents that may place a vulnerable person at risk of harm must also be reported. Reasonable cause can be as simple as doubting the explanation given for an injury.

- Immediately means *"right-away;"* however reporting may be delayed to prevent harm (e.g., for as long as it takes to call emergency responders and/or address the need to maintain supervision.) Staff "going off-duty" does not justify a reporting delay. In any event, reports must be made to the VPCR within 24 hours.

- Discovery comes from witnessing the situation or when the vulnerable person or another individual comes to you and the available information indicates reasonable cause.

In addition to Mandated Reporters, anyone who has reasonable cause to suspect a Reportable Incident involving a Vulnerable Person should immediately call the VPCR.

If a Mandated Reporter or any other person has doubts about whether the available information indicates such reasonable cause, he or she should call the VPCR.

Reporting to the VPCR is an additional reporting requirement and does not relieve the Mandated Reporter of any other reporting requirements or duties that may be required by law, regulation or policy.

WHO ARE VULNERABLE PERSONS?

The Act defines a Vulnerable Person as a person who due to physical or cognitive disabilities or the need for services or placement is receiving care from a facility or provider within the systems of the State Oversight Agencies (SOA).

WHAT FACILITIES & PROGRAMS ARE COVERED BY THE ACT?

- Facilities and programs that are operated, certified, or licensed by the Office for People With Developmental Disabilities (OPWDD);
- Facilities and programs that are operated, certified, or licensed by the Office of Mental Health (OMH), except Secure Treatment Facilities and programs located in correctional facilities;
- Facilities and programs that are operated, certified, or licensed by the Office of Alcoholism and Substance Abuse Services (OASAS);
- Facilities and programs operated by the Office of Children and Family Services (OCFS) for youth placed in the custody of the Commissioner of OCFS; OCFS licensed or certified residential facilities that care for abandoned, abused, neglected, and dependent children, Persons In Need of

Supervision, or juvenile delinquents; Family Type Homes for Adults; OCFS certified runaway and homeless youth programs; and OCFS certified youth detention facilities.

- Adult homes licensed by the Department of Health (DOH) that have over 80 beds, and where at least 25% of the residents are persons diagnosed with a serious mental illness and have fewer than 55% of beds designated as Assisted Living Program (ALP) beds.
- Overnight summer day and traveling summer day camps for children with developmental disabilities under the jurisdiction of DOH;
- New York State School for the Blind; New York State School for the Deaf; State-supported (4201) schools that have a residential component; special act school districts; and in-state private residential schools approved by the New York State Education Department (NYSED)

AS A MANDATED REPORTER, WHAT ARE MY OBLIGATIONS RELATED TO NOTIFYING LAW ENFORCEMENT?

Possible crimes should be immediately reported to law enforcement. When a report is received by the VPCR, staff can consult with supervisors to decide if local police should be contacted, if such a call has not already been made.

WHAT CONSTITUTES ABUSE OR NEGLECT?

The Act defines Abuse and Neglect of Vulnerable Persons in broad terms, including both actual harm and the risk of harm:

Terms	Examples of Custodian Behaviors
Physical Abuse	Intentional contact (hitting, kicking, shoving, etc.) corporal punishment, injury which cannot be explained and is suspicious due to extent or location, the number of injuries at one time, or the frequency over time
Psychological Abuse	Taunting, name calling, using threatening words or gestures
Sexual Abuse	Inappropriate touching, indecent exposure, sexual assault, taking or distributing sexually explicit pictures, voyeurism or other sexual exploitation. All sexual contact between a Custodian and a service recipient is sexual abuse, unless the Custodian is also a person receiving services
Neglect	Failure to provide supervision, or adequate food, clothing, shelter, health care; or access to an educational entitlement
Deliberate misuse of restraint or seclusion	Use of these interventions with excessive force, as a punishment or for the convenience of staff
Controlled Substances	Using, administering or providing any controlled substance contrary to law
Aversive conditioning	Unpleasant physical stimulus used to modify behavior without person-

	specific legal authorization
Obstruction	Interfering with the discovery, reporting or investigation of abuse / neglect, falsifying records or intentionally making false statements

WHAT CONSTITUTES A SIGNIFICANT INCIDENT?

New York State law also recognizes that Vulnerable Persons can be harmed or put at risk in many types of circumstances. The Act defines a Significant Incident as an incident that is not abuse or neglect, but has the potential to result in harm to the health, safety or welfare of a person receiving services. Examples may include, but are not limited to the following:

- The use of restraint when it is avoidable, involves a banned technique, or is used by inadequately trained staff;
- Unauthorized seclusion or time-out;
- Harmful interactions between Vulnerable Persons that could reasonably have been prevented; and
- Administration of a medication contrary to a medical order resulting in an adverse impact.
- Any other conduct identified in regulations of the State Oversight Agency, according to guidelines or standards established by the Justice Center.

WHAT HAPPENS WHEN A REPORT IS MADE TO THE VPCR?

Trained VPCR staff will take a full report over the phone or via a web form and, based upon the information provided, categorize the reportable incident (abuse, neglect, significant incident) and notify the appropriate SOA. In addition, the Justice Center will be responsible for ensuring that the reportable incident is investigated or reviewed by the appropriate entity.

WHAT PROTECTIONS AND LIABILITIES DO MANDATED REPORTERS HAVE?

- **Immunity from Liability** - The law grants immunity to Mandated Reporters and other reporters from any legal claims which may arise from a good faith act of providing information to the VPCR.

- **Protection from Retaliatory Personnel Action** - The law prohibits an employer or agency from taking any retaliatory personnel action against a person as a result of a good faith act of providing information to the VPCR.

- **Confidentiality** - The law provides protections against the disclosure of the reporter's identity, subject to limited exceptions (e.g., the reporter's consent, a court order).

- **Failure to Report -** Failure by a Mandated Reporter to report suspected Abuse or Neglect to the VPCR is a serious matter and possible consequences include administrative discipline, termination, civil liability and criminal prosecution.

WHERE CAN I GET MORE INFORMATION?

Please contact the Justice Center at: 1-518-549-0200. We will be pleased to answer any questions you may have.

OTSAR FAMILY SERVICES/OTSAR EARLY CHILDHOOD CENTER POLICY AND PROCEDURE

Re: Otsar Family Services/Otsar ECC Dress Code Policy and Procedures

Date: January 1, 2014

DRESS CODE POLICY AND PROCEDURES

To ensure the comfort of every participant, regardless of race, religion, class, or ethnicity, Otsar Family Services/Otsar ECC has developed a staff dress code policy. The dress code has been developed and instituted to ensure that staff members exhibit a look that confirms the professionalism of Otsar Family Services/Otsar ECC to our participants and our coworkers.

- Slacks that are similar to Dockers and other makers of cotton or synthetic material pants, wool pants, flannel pants, dressy capris, and nice looking dress synthetic pants are acceptable. Inappropriate slacks or pants include torn,"weathered" "distressed", etc. jeans, sweatpants, exercise pants, Bermuda shorts, shorts, leggings, and any spandex or other form-fitting pants unless worn under a skirt.
- Casual dresses and skirts are acceptable. Dress and skirt length should be below the knee either standing as well as when sitting. Slits should not exceed knee height. Mini-skirts, skorts, sun dresses, beach dresses, and spaghetti-strap dresses are inappropriate.
- Casual shirts, dress shirts, sweaters, and turtlenecks are acceptable attire for work. All tops should have a modest neckline and sleeves to the elbow. Tank tops; midriff tops; shirts with potentially offensive words, terms, logos, pictures, cartoons, or slogans; halter-tops; and tops with bare shoulders are all inappropriate for work.
- Flashy athletic shoes, thongs, flip-flops, slippers and going barefoot are not acceptable at work.
- While hats are not appropriate for the office, head covers that are required for religious purposes or to honor cultural tradition are allowed.
- While business-appropriate attire is expected, ties are not required.
- No dress code can cover all contingencies. Employees are expected to exercise a certain amount of judgment in their choice of clothing to wear to work.

- Community Hab & Respite workers are expected to respect the parent/family requests for modest dress.

Date: January 1, 2014

OTSAR FAMILY SERVICES/OTSAR EARLY CHILDHOOD CENTER DRESS CODE POLICY AND PROCEDURES

(cont.)

- If clothing fails to meet these standards, as determined by the employee's supervisor and Human Resources staff, the employee will be asked not to wear the inappropriate item to work again. If the problem persists, the employee may be sent home to change clothes, may not receive pay for the time away/sent home, and will receive a verbal warning for the first offense. Progressive disciplinary action will be applied if dress code violations continue.
- Employee dress code is subject to the discretion of the supervisor and is not limited to the aforementioned topics. Supervisors can ask an employee to abide by dress code standards not listed in this policy based on participant feedback and/or cultural sensitivity.

OTSAR FAMILY SERVICES/OTSAR EARLY CHILDHOOD CENTER
Re: Otsar Family Services Dress Code Policy and Procedures

Date: January 1, 2014

OTSAR FAMILY SERVICES/OTSAR EARLY CHILDHOOD CENTER DRESS CODE POLICY AND PROCEDURES

I have read and been informed about the content, requirements, and expectations of the dress code policy for employees at Otsar Family Services/Otsar ECC.

I have received a copy of the policy and agree to abide by the policy guidelines as a condition of my employment and my continuing employment at Otsar Family Services/Otsar ECC.

I understand that if I have questions, at any time, regarding the dress code policy, I will consult with my immediate supervisor or the Otsar Family Services/Otsar ECC Human Resources Department.

Employee Signature:_____

Employee Printed Name:_____ Date:_____

Administrative Signature:_____ Date:_____

FINGERPRINTING IN BROOKLYN

1. **Hebrew Academy for Special Children** (HASC)-1221 East 14th Street (bet. Aves. L and M) 718-535-1984. Ask for Rivky. If she isn't available, leave a message.
2. **Human Care** 1042 38th Street Brooklyn 718-854-2747 Ask for Bina or anyone from fingerprinting unit
3. **Women's League Community Residence** 1556 38th St. 347-390-1306
4. **Brooklyn DDSO** 888 Fountain Avenue Brooklyn 718-642-8521 Only available for fingerprinting on Mondays and Wednesdays from 8:30 AM to 3:30 PM

The top 3 places are easily accessible by subway; the Brooklyn DDSO may only be available by car or bus.

You must call to make an appointment for fingerprinting. Tell them you need to be fingerprinted in order to work for Otsar Family Services. When you go to the appointment, first complete the paperwork at home and then bring all of the papers with you PLUS two proofs of identification (one must be a picture ID: driver's license or passport). Double check the requirements when you call for an appointment. Make sure you come on time for your appointment; people have been sent away if they can late! After you are fingerprinted you will be given back 1-2 pieces of paper from the papers that you filled out. These papers must be MAILED to our office right after you are fingerprinted.

Criminal Background Check Unit 161 Delaware Avenue Delmar, NY 12054 Fax: 518-549-0464 Email: cbc@JusticeCenter.ny.gov	**Request for Criminal History Record Check**	NYS Justice Center For the Protection of People with Special Needs

The purpose of this form is to formally request a criminal history record check. For state employees, DDSO should use Form OPWDD 106S.

Instructions:

1. Complete **all** fields on the form. Please print legibly.
2. Authorized person must sign and date the form.
3. If Livescan prints are being taken, give completed form to applicant to bring to Livescan location.
4. If "ink and roll" is being used, mail the completed form along with fingerprint cards and JC Form JC CBC Unit at PO Box 3003, Schenectady, NY 12303-0005.

Agency/DDSO /Registered Provider Name	Five Digit ID Number	Check Type
Otsar Family Services, Inc	21760	☐ DDSO ☑ Voluntary Provider ☐ Registered Provider

Applicant's Last Name	First Name	MI

Date of Birth	Social Security Number

Street Address or PO Box (applicant's)

City	State	Zip

Status (check one)	Program Type	
☑ E – Employee (non state) ☐ V – Volunteer ☐ F – Family Care Provider ☐ N – Employees of vendors and contractors	For Voluntary Agencies enter four digit code from page 2 0 2 1 9	For Registered Providers select either: ☐ Transportation 0670 ☐ Subcontract Service 0880

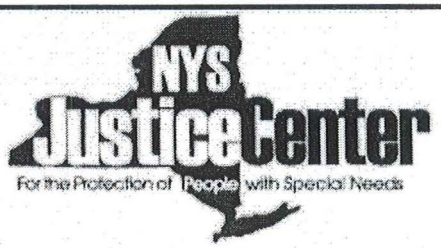
The applicant will have regular and substantial unsupervised or unrestricted physical contact with individuals receiving services and is a subject party concerning whom a criminal history record check is required by law. The results of the criminal history record check will be used solely for purposes authorized by law. Informed consent has been given by the applicant and is on file.

Please check if applicable:

☐ The subject party is a subject party for a position which requires simultaneous criminal history record checks by both Justice Center and OASAS.

Name of Authorized Person Shanie Spiegel E-mail shanie@otsar.org

Signature of Authorized Person Shanie Spiegel Date

NYS Justice Center for the Protection of People with Special Needs (Justice Center) Criminal Background Check Unit 161 Delaware Avenue Delmar, NY 12054 Email: cbc@JusticeCenter.ny.gov	**Fingerprint Submission Authorization Form**	

This form provides NYS Division of Criminal Justices Services (DCJS) the information necessary to process the fingerprints that are submitted. The information is required when using LIVESCAN or when scanning prints from fingerprint cards. The form must be completed prior to presentation to the LIVESCAN operator, however, the operator will confirm that information on the form matches the physical attributes of the applicant and may change the information to reflect actual physical attributes. The LIVESCAN operator MUST confirm the identification of the applicant by means of one of the following documents which includes a photograph: valid driver's license, valid school identification document, valid passport, or valid military identification. If one of these is not available, documents that can confirm identity for employment purposes can be utilized. If "ink and roll" is being used the individual taking the prints must confirm the identification of the applicant.

Instructions:

1. Complete ***all*** fields on the form. Please print legibly.
2. If Livescan prints are being taken, give completed form to applicant to bring to Livescan location.
3. If "ink and roll" is being used, mail the completed form along with fingerprint cards and JC Fingerprint Submission Form to the JC CBC Unit at PO Box 3005 Schenectady, NY 12303-0005.

Applicant

Last Name	First Name	Middle Name	Suffix

Social Security Number	Date of Birth	Birth State	Birth Country

Citizenship	Alien Registration # if applicable	

Gender:

☐ Male ☐ Female

Race: Check the code which best describes the person.

☐ W (white) ☐ B (black)
☐ I (American Indian or Alaskan Native) ☐ A (Asian or Pacific Islander)
☐ U (Unknown) ☐ O (Other)

Eye Color: Check the eye color code which best describes the person's eye color.

☐ BLK – Black ☐ GRY – Gray ☐ MAR – Maroon ☐ XXX – Unknown
☐ BLU – Blue ☐ GRN – Green ☐ PNK – Pink ☐ MUL – Multi-color
☐ BRN – Brown ☐ HAZ – Hazel

Hair Color: Check the hair color code which best describes the person's hair color.

☐ BAL – Bald ☐ BRO – Brown ☐ SDY – Sandy ☐ BLU – Blue
☐ BLK – Black ☐ GRY – Gray ☐ WHI – White ☐ GRN – Green
☐ BLN – Blonde ☐ RED – Red ☐ XXX – Unknown ☐ ONG – Orange
☐ PNK – Pink ☐ PLE – Purple

Skin Tone			Ethnic Origin (Enter either Hispanic or Non-Hispanic)
☐ Albino	☐Light	☐Ruddy	
☐Black	☐Light Brown	☐Sallow	
☐Dark	☐Medium	☐Yellow	
☐Dark Brown	☐Med Brown	☐Other	
☐Fair	☐Olive	☐Unknown	

Weight (enter whole numbers only)	Height (enter feet and inches)

Driver's License State	Driver's License Number

Street Address	

City	State	Zip

County	Country

Applicant Type: Check appropriate response (check only one)

☑ Direct Service Provider ☐ Operator

☐ Family Care ☐ Volunteer

Aliases (this includes maiden name)

Last Name	First Name	Middle Name	Suffix

Position: Choose the appropriate type (check only one)

☐Administration	☐Food Service	☐Other Support	☐Rehabilitation
☐Other Support	☐Housekeeping	☐Physician-non-Psychiatric	☐Research
■Direct Care	☐ Intensive Case Mgmt	☐Psychiatry	☐Residential Care
☐Clinical Ancillary Services	☐ Maintenance & Engineering	☐Psychology	☐Safety
☐Clinical Mgmt	☐ Nursing	☐Quality Assurance	☐Social Work

Justice Center/OASAS Waiver

☐ Yes ☑ No

■ New Hire

OR

☐ Transfer from other Provider/Program/Agency

Program Code (enter four digit code from Page 3)

0219

Job Duties: Please enter detailed information about the job duties that indicate **how** the applicant will have direct and substantial unsupervised contact with persons receiving services/care and to what degree. (150 Character limit)

Worker is in a group setting under supervision. He or she works with other staff in a classroom or out in the community. The worker could be focusing on the class as a whole or on one or two individuals within the group. Worker will assist in learning skills, engaging in activities, and personal hygiene.

User Department Division – Please enter the name of the DDSO, agency or registered provider with which the applicant will be associated.

DDSO/Agency/Registered Provider Name Otsar Family Services, Inc.

NYS Justice Center for the Protection of People with Special Needs (Justice Center) Criminal Background Check Unit 161 Delaware Avenue Delmar, NY 12054 Fax: 518-549-0464 Email: cbc@JusticeCenter.ny.gov	**Applicant Consent Form for Fingerprinting for Justice Center Criminal Background Check (CBC)**	NYS Justice Center For the Protection of People with Special Needs

Part 1. Applicant Information (Please print clearly)

Last Name:	First Name:	MI:
Date of Birth:	Social Security Number:	
Applicant address:	Applicant type:	
Facility/Provider:		
State Oversight Agency: OMH	OPWDD	OCFS — **Circle all that apply**

Part 2. Attestation

1. I have been advised that as part of the application process, the law requires the facility or provider agency listed above to request a criminal history information check with the NYS Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI) and authorizes the Justice Center to review and evaluate the results of the criminal history information check received by DCJS and FBI. The Justice Center will provide a summary of NYS criminal history, if any, to the facility or provider agency. A conviction for certain crimes may affect my suitability for employment in this position.
2. I consent to having my fingerprints taken and submitted for the purpose of a criminal history information check to DCJS and the FBI and consent to the Justice Center sharing with the facility for 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 history information check forwarded to the Justice Center by DCJS and the FBI 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)
   ____ have been convicted of a crime in New York State or any other jurisdiction.
   ____ have pending arrest charges.
   If checked, provide details:_____
   _____
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 which is maintained as part of the Vulnerable Persons' Central Register and that such check is required by Social Services Law §495 and will be performed prior to the criminal history information check. 14 NYCRR Part 702 provides for the collection of social security numbers for this purpose and the failure to provide my social security number may preclude me from being considered for the position applied for.

Applicant Signature		Date:
Signature Parent/ Guardian if Applicant under 18 years		Date:
Part 3	**Facility of Provider Agency Authorized Person Information**	
Name:	Shanie Spiegel	Title: HR
Signature:	Shanie Spiegel	Email: shanie@otsar.org

Otsar Family Services, Inc
2334 West 13th Street Brooklyn NY 11223
(718) 946-7301

THINGS YOU NEED TO KNOW ABOUT HIPAA

What is HIPAA?

HIPAA stands for the federal law entitled to the Health Insurance Portability and Accountability Act, which was passed in 1996.

Regulations issued under HIPAA that protect the privacy of health information for all Americans go into effect April 14, 2003.

How does HIPAA affect professional in the MR/DD field?

As professionals in the MR/DD field, we are legally responsible to protect the health information of our consumers. Special laws mandate the ways in which we store and share this information.

All the consumers we work with need to be given a **privacy statement**, which explains how their health information will be used, and their rights under this new privacy law.

What information does HIPAA protect?

The HIPAA regulation safeguard **Protect Health Information** (PHI)
Protected Health Information (PHI) includes an individual's:

- Health (Diagnosis)
- Provision of care (Services received)
- Payment of services (How payment will be made)
- Information which identifies the individual (Name, address, social security, etc.)

When can PHI be shared?

Protected Health information (PHI) may be shared for:

- Treatment (e.g., for day program or residential services, clinic, etc.)
- Payment (e.g., billing for services)
- Health Care Operations (e.g. such as quality assurance, program oversight)

In most instances you do not need consumer consent for these purposes unless you are sharing sensitive information (e.g. HIV/ AIDS information, mental health records) that is protected by special state laws.

When sharing information for Treatment, Payment and Health Care Operations. How *much* information may I share?

For the purposes of **payment** and **health care operations** the ***minimum information necessary*** should be shared. For purposes of **treatment** the concept of minimum necessary should not impede the free flow of information necessary to ensure comprehensive treatment.

When do I need a special consent to share PHI?

Under most other circumstances, it would be necessary to get the consent of the consumer or his/her representative to release their PHI. (For example: marketing, publicity, referrals to non-treatment programs such as recreation, etc.)

In these cases, it is very important to explain carefully to consumers what they are agreeing to and to use the Agency's standard authorization form.

Are there other circumstances where information may be disclosed without consent?

There are a number of possible situations where this information can be disclosed for "public need" purposes without consent. These include, but are not limited to the following:

- Government audits and investigations
- Public health and safety
- A Subpoena from the courts

What are the steps professionals need to take to protect the consumer's PHI?

Discussion: Don't discuss information about consumers in a public place where others can overhear.

Files: Make sure files are not kept where unauthorized people can see them and that they are locked away when not in use.

Fax: When sending a fax, make sure an authorized person is on the other end to receive it.

Computers: All computers should be password protected.
Never share your computer password with anyone else.
Your computer screen should face away from public area/viewing.
When stepping away from a computer in use, you can protect consumer information by:

- Closing all applications
- Using screensaver (if possible, with password protection)

Do not sent PHI by e-mail unless it is encrypted

How do I dispose of documents containing PHI?

Anything containing PHI has to be disposed of in a way that makes the information unreadable. (For example: use a shredder)

If I don't know whether or not to give out information, whom do I talk to?

You should speak to your supervisor or your agency's designated privacy officer.

Otsar Family Services, Inc

Privacy Notice- Acknowledgment of Receipt

New federal regulations require Otsar Family Services, Inc to send a Privacy Notice to everyone who works at / for Otsar. These regulations are known as the HIPAA Privacy rule. HIPAA is short for Health Insurance Portability and Accountability Act of 1996.

By signing this acknowledgment form I am confirming that:

- I have received a copy of Otsar's Privacy Notice.

Staff name (please print):_____

Staff signature:_____

Date:_____

Please return this form **AS SOON AS POSSIBLE**, using the enclosed envelope.

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire 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 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	E-mail Address	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):

☐ A citizen of the United States

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

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

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

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date *(mm/dd/yyyy):*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

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

Signature of Preparer or Translator:	Date *(mm/dd/yyyy):*

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

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

STOP ***Employer Completes Next Page*** STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A **Identity and Employment Authorization**	**OR**	**List B** **Identity**	**AND**	**List C** **Employment Authorization**
Document Title:		Document Title:		Document Title:
Issuing Authority:		Issuing Authority:		Issuing Authority:
Document Number:		Document Number:		Document Number:
Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				

3-D Barcode
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	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Last Name *(Family Name)* First Name *(Given Name)*		Employer's Business or Organization Name
Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State / Zip Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)* Last Name *(Family Name)* First Name *(Given Name)* Middle Initial	**B.** Date of Rehire *(if applicable) (mm/dd/yyyy):*

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current 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:	Date *(mm/dd/yyyy):*	Print Name of Employer or Authorized Representative:

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** Native American tribal document
		6. Military dependent's ID card		**6.** U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		**8.** Employment authorization document issued by the Department of Homeland Security
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**10.** School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.

OTSAR FAMILY SERVICES, INC.
MEDICAID WAIVER PROGRAM
2334 WEST 13™ STREET
BROOKLYN, NY 11223

JOB DESCRIPTION/RESPONSIBILITIES

Employee Name: _____

Qualifications:
A Community Habilitation (Comm Hab) worker must be a mature, responsible individual who expresses a desire to work with developmentally disabled individuals. The worker must be at least 16 years of age (with working papers) and have the ability to work with developmentally disabled individuals, their parents and assigned professionals. Experience working with developmentally disabled individuals is preferred. The Comm Hab worker must have the ability to carry out a daily schedule of goals, with minimal direction, and be able to make independent judgments.

Responsibilities:
Each Comm Hab worker will be under the direct supervision of a Comm Hab supervisor and (indirectly) the Director of Medicaid Waiver Services. The Comm Hab worker's responsibilities will include, but not be limited to:

1. Plans and/or implements goals and activities developed for the consumer by focusing on self-help/greater independence (i.e. toileting, grooming, dressing, eating), socialization, and recreational activities as outlined on the Daily Goal Sheets. These goals will be implemented by defined techniques under the guidance of the Comm Hab supervisor and/or other professional staff.
2. Records goal progress of assigned consumers accurately and **daily upon completion of goal implementation** on the consumer's goal sheets. Writes Monthly Progress Reports (MPRs) for each consumer highlighting his/her progress in goals per month (due at the end of each month).
3. Participates (in person, by phone, through notes/email, etc.) in the team process and assists in the formulation of consumer goals. Calls or contacts the Comm Hab supervisor if there are any problems in implementing the goals of a consumer.

Daily Responsibilities:
1. The Community Habilitation worker will arrive on time for her/his scheduled hours.
2. If the Community Habilitation worker cannot be at work on time or will not be able to work at all, she/he must make two phone calls.
She/he must call:
   A. The family to tell them of her/his change of plans and to try to make alternate arrangements AND
   B. The Otsar office and speak with either Joel (ext. 201) or Rachel (ext. 202), whomever is the appropriate supervisor or with Stephanie (ext. 204) the Comm Hab secretary.
3. Any long term changes in schedule, e.g. switching days and hours, must be confirmed with the

consumer's parents and the appropriate Comm Hab supervisor.

4. No substitutes are allowed **without prior approval** from the appropriate Comm Hab supervisor. The Comm Hab worker needs to understand that Otsar is providing these services under the auspices of the Office of People with Developmental Disabilities (OPWDD) and these are their rules and regulations.
5. A Comm Hab worker may not work more than 6 consecutive hours a day with an assigned consumer. If a situation arises where the parent(s) needs the Comm Hab worker for more than 6 hours, it is the responsibility of the **parent** to call the appropriate Comm Hab supervisor **in advance** to get approval.

TIME SHEETS:

1. Time sheets will only be accepted for payment if they are:
    A. Original copies. No faxed documents will be accepted. Use a pen only (no pencil).
    B. Signed by the worker and the parent.
    C. Filled out so that the day of the week corresponds with the day of the month.
    D. Are accompanied by goal sheets for each day billed. Goals sheets must also be signed by the parent and worker.

"White out" is not allowed. If you need to make a correction on your time sheet, cross out the error and INITIAL the error. Any time sheets not meeting these requirements will be returned. You will not be paid until any and all oversights are resolved.

Daily goal sheets, and time sheets are to be submitted together for the first 2 weeks of each month (on or about the 12th for the pay period ending on the 15th); Daily goal sheets, time sheets and monthly progress reports for that month are to be submitted together for the second 2 weeks of each month (on or about the 27th for the pay period ending on the 30th). If you submit the above paperwork according to the schedule, you will receive your check in approximately 2 to 3 weeks.

Please sign and return the signature sheet (page 3) as soon as possible. A Comm Hab supervisor signed copy will be returned to you as confirmation of our receipt of your signed job description.

OTSAR FAMILY SERVICES, INC.
MEDICAID WAIVER PROGRAM
2334 WEST 13™ STREET
BROOKLYN, NY 11223

JOB DESCRIPTION/RESPONSIBILITIES SIGNATURE SHEET

Employee Name: _____

Due to government regulations, please understand that it is critical that paperwork be returned to Otsar in a timely manner.

I acknowledge that after 30 days, if the documentation is not submitted, it is considered as a terminable offense and my employment can be immediately terminated.

By my signature below, I acknowledge that I have read and understand all of the above responsibilities/components of the position.

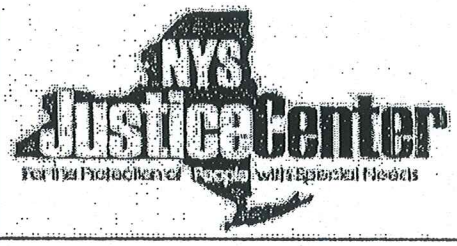
_____ _____
EMPLOYEE SIGNATURE DATE

Email address: _____ (for ease of contact)

_____ _____
COMMUNITY HABILITATION SUPERVISOR DATE

PPD results should be read from 48 hours and NO LATER than 72 hours from the time the test is administered.

VERIFICATION OF P.P.D. TEST	
NAME:	
DATE OF TEST:	
READ ON:	
MEASURED:	
ADMINISTERED BY:	
DR.'S SIGNATURE:	
AND DR.'S STAMP:	

NYS Justice Center for the Protection of People with Special Needs (Justice Center) Criminal Background Check Unit 161 Delaware Avenue Delmar, NY 12054 Fax: 518-549-0464	**Request for Staff Exclusion List Check Form**	

The Justice Center maintains a Vulnerable Persons Central Register (VPCR) that includes a Staff Exclusion List (SEL) containing the names of individuals who have committed serious acts of abuse and are deemed ineligible to work in a position involving regular and substantial contact with a service recipient. Providers must request the Justice Center to conduct a check of the SEL before determining whether to hire or otherwise allow "any person" to have regular and substantial contact with a service recipient. "Any person" can include an employee, administrator, consultant, intern, volunteer, or contractor.

Instructions:

1. The provider's Authorized Person must complete this form and fax it to the Justice Center's Criminal Background Check (CBC) unit for an applicant under serious consideration to be hired or otherwise permitted to have regular and substantial contact with a service recipient.
2. The Justice Center's CBC unit will send the Authorized Person an email indicating the results of the SEL check.
3. If the Applicant is on the SEL, he or she may not be hired in a position involving regular and substantial contact with a service recipient in a facility or provider agency defined in Social Services Law §488(4) or by other providers of services in programs licensed or certified by the Office of Mental Health, Office for People With Developmental Disabilities, Office of Alcohol and Substance Abuse Services, Office of Children and Family Services, Department of Health and State Education Department.
4. If the Applicant is on the SEL, certain other providers have discretion whether to hire the individual as provided in Social Services Law §495(3).
5. If the Applicant is not on the SEL, a criminal background check through the Justice Center, if required, and an inquiry of the Statewide Central Register of Child Abuse and Maltreatment through the Office of Children and Family Services, if required, must be conducted.

Part 1. Applicant Information (Please Print)

Last Name:	First Name:	MI:
Date of Birth:	Social Security Number:	Alien Reg#:
Applicant address:	Applicant type: 0219	
Facility/Provider Name: Address:	Otsar Family Services 2334 West 13 St Brooklyn NY 11223	
State Oversight Agency: OMH (OPWDD) OCFS DOH SED OASAS		Please circle appropriate agency(ies)

Part 2. Authorized Person Information Please print clearly

Name: (Please Print)	Shanie Spiegel	Email: shanie@otsar.org
Signature:	Shanie Spiegel	Phone: 718-946-7301
Facility/Provider name:	Otsar Family Services, Inc.	Address: 2334 West 13th St Brooklyn, NY 11223

Form W-4 (2015)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2015 expires February 16, 2016. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2015. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A** _____
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	**B** _____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C** _____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D** _____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	**E** _____
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F** _____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $65,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $65,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child	**G** _____
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ►	**H** _____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

► **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2015

1 Your first name and middle initial	Last name	**2 Your social security number**	
Home address (number and street or rural route)		**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code		**4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐	
5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)		**5**	
6 Additional amount, if any, you want withheld from each paycheck		**6** $	
7 I claim exemption from withholding for 2015, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ►		**7**	

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

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

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1 Enter an estimate of your 2015 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1951) of your income, and miscellaneous deductions. For 2015, you may have to reduce your itemized deductions if your income is over $309,900 and you are married filing jointly or are a qualifying widow(er); $284,050 if you are head of household; $258,250 if you are single and not head of household or a qualifying widow(er); or $154,950 if you are married filing separately. See Pub. 505 for details . . . . 1 $

2 Enter: { $12,600 if married filing jointly or qualifying widow(er); $9,250 if head of household; $6,300 if single or married filing separately } . . . . . 2 $

3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" . . . . . 3 $

4 Enter an estimate of your 2015 adjustments to income and any additional standard deduction (see Pub. 505) 4 $

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2015 Form W-4* worksheet in Pub. 505.) . . . . . 5 $

6 Enter an estimate of your 2015 nonwage income (such as dividends or interest) . . . . . 6 $

7 **Subtract** line 6 from line 5. If zero or less, enter "-0-" . . . . . 7 $

8 **Divide** the amount on line 7 by $4,000 and enter the result here. Drop any fraction 8

9 Enter the number from the **Personal Allowances Worksheet,** line H, page 1 9

10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 10

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) 1

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3" 2

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet 3

Note. If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet 4

5 Enter the number from line 1 of this worksheet 5

6 **Subtract** line 5 from line 4 6

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . 7 $

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . 8 $

9 Divide line 8 by the number of pay periods remaining in 2015. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2015. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 $

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $6,000	0	$0 - $8,000	0
6,001 - 13,000	1	8,001 - 17,000	1
13,001 - 24,000	2	17,001 - 26,000	2
24,001 - 26,000	3	26,001 - 34,000	3
26,001 - 34,000	4	34,001 - 44,000	4
34,001 - 44,000	5	44,001 - 75,000	5
44,001 - 50,000	6	75,001 - 85,000	6
50,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$600	$0 - $38,000	$600
75,001 - 135,000	1,000	38,001 - 83,000	1,000
135,001 - 205,000	1,120	83,001 - 180,000	1,120
205,001 - 360,000	1,320	180,001 - 395,000	1,320
360,001 - 405,000	1,400	395,001 and over	1,580
405,001 and over	1,580		

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 who claims no withholding allowances; 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 possessions 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.