

TERRIFIC SERVICES INC

129 S 8TH ST BROOKLYN, NY 11211

Tel: (718) 387-7702

APPLICATION FOR EMPLOYMENT

We consider applicants for all positions without regard to sexual orientation, age, race, creed, religion, marital status, national origin, handicap, citizenship and alienage.

WE ARE AN EQUAL OPPORTUNITY EMPLOYER

Position You Are Applying For _____ Date: _____

Last Name:	First Name:	Middle Name:
Address:	Apt:	City: State: Zip:
Phone Number: (Please circle) home / cell	Email:	
Social Security Number:	Birthdate:	Gender:

Are you a United States citizen? Yes ____ No ____ Alien Reg. # _____ Exp Date: _____

State ID/License # _____ State: _____ Exp Date: _____

Shifts you can work: Day ____ Evening ____ Night ____ Fulltime ____ Weekends ____ Temp ____

On what date would you be available for work? _____

Have you worked for this Nursing Home: Yes ____ No ____ When? _____

Name of any friend or relative working here: _____

If you are less than 18 years of age, do you have a work permit? Yes ____ No ____

Are you currently a member of a Union? If so, which union: _____

Are you physically able to perform the duties for which you are applying? Yes ____ No ____

EDUCATION: Circle the highest completed: 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4
 GRADE SCHOOL HIGH SCHOOL COLLEGE

DIPLOMA / DEGREE: _____

VOACTIONAL OR TRADE TRAINING: _____

REFERENCES: Give name, address, & telephone number of two references not related to you:

1)

2)

EMPLOYMENT HISTORY:

List below your work experience starting with your most recent place of employment:

1. DATES EMPLOYED	NAME & ADDRESS OF EMPLOYER	POSITION HELD	NAME OF SUPERVISOR
From _____	_____	_____	_____
To _____	_____	_____	_____
Reason for leaving: _____			
2. DATES EMPLOYED	NAME & ADDRESS OF EMPLOYER	POSITION HELD	NAME OF SUPERVISOR
From _____	_____	_____	_____
To _____	_____	_____	_____
Reason for leaving: _____			
3. DATES EMPLOYED	NAME & ADDRESS OF EMPLOYER	POSITION HELD	NAME OF SUPERVISOR
From _____	_____	_____	_____
To _____	_____	_____	_____
Reason for leaving: _____			

May we contact present employer? Yes ____ No ____

APPLICANT STATEMENT:

I understand that my employment will be on a 90 day probationary basis. All benefits, including PTO and holidays, will only begin once the probationary period is over. If employed, I agree to abide by the rules and regulations. The above information is complete and true to the best of my knowledge. I understand that discovery of misrepresentation or omission of facts herein will cause for immediate dismissal.

I authorize my employer to contact and/or check all of my references for complete information.

I understand that I must furnish proof of Employment Eligibility as required by the U.S. Department of Immigration Reform and Control Act of 1986, upon notification of hire.

I understand that I must furnish a physical, to have been completed within the last six months upon beginning employment. Physicals are required to be done annually. I agree that my examining physician disclose the findings of my physical examination to this facility or authorized agent of this facility. PPD (Mantoux Test) is required every year. If positive, Chest X-ray is required every 5 years.

I hereby understand and acknowledge that, unless otherwise defined by applicable law, any employment relationship with this organization is of an "at will" nature, which means that the Employee may resign at any time and the Employer may discharge Employee at any time with or without cause. It is further understood that this "at will" employment relationship may not be changed by any written document or by conduct unless such change is specifically acknowledged in writing by an authorized executive of this organization.

Applicant's Signature

Date



Please provide a current resume along with this application.



Fairview Nursing Care Center

69-70 Grand Central Parkway, Forest Hills, New York 11375

Tel: 718.263.4600 Fax: 718.575.8945

Dear Prospective Employee,

Thank you showing an interest in Fairview Nursing Care Center. In this packet, you will find forms that are required in order to process your application. Please be sure to fill out all sections of the Application as well as the two employee reference letters. Once those forms are completed and submitted, they will be processed and a decision will be made whether or not to offer you an employment interview.

Following your interview, you will be required to submit a pre-employment physical health examination form (enclosed), to be completed by your own physician no more than 180 days prior to the commencement of your orientation.

All forms must be completed here at Fairview Nursing Care Center. Do not take them home with you. Faxed or emailed application forms will not be accepted or processed.

Fairview Nursing Care Center is an Equal Opportunity Employer. This means that we do not discriminate in our policies regarding employment or the provision of services based on race, creed, color, national origin, ancestry handicap, source of payment, religion, sex, marital status, sexual orientation, age, genetic predisposition or carrier status, or any other protected classifications under local, State and Federal laws.

Thank you again for applying for a position at Fairview Nursing Care Center.

Sincerely,
Administration



Fairview Nursing Care Center

69-70 Grand Central Parkway, Forest Hills, New York 11375

Tel: 718.263.4600 Fax: 718.575.8945

Contact Information Form

In an effort to ensure that the quality of care we provide to each patient/resident is maintained please provide us with your most updated contact information below.

Personal Contact Information

Legal Name: _____

Last

First

Middle

Address: _____

House #

Street

Apt #

City

State

Zip Code

Phone #1) (please circle) home / cell _____

#2) (please circle) home / cell _____

Email: _____

Emergency Contact Information

Emergency Contact Name: _____

Relationship: _____

Emergency Contact Number:

(please circle) home / cell _____



Fairview Nursing Care Center

69-70 Grand Central Parkway, Forest Hills, New York 11375

Tel: 718.263.4600 Fax: 718.575.8945

Employee Reference Verification

To be filled out by applicant:

Applicant Name: _____

Last

First

Middle

Address: _____

Street

City

State

Zip

Previous Employer Contact: _____

Telephone #: _____

Fax #: _____

I hereby release from all liability the company or person named above and authorizes them to release all information regarding my employment

Applicant's Signature

Date



To be filled out by previous employer:

The above applicant is a former employee of yours and we would appreciate it if you would answer the questions below as truthfully as you can. Please be assured that all information will be held in strict confidence.

Worked for you in the position of: _____

Worked for you in the years of: _____

The applicant's

Reliability is	<input type="checkbox"/>	Excellent	<input type="checkbox"/>	Good	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor
Integrity is	<input type="checkbox"/>	Excellent	<input type="checkbox"/>	Good	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor
Conscientiousness is	<input type="checkbox"/>	Excellent	<input type="checkbox"/>	Good	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor
Intelligence is	<input type="checkbox"/>	Excellent	<input type="checkbox"/>	Good	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor
Neatness is	<input type="checkbox"/>	Excellent	<input type="checkbox"/>	Good	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor
Cooperation is	<input type="checkbox"/>	Excellent	<input type="checkbox"/>	Good	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor
Skill in position was	<input type="checkbox"/>	Excellent	<input type="checkbox"/>	Good	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor
Absenteeism was	<input type="checkbox"/>	Excellent	<input type="checkbox"/>	Good	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor

Would you re-employ the above named applicant? ☐ Yes ☐ No

Why? _____

Would you recommend the applicant for the position applied for? ☐ Yes ☐ No

What is the reason for separation? _____

Other comments / remarks: _____

Signature

Title:



Fairview Nursing Care Center

69-70 Grand Central Parkway, Forest Hills, New York 11375

Tel: 718.263.4600 Fax: 718.575.8945

Employee Reference Verification

To be filled out by applicant:

Applicant Name: _____

Last

First

Middle

Address: _____

Street

City

State

Zip

Previous Employer Contact: _____

Telephone #: _____

Fax #: _____

I hereby release from all liability the company or person named above and authorizes them to release all information regarding my employment

Applicant's Signature

Date



To be filled out by previous employer:

The above applicant is a former employee of yours and we would appreciate it if you would answer the questions below as truthfully as you can. Please be assured that all information will be held in strict confidence.

Worked for you in the position of: _____

Worked for you in the years of: _____

The applicant's

Reliability is	<input type="checkbox"/>	Excellent	<input type="checkbox"/>	Good	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor
Integrity is	<input type="checkbox"/>	Excellent	<input type="checkbox"/>	Good	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor
Conscientiousness is	<input type="checkbox"/>	Excellent	<input type="checkbox"/>	Good	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor
Intelligence is	<input type="checkbox"/>	Excellent	<input type="checkbox"/>	Good	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor
Neatness is	<input type="checkbox"/>	Excellent	<input type="checkbox"/>	Good	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor
Cooperation is	<input type="checkbox"/>	Excellent	<input type="checkbox"/>	Good	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor
Skill in position was	<input type="checkbox"/>	Excellent	<input type="checkbox"/>	Good	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor
Absenteeism was	<input type="checkbox"/>	Excellent	<input type="checkbox"/>	Good	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor

Would you re-employ the above named applicant? ☐ Yes ☐ No

Why? _____

Would you recommend the applicant for the position applied for? ☐ Yes ☐ No

What is the reason for separation? _____

Other comments / remarks: _____

Signature

Title:

NYS Department of Health

ACKNOWLEDGEMENT AND CONSENT FORM FOR FINGERPRINTING AND DISCLOSURE OF CRIMINAL HISTORY RECORD INFORMATION

THIS FORM IS TO BE RETAINED BY THE AGENCY- DO NOT FORWARD TO THE DOH CHRC UNIT.

chrc@health.state.ny.us

The purpose of this form is to obtain consent from the subject individual for fingerprints and criminal history record information pursuant to Article 28-E of the Public Health Law and Section 845-b of the Executive Law.

SECTION 1 – SUBJECT INDIVIDUAL INFORMATION

LAST Name	FIRST Name	M.I.	
Date of Birth (mm/dd/yyyy)	Mother's Maiden Name	Alias: AKA	
Mailing Address (street)	City	State	Zip

SECTION 2 - ATTESTATION

- I have applied to an agency to provide direct care or supervision to residents or patients. I understand that as part of the application process, the Public Health Law (PHL) Article 28-E requires that the New York State Department of Health perform a criminal history check on me with the New York State Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI).
- I acknowledge and consent to having my fingerprints taken for the purpose of a criminal history record check by the DCJS and the FBI.
- I have been advised that DOH is authorized by law to receive the results of the criminal history record check from DCJS and the FBI for the purpose of developing a criminal history record summary to be provided to the agency to which I applied for a position to provide direct care or supervision to residents or patients. I have been advised that the criminal history record summary will indicate whether I have a criminal history, as maintained by DCJS or the FBI, including convictions of a crime (felony or misdemeanor) or criminal charges which do not reflect a disposition. I have been advised that by law, DOH is authorized and may be required to provide the results of the criminal history record check through a criminal history record summary to the agency. The criminal history record summary prepared by DOH and sent to the agency will contain the results of the criminal history record check performed by DCJS. I have been advised that the information shall be confidential pursuant to applicable federal and state laws, rules and regulations and shall only be disclosed to persons authorized by law.
- I hereby consent to DOH sharing with any DCJS agency to which I applied for a position to provide direct care or supervision, any criminal history record check information provided to DOH by the FBI, including the specific crime(s) for which I was convicted or charged, the date of the arrest for such charge, and/or date of conviction, and the jurisdiction in which the arrest or conviction took place.
- I have been informed of the procedures and my rights to obtain, review and seek correction of my criminal history information pursuant to regulations and procedures established by the DCJS and the FBI.
- I understand that I have the right to withdraw my application for employment, without prejudice, any time before employment is offered or declined, regardless of whether an agency, DOH or I have reviewed my criminal history information.
- I certify to the best of my knowledge and belief that I (check as appropriate):

☐ **Have** ☐ **Have not been convicted of a crime in New York State or any other jurisdiction**
☐ **Do** ☐ **Do not have a final finding of patient or resident abuse**

 If you have checked either "Have" and/or "Do", please provide a brief explanation. (Optional)

8. My current mailing or home address is indicated in Section 1 of this form.

9. I have read this form and hereby consent to the request by the agency to use my fingerprints to obtain my criminal history record, if any, from the DCJS and the FBI. I hereby consent to the redisclosure of any convictions or open charges on my criminal history record, received by DOH from DCJS, to the requesting agency. I declare and affirm that the information I have provided on this consent form is true, complete and accurate and that the fingerprints to be submitted are my own (not applicable for Expedited Review submitted pursuant to CHRC Form 104).

Applicant Signature: _____ Date: _____

Signature of Parent or Legal Guardian _____ Date: _____
(if subject individual is under 18 years of age)

SECTION 3 – AGENCY AUTHORIZED PERSON INFORMATION

Agency Name: Fairview Nursing Care Center	PFI/Operating License Number: 1678
Print Name of Authorized Person:	Title:
Signature of Authorized Person:	Date:

<p>NYS Department of Health</p> <div style="text-align: center;">  </div> <p style="text-align: center;">CHRC Unit P. O. Box 2607 Albany, NY 12220-0607 Phone: 518.402.5549 Fax: 518.474.7477 www.nyhealth.gov/chrc chrc@health.state.ny.us</p>	<p>REQUEST FOR CRIMINAL HISTORY RECORD CHECK PAGE 1 INSTRUCTIONS</p> <p>CRIMINAL HISTORY RECORD CHECK (CHRC) PROGRAM</p>	<p style="text-align: right;"><i>For Department use only Leave blank</i></p>
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This form is to be used to request a criminal history record check (CHRC) for a subject individual from the DOH CHRC Unit.

For purposes of this form, the term **"Agency"** means residential health care facility, certified home health agency, licensed home care services agency or long term home health care programs that are authorized by law to request a check of criminal history record information pursuant to Article 28-E of the Public Health Law and Section 845-b of the Executive Law.

"Authorized Person" is the individual that is allowed to request, on behalf of the Agency, fingerprints and criminal history record checks.

"Subject individual" is an "employee" as defined by Public Health Law Section 2899(3).

INSTRUCTIONS:

1. This form is to be completed by the Authorized Person, who will sign and date where indicated in Section 3.
2. Please obtain subject individual information and complete all sections on page 2 of this form prior to or at the time of fingerprinting. This information will be used to conduct both a Federal and State criminal history record check pursuant to State law.
3. If subject individual is employed by a staffing organization with an Agency work location, the Agency is responsible for completing this form and the staffing agency may complete Section 4 if that staffing agency fingerprints the subject individual.
4. Subject individual is required to present two (2) forms of identification (ID) when fingerprinted. One must be a government-issued ID with subject individual's signature. At least one of the two forms of ID must contain a current photograph. Acceptable forms of government-issued IDs are: valid driver's license or Department of Motor Vehicles (DMV) ID, valid passport, valid military identification or valid school identification document. The type of government-issued ID presented is recorded in Section 2 of this form. Refer to the Employment Eligibility Verification Form I-9 for examples of other forms of identification. The second ID must be produced but not recorded in Section 2 of this form.
5. If subject applicant is fingerprinted by other than the Authorized Person, provide this instructional page to that individual for assistance in completing Section 4 of this form.
6. Authorized Person is to ensure that all fields in all sections must be completed for accurate and timely submissions.
7. Authorized Person will forward Page 2 of this Form to the DOH CHRC Unit at the address indicated above.

FIELD DESCRIPTIONS:

<p><u>SEX FIELD</u> M – Male F – Female</p>	<p><u>RACE FIELD</u> A – Chinese, Japanese, Filipino, Korean, Polynesian, Indian, Indonesian, Asian Indian, Samoan or any other Pacific Islander B – African black racial groups I – American Indian, Eskimo, or Alaskan native U – Of indeterminable race W – Caucasian, Mexican, Puerto Rican, Cuban, Central/South American or other Spanish origin</p>
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BIRTH COUNTRY/PLACE FIELD
Enter **United States of America** for those of American birth
Enter Country of Birth for those not of American birth

HEIGHT FIELD
To be completed as a three (3) character value. If reported in feet and inches, the first (leftmost) digit is used to show feet with the two rightmost digits are used to show the inches between 00 and 11. If reported in inches, the leftmost character is "N" followed by two digits. If height is unknown, 000 is entered.

The allowable range is 400 to 711. Heights shorter than 4 ft. will be recorded as 400 and taller than 7 ft. 11 in. will be recorded as 711.

WEIGHT FIELD
In this field, the subject applicant's weight in pounds is entered (000-499). If weight is unknown, 000 is entered.
All weight in excess of 499 pounds will be recorded as 499 lbs.

<p><u>HAIR FIELD – COLOR CODES</u> BAL – Bald BLK – Black BLN – Blonde or Strawberry BLU – Blue BRO – Brown GRN – Green GRY – Gray or Partially Gray ONG – Orange PNK – Pink PLE – Purple RED – Red or Auburn SDY – Sandy WHI – White XXX – Unknown</p>	<p><u>EYE FIELD – COLOR CODES</u> BLK – Black BLU – Blue BRO – Brown GRY – Gray GRN – Green HAZ – Hazel MAR – Maroon MUL – Multicolored PNK – Pink XXX – Unknown</p>
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DOH CHRC 103 (9/06) - Page 2

NYS Department of Health		CRIMINAL HISTORY RECORD CHECK	
Resubmission <input type="radio"/>	Type or print all information - USE CAPITAL LETTERS. Inaccurate, incomplete or illegible information will delay processing.		DOH use only. Leave blank
SECTION 1 - SUBJECT INDIVIDUAL INFORMATION			
Social Security Number* <input type="text"/> - <input type="text"/> - <input type="text"/>		Date of Birth mm/dd/yyyy <input type="text"/> / <input type="text"/> / <input type="text"/>	
LAST Name <input type="text"/>		FIRST Name <input type="text"/> M.I. <input type="text"/>	
Maiden Name <input type="text"/>		Alias (AKA) <input type="text"/>	
Street Nbr <input type="text"/>	Street Name <input type="text"/>		Apt # <input type="text"/>
City <input type="text"/>	St <input type="text"/>	Zip <input type="text"/>	Home Phone <input type="text"/> - <input type="text"/> - <input type="text"/>
Sex <input type="text"/>	Birth Country/Place <input type="text"/>	Cell Phone <input type="text"/> - <input type="text"/> - <input type="text"/>	
Race <input type="text"/>	Height (ft-inch) <input type="text"/> - <input type="text"/>	Weight (lbs) <input type="text"/>	Hair <input type="text"/> Eyes <input type="text"/>
SECTION 2 - SUBJECT INDIVIDUAL IDENTIFICATION			
Please Select the Type of PICTURE IDENTIFICATION (select one):			
<input type="radio"/> Drivers License/DMV ID <input type="radio"/> Passport <input type="radio"/> Military <input type="radio"/> School <input type="radio"/> Other Identify: <input type="text"/>			
Issuing State/Country/Armed Force/School: <input type="text"/>		ID Number <input type="text"/>	ID Expire Date mm/dd/yy <input type="text"/> / <input type="text"/> / <input type="text"/>
SECTION 3 - AGENCY IDENTIFICATION			
<input type="radio"/> Nursing Home <input type="radio"/> CHHA <input type="radio"/> LTHHCP PFI# <input type="text"/> <input type="radio"/> LHCSA LICENSE # <input type="text"/>			
Full name of Agency where applicant will be working <input type="text"/>		Telephone number with area code <input type="text"/> - <input type="text"/> - <input type="text"/>	
Authorized Person LAST Name <input type="text"/>		FIRST Name <input type="text"/>	
Agency's Street Nbr <input type="text"/>		Street Name <input type="text"/>	
City <input type="text"/>		State <input type="text"/>	Zip <input type="text"/>
Authorized Party's e-mail: <input type="text"/>			
The subject individual, whose identification I have confirmed, will provide direct care or supervision to individuals receiving care and/or services and is a subject individual concerning whom a criminal history record check is required by law (Article 28-E of the Public Health Law and Section 845-B of the Executive Law). I understand that the results of the criminal history record check will be used solely for purposes authorized by law and I will abide by the confidentiality requirements set forth in law. Informed consent (DOH CHRC Form 102) has been given by the subject individual and is on file.			
Signature of Agency Authorized Person: <input type="text"/>		Date: <input type="text"/> / <input type="text"/> / <input type="text"/> MM DD YY	
SECTION 4 - FINGERPRINTING METHOD/IDENTIFICATION			
Fingerprint Method: <input type="radio"/> Ink & Roll <input type="radio"/> Live Scan	Name & Address of Location where fingerprint services were performed <input type="text"/> <input type="text"/> City <input type="text"/> State <input type="text"/> Zip <input type="text"/>		
Identification verified before fingerprinting: (refer to Instruction #4) <input type="radio"/> Yes <input type="radio"/> No	The subject individual, whose identification I have confirmed, appeared before me for fingerprinting. I secured his/her fingerprints via the method indicated. Signature: <input type="text"/>	First Name: <input type="text"/> Last Name: <input type="text"/> Title: <input type="text"/>	Date Fingerprinted <input type="text"/> / <input type="text"/> / <input type="text"/> MM DD YYYY

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*The Authorized Person shall inform the subject individual that disclosure of the Social Security Number (SSN) is voluntary and not mandatory and that it will be used to assist DOH-CHRC Unit in performing criminal history record checks.



Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

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

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

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

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

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number [][][] - [][] - [][][][]		Employee's E-mail Address		Employee's Telephone Number	

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

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

<input type="checkbox"/> 1. A citizen of the United States
<input type="checkbox"/> 2. A noncitizen national of the United States (<i>See instructions</i>)
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. (<i>See instructions</i>) <i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i> 1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____
QR Code - Section 1 Do Not Write In This Space

Signature of Employee	Today's Date (mm/dd/yyyy)
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Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code



Employer Completes Next Page





Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

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

Section 2. Employer or Authorized Representative Review and Verification

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

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
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		<div>Additional Information</div> <div>QR Code - Sections 2 & 3 Do Not Write In This Space</div>		
Issuing Authority				
Document Number				
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)				

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment (mm/dd/yyyy): _____ (See instructions for exemptions)

Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)		Title of Employer or Authorized Representative	
Last Name of Employer or Authorized Representative		First Name of Employer or Authorized Representative		Employer's Business or Organization Name	
Employer's Business or Organization Address (Street Number and Name)			City or Town		State ZIP Code

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

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date (if any) (mm/dd/yyyy)
----------------	-----------------	---------------------------------------

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
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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
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (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. 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 		<ol style="list-style-type: none"> 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 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 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority For persons under age 18 who are unable to present a document listed above: 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record 	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.



Fairview Nursing Care Center

69-70 Grand Central Parkway, Forest Hills, New York 11375
Tel: 718.263.4600 Fax: 718.575.8945

AFFIRMATION OF APPLICANT REGARDING PRIOR FINDINGS AND/OR CONVICTIONS

I, _____, hereby state as follows:

1. I acknowledge that prior to being offered provisional employment, pursuant the New York State Department of Health's Criminal History Record Checks Regulations set forth under Title 10, Section 400.23 of the New York Code of Rules and Regulations ("Criminal History Regulations"), I must complete this sworn statement.

2. I certify that: (please check one)

() there have been no prior findings by any governmental agency or regulatory body of patient or resident abuse against me, nor have I ever been convicted of a crime or violation other than traffic infraction.

() there have been prior finding of patient or resident abuse against me by a governmental agency or regulatory body, and/or I have been convicted of a crime or violation other than traffic infraction, as explained below. (Use additional paper if necessary).

3. I understand that as part of satisfying the requirements of the Criminal History Regulations, The Attorney General of the United States will conduct a full search of records of the Federal Bureau of Investigation to ascertain if I have any record of criminal conviction. If the search reveals I have been convicted of certain enumerated crimes, my employment will be terminated.

I have read the above statement consisting of 3 numbered paragraphs. I fully understand its contents, and I certify it is true and correct to the best of my knowledge and belief.

(Prospective Employee Signature)

(Date)





Fairview Nursing Care Center

**69-70 Grand Central Parkway, Forest Hills, New York 11375
Tel: 718.263.4600 Fax: 718.575.8945**

AUTHORIZATION FOR SEARCH AND EXCHANGE OF INFORMATION

I, _____ hereby authorize Fairview Nursing Care Center, to submit a request to the Attorney General of the United States to conduct a search of the records of the Criminal Justice Information Services Division of the Federal Bureau of Investigation for any criminal history records corresponding to the fingerprints of other identification information submitted by me. I further authorize the exchange of such information between the Attorney General of the United States, the New York State Department of Health and Fairview Nursing Care Center. This information may be used only by Fairview Nursing Care Center and only for the purpose of determining my suitability for employment in a position involved in direct patient care supervision.

Signature: _____

Date: _____



Name: _____

(Print)

TERRIFIC SERVICES INC
129 S 8TH ST BROOKLYN, NY 11211
Tel: (718) 387-7702

- Payroll Information Form -
NOTICE AND ACKNOWLEDGEMENT OF PAY RATE AND PAYDAY

	Name (Last, First, MI)	Gender	Date of Birth	Social Security	
	Employment Date/ Date of Hire	Position/ Dept.	Starting Salary	For Payroll Period Ending	
Complete for All Changes	Mark All Applicable Boxes: <input type="checkbox"/> New Hire <input type="checkbox"/> Replacement for open position <input type="checkbox"/> Full Time <input type="checkbox"/> Staff (non- <input type="checkbox"/> Personal Data Change <input type="checkbox"/> Rehire <input type="checkbox"/> Reinstatement <input type="checkbox"/> Part Time <input type="checkbox"/> Union <input type="checkbox"/> New Address <input type="checkbox"/> Salary Change <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Temporary <input type="checkbox"/> Agency <input type="checkbox"/> Promotion <input type="checkbox"/> Termination <input type="checkbox"/> Transfer <input type="checkbox"/> Other Change				
	Hrs of work per week _____				
Complete For Addition to Payroll and Personal Data Changes	Street Address		City	State Zip	
	Apt Number		Home phone		
	Cell Phone		Emergency Contact:		
New Employees	CNA Registry Check Date:		Criminal Background Check Date:		
Notice and Acknowledgement of Pay Rate and Payday	Notice Given: <input type="checkbox"/> At hiring <input type="checkbox"/> Before a change in pay rate(s), allowances claimed or payday Regular Payday: Friday Pay is: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Other Overtime Pay Rate: _____/hr (Must be at least 1 1/2 times the worker's regular rate, w/ a few exceptions) Allowances Taken: <input type="checkbox"/> None <input type="checkbox"/> Tips _____/hr <input type="checkbox"/> Meals _____/meal <input type="checkbox"/> Lodging _____ <input type="checkbox"/> Other _____				
Complete For All Salary Changes	Salary and Position				
		Effective Date Day-Yr	Mo-	Position Title	Salary (Annual / Hourly) Reason for Change
	Previous Salary				
	Current Salary				
	New Salary				
	*Please note Fairview Benefit policy: There are no benefit payouts for unused benefit time. Benefits (PTO, Holiday, etc.) do not begin until after probation period ends.				
	Benefits	# Vacation Days _____	# Sick Days _____	# Holidays _____	# Personal Days _____ Birthday _____
Benefits	Medical : _____ Yes _____ No Dental: _____ Yes _____ No				
Complete for Inter-facility Transfer	From:		To:		
	Department		Department		
	Position		Position		
	Salary		Salary		
	Reason for Transfer:				
Complete for Leave	<input type="checkbox"/> Personal <input type="checkbox"/> Maternity <input type="checkbox"/> Illness <input type="checkbox"/> FMLA <input type="checkbox"/> Other			From:	Return:
	Reason for Leave:				
Complete for Termination	Date Of Payroll:		Basis for Termination Pay		
	Last Day Worked:	Separation Pay Days/Weeks	Vacation Days Earned _____ Taken _____ Due _____		Sick Days Earned _____ Taken _____ Due _____
	Type: <input type="checkbox"/> Discharge <input type="checkbox"/> Release <input type="checkbox"/> Resignation <input type="checkbox"/> Retirement <input type="checkbox"/> Disability <input type="checkbox"/> Death <input type="checkbox"/> Other				
	Eligible for Re-employment: <input type="checkbox"/> Yes <input type="checkbox"/> No		Reason for Termination:		
Employee Acknowledgement:	On this day, I have been notified of my pay rate, overtime rate (if eligible), allowances and designated payday. I told my employer what my primary language is. Check one <input type="checkbox"/> I have been given this pay notice in English because it is my primary language. <input type="checkbox"/> My primary language is _____. I have been given this pay notice in English only, because the Department of Labor does not yet offer a pay notice form in my primary language.				
	Employee Name: _____		Employee Signature: _____		Date: _____
	_____		_____		_____
	Department Head	Date	Administrator	Date	
	_____	_____	_____	_____	
Controller	Date	Owner	Date		
_____	_____	_____	_____		

Original: Employee Payroll File
cc: Employee

Personnel File

Accounting Purposes Only
Employee Number:

Employee's Withholding Certificate

- ▶ **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
 ▶ **Give Form W-4 to your employer.**
 ▶ **Your withholding is subject to review by the IRS.**

2020**Step 1:
Enter
Personal
Information**

(a) First name and middle initial	Last name	(b) Social security number
Address		▶ Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
City or town, state, and ZIP code		
(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly (or Qualifying widow(er)) <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.)		

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

**Step 2:
Multiple Jobs
or Spouse
Works**

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

Do **only one** of the following.

- (a) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3–4); **or**
 (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**
 (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld ▶ ☐

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

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

**Step 3:
Claim
Dependents**

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

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

Multiply the number of other dependents by \$500 ▶ \$ _____

Add the amounts above and enter the total here **3** \$ _____

**Step 4
(optional):
Other
Adjustments**

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

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

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

**Step 5:
Sign
Here**

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

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

**Employers
Only**

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

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.

Exemption from withholding. You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 **and** you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), 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 2020 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1a, 1b, and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2021.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

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

1. Expect to work only part of the year;
2. Have dividend or capital gain income, or are subject to additional taxes, such as the additional Medicare tax;
3. Have self-employment income (see below); or
4. Prefer the most accurate withholding for multiple job situations.

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.

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

If you (and your spouse) have a total of only two jobs, you may instead 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 roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount 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. Step 3 of Form W-4 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 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. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. 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 (optional).

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 5, if you expect to claim deductions other than the basic standard deduction on your 2020 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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.

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.

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 4. 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 4 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 4 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 (along with any other additional amount you want withheld) **4** \$ _____

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

- 1** Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 10% of your income **1** \$ _____
- 2** Enter: $\left\{ \begin{array}{l} \bullet \$24,800 \text{ if you're married filing jointly or qualifying widow(er)} \\ \bullet \$18,650 \text{ if you're head of household} \\ \bullet \$12,400 \text{ if you're single or married filing separately} \end{array} \right\}$ **2** \$ _____
- 3** If line 1 is greater than line 2, subtract line 2 from line 1. If line 2 is greater than line 1, enter "-0-" . . . **3** \$ _____
- 4** Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Schedule 1 (Form 1040 or 1040-SR)). See Pub. 505 for more information . . . **4** \$ _____
- 5 Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 **5** \$ _____

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 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.

Married Filing Jointly or Qualifying Widow(er)

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	\$220	\$850	\$900	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,210	\$1,870	\$1,870
\$10,000 - 19,999	220	1,220	1,900	2,100	2,220	2,220	2,220	2,220	2,410	3,410	4,070	4,070
\$20,000 - 29,999	850	1,900	2,730	2,930	3,050	3,050	3,050	3,240	4,240	5,240	5,900	5,900
\$30,000 - 39,999	900	2,100	2,930	3,130	3,250	3,250	3,440	4,440	5,440	6,440	7,100	7,100
\$40,000 - 49,999	1,020	2,220	3,050	3,250	3,370	3,570	4,570	5,570	6,570	7,570	8,220	8,220
\$50,000 - 59,999	1,020	2,220	3,050	3,250	3,570	4,570	5,570	6,570	7,570	8,570	9,220	9,220
\$60,000 - 69,999	1,020	2,220	3,050	3,440	4,570	5,570	6,570	7,570	8,570	9,570	10,220	10,220
\$70,000 - 79,999	1,020	2,220	3,240	4,440	5,570	6,570	7,570	8,570	9,570	10,570	11,220	11,240
\$80,000 - 99,999	1,060	3,260	5,090	6,290	7,420	8,420	9,420	10,420	11,420	12,420	13,260	13,460
\$100,000 - 149,999	1,870	4,070	5,900	7,100	8,220	9,320	10,520	11,720	12,920	14,120	14,980	15,180
\$150,000 - 239,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,190	16,050	16,250
\$240,000 - 259,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,520	17,170	18,170
\$260,000 - 279,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	13,120	15,120	17,120	18,770	19,770
\$280,000 - 299,999	2,040	4,440	6,470	7,870	9,190	10,720	12,720	14,720	16,720	18,720	20,370	21,370
\$300,000 - 319,999	2,040	4,440	6,470	8,200	10,320	12,320	14,320	16,320	18,320	20,320	21,970	22,970
\$320,000 - 364,999	2,720	5,920	8,750	10,950	13,070	15,070	17,070	19,070	21,290	23,590	25,540	26,840
\$365,000 - 524,999	2,970	6,470	9,600	12,100	14,530	16,830	19,130	21,430	23,730	26,030	27,980	29,280
\$525,000 and over	3,140	6,840	10,170	12,870	15,500	18,000	20,500	23,000	25,500	28,000	30,150	31,650

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	\$460	\$940	\$1,020	\$1,020	\$1,470	\$1,870	\$1,870	\$1,870	\$1,870	\$2,040	\$2,040	\$2,040
\$10,000 - 19,999	940	1,530	1,610	2,060	3,060	3,460	3,460	3,460	3,640	3,830	3,830	3,830
\$20,000 - 29,999	1,020	1,610	2,130	3,130	4,130	4,540	4,540	4,720	4,920	5,110	5,110	5,110
\$30,000 - 39,999	1,020	2,060	3,130	4,130	5,130	5,540	5,720	5,920	6,120	6,310	6,310	6,310
\$40,000 - 59,999	1,870	3,460	4,540	5,540	6,690	7,290	7,490	7,690	7,890	8,080	8,080	8,080
\$60,000 - 79,999	1,870	3,460	4,690	5,890	7,090	7,690	7,890	8,090	8,290	8,480	9,260	10,060
\$80,000 - 99,999	2,020	3,810	5,090	6,290	7,490	8,090	8,290	8,490	9,470	10,460	11,260	12,060
\$100,000 - 124,999	2,040	3,830	5,110	6,310	7,510	8,430	9,430	10,430	11,430	12,420	13,520	14,620
\$125,000 - 149,999	2,040	3,830	5,110	7,030	9,030	10,430	11,430	12,580	13,880	15,170	16,270	17,370
\$150,000 - 174,999	2,360	4,950	7,030	9,030	11,030	12,730	14,030	15,330	16,630	17,920	19,020	20,120
\$175,000 - 199,999	2,720	5,310	7,540	9,840	12,140	13,840	15,140	16,440	17,740	19,030	20,130	21,230
\$200,000 - 249,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
\$250,000 - 399,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
\$400,000 - 449,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,450	19,940	21,240	22,540
\$450,000 and over	3,140	6,230	8,810	11,310	13,810	15,710	17,210	18,710	20,210	21,700	23,000	24,300

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	\$830	\$930	\$1,020	\$1,020	\$1,020	\$1,480	\$1,870	\$1,870	\$1,930	\$2,040	\$2,040
\$10,000 - 19,999	830	1,920	2,130	2,220	2,220	2,680	3,680	4,070	4,130	4,330	4,440	4,440
\$20,000 - 29,999	930	2,130	2,350	2,430	2,900	3,900	4,900	5,340	5,540	5,740	5,850	5,850
\$30,000 - 39,999	1,020	2,220	2,430	2,980	3,980	4,980	6,040	6,630	6,830	7,030	7,140	7,140
\$40,000 - 59,999	1,020	2,530	3,750	4,830	5,860	7,060	8,260	8,850	9,050	9,250	9,360	9,360
\$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,780	10,980	11,180	11,580	12,380
\$80,000 - 99,999	1,900	4,300	5,710	7,000	8,200	9,400	10,600	11,180	11,670	12,670	13,580	14,380
\$100,000 - 124,999	2,040	4,440	5,850	7,140	8,340	9,540	11,360	12,750	13,750	14,750	15,770	16,870
\$125,000 - 149,999	2,040	4,440	5,850	7,360	9,360	11,360	13,360	14,750	16,010	17,310	18,520	19,620
\$150,000 - 174,999	2,040	5,060	7,280	9,360	11,360	13,480	15,780	17,460	18,760	20,060	21,270	22,370
\$175,000 - 199,999	2,720	5,920	8,130	10,480	12,780	15,080	17,380	19,070	20,370	21,670	22,880	23,980
\$200,000 - 249,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
\$250,000 - 349,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
\$350,000 - 449,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,900	25,200
\$450,000 and over	3,140	6,840	9,560	12,140	14,640	17,140	19,640	21,530	23,030	24,530	25,940	27,240



**Notice and Acknowledgement of Pay Rate and Payday
Under Section 195.1 of the New York State Labor Law
Notice for Hourly Rate Employees**

1. Employer Information

Name:

Doing Business As (DBA) Name(s):

FEIN (optional):

Physical Address:

Mailing Address:

Phone:

3. Employee's rate of pay:

\$ _____ per hour

4. Allowances taken:

- ☐ None
☐ Tips _____ per hour
☐ Meals _____ per meal
☐ Lodging _____
☐ Other _____

5. Regular payday: _____

6. Pay is:

- ☐ Weekly
☐ Bi-weekly
☐ Other _____

7. Overtime Pay Rate:

\$ _____ per hour (This must be at least
1½ times the worker's regular rate with
few exceptions.)

8. Employee Acknowledgement:

On this day I have been notified of my pay rate, overtime rate (if eligible), allowances, and designated pay day on the date given below. I told my employer what my primary language is.

Check one:

☐ I have been given this pay notice in English because it is my primary language.

☐ My primary language is _____. I have been given this pay notice in English only, because the Department of Labor does not yet offer a pay notice form in my primary language.

Print Employee Name

Employee Signature

Date

Preparer's Name and Title

The employee must receive a signed copy of this form. The employer must keep the original for 6 years.

Please note: It is unlawful for an employee to be paid less than an employee of the opposite sex for equal work. Employers also may not prohibit employees from discussing wages with their co-workers.

2. Notice given:

- ☐ At hiring
☐ Before a change in pay rate(s), allowances claimed or payday



Department of Taxation and Finance

Employee's Withholding Allowance Certificate

New York State • New York City • Yonkers

IT-2104

First name and middle initial		Last name		Your Social Security number	
Permanent home address (number and street or rural route)			Apartment number		Single or Head of household <input type="checkbox"/> Married <input type="checkbox"/>
City, village, or post office			State	ZIP code	Married, but withhold at higher single rate <input type="checkbox"/>
Note: If married but legally separated, mark an X in the <i>Single or Head of household</i> box.					
Are you a resident of New York City? Yes <input type="checkbox"/> No <input type="checkbox"/> Are you a resident of Yonkers? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Complete the worksheet on page 4 before making any entries.					
1 Total number of allowances you are claiming for New York State and Yonkers, if applicable (from line 20)				1	
2 Total number of allowances for New York City (from line 35)				2	
Use lines 3, 4, and 5 below to have additional withholding per pay period under special agreement with your employer.					
3 New York State amount				3	
4 New York City amount				4	
5 Yonkers amount				5	

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

Employee's signature	Date
----------------------	------

Penalty – A penalty of \$500 may be imposed for any false statement you make that decreases the amount of money you have withheld from your wages. You may also be subject to criminal penalties.

Employee: detach this page and give it to your employer; keep a copy for your records.

Employer: Keep this certificate with your records.

Mark an **X** in box A and/or box B to indicate why you are sending a copy of this form to New York State (see instructions):

A Employee claimed more than 14 exemption allowances for NYS A ☐

B Employee is a new hire or a rehire ... B ☐ First date employee performed services for pay (mm-dd-yyyy) (see instr.):

Are dependent health insurance benefits available for this employee? Yes ☐ No ☐

If Yes, enter the date the employee qualifies (mm-dd-yyyy):

Employer's name and address (Employer: complete this section only if you are sending a copy of this form to the NYS Tax Department.)	Employer identification number
--	--------------------------------

Instructions**Changes effective for 2020**

Form IT-2104 has been revised for tax year 2020. The worksheet on page 4 and the charts beginning on page 5, used to compute withholding allowances or to enter an additional dollar amount on line(s) 3, 4, or 5, have been revised. If you previously filed a Form IT-2104 and used the worksheet or charts, you should complete a new 2020 Form IT-2104 and give it to your employer.

Who should file this form

This certificate, Form IT-2104, is completed by an employee and given to the employer to instruct the employer how much New York State (and New York City and Yonkers) tax to withhold from the employee's pay. The more allowances claimed, the lower the amount of tax withheld.

If the federal Form W-4 you most recently submitted to your employer was for tax year 2019 or earlier, and you do not file Form IT-2104, your employer may use the same number of allowances you claimed on your federal Form W-4. Due to differences in tax law, this may result in the wrong amount of tax withheld for New York State, New York City, and Yonkers.

For tax years 2020 or later, withholding allowances are no longer reported on federal Form W-4. Therefore, if you submit a federal Form W-4 to your

employer for tax year 2020 or later, and you do not file Form IT-2104, your employer may use zero as your number of allowances. This may result in the wrong amount of tax withheld for New York State, New York City, and Yonkers.

Complete Form IT-2104 each year and file it with your employer if the number of allowances you may claim is different from federal Form W-4 or has changed. Common reasons for completing a new Form IT-2104 each year include the following:

- You started a new job.
- You are no longer a dependent.
- Your individual circumstances may have changed (for example, you were married or have an additional child).
- You moved into or out of NYC or Yonkers.
- You itemize your deductions on your personal income tax return.
- You claim allowances for New York State credits.
- You owed tax or received a large refund when you filed your personal income tax return for the past year.
- Your wages have increased and you expect to earn \$107,650 or more during the tax year.

- The total income of you and your spouse has increased to \$107,650 or more for the tax year.
- You have significantly more or less income from other sources or from another job.
- You no longer qualify for exemption from withholding.
- You have been advised by the Internal Revenue Service that you are entitled to fewer allowances than claimed on your original federal Form W-4 (submitted to your employer for tax year 2019 or earlier), and the disallowed allowances were claimed on your original Form IT-2104.
- You are a covered employee of an employer that has elected to participate in the Employer Compensation Expense Program.
- You made contributions to a New York Charitable Gifts Trust Fund (the Health Charitable Account or the Elementary and Secondary Education Account).

Exemption from withholding

You cannot use Form IT-2104 to claim exemption from withholding. To claim exemption from income tax withholding, you **must** file Form IT-2104-E, *Certificate of Exemption from Withholding*, with your employer. You must file a new certificate each year that you qualify for exemption. This exemption from withholding is allowable only if you had no New York income tax liability in the prior year, you expect none in the current year, **and** you are over 65 years of age, under 18, or a full-time student under 25. You may also claim exemption from withholding if you are a military spouse and meet the conditions set forth under the Servicemembers Civil Relief Act as amended by the Military Spouses Residency Relief Act and the Veterans Benefits and Transition Act. If you are a dependent who is under 18 or a full-time student, you may owe tax if your income is more than \$3,100.

Withholding allowances

You may **not** claim a withholding allowance for yourself or, if married, your spouse. Claim the number of withholding allowances you compute in Part 1 and Part 5 of the worksheet on page 4. If you want more tax withheld, you may claim fewer allowances. **If you claim more than 14 allowances**, your employer **must** send a copy of your **Form IT-2104** to the New York State Tax Department. You may then be asked to verify your allowances. If you arrive at negative allowances (less than zero) on lines 1 or 2 and your employer cannot accommodate negative allowances, **enter 0** and see *Additional dollar amount(s)* below.

Income from sources other than wages – If you have more than \$1,000 of income from sources other than wages (such as interest, dividends, or alimony received), reduce the number of allowances claimed on line 1 and line 2 (if applicable) of the IT-2104 certificate by one for each \$1,000 of nonwage income. If you arrive at negative allowances (less than zero), see *Withholding allowances* above. You may also consider making estimated tax payments, especially if you have significant amounts of nonwage income. Estimated tax requires that payments be made by the employee directly to the Tax Department on a quarterly basis. For more information, see the instructions for Form IT-2105, *Estimated Tax Payment Voucher for Individuals*, or see *Need help?* on page 7.

Other credits (Worksheet line 14) – If you will be eligible to claim any credits other than the credits listed in the worksheet, such as an investment tax credit, you may claim additional allowances.

Find your filing status and your New York adjusted gross income (NYAGI) in the chart below, and divide the amount of the expected credit by the number indicated. Enter the result (rounded to the nearest whole number) on line 14.

Single and NYAGI is:	Head of household and NYAGI is:	Married and NYAGI is:	Divide amount of expected credit by:
Less than \$215,400	Less than \$269,300	Less than \$323,200	65
Between \$215,400 and \$1,077,550	Between \$269,300 and \$1,616,450	Between \$323,200 and \$2,155,350	68
Over \$1,077,550	Over \$1,616,450	Over \$2,155,350	88

Example: You are married and expect your New York adjusted gross income to be less than \$323,200. In addition, you expect to receive a flow-through of an investment tax credit from the S corporation of which

you are a shareholder. The investment tax credit will be \$160. Divide the expected credit by 65. $160/65 = 2.4615$. The additional withholding allowance(s) would be 2. Enter 2 on line 14.

Married couples with both spouses working – If you and your spouse both work, you should each file a separate IT-2104 certificate with your respective employers. Your withholding will better match your total tax if the higher wage-earning spouse claims all of the couple's allowances and the lower wage-earning spouse claims zero allowances. **Do not** claim more total allowances than you are entitled to. If your combined wages are:

- less than \$107,650, you should each mark an **X** in the box *Married, but withhold at higher single rate* on the certificate front, and divide the total number of allowances that you compute on line 20 and line 35 (if applicable) between you and your working spouse.
- \$107,650 or more, use the chart(s) in Part 6 and enter the additional withholding dollar amount on line 3.

Taxpayers with more than one job – If you have more than one job, file a separate IT-2104 certificate with each of your employers. Be sure to claim only the total number of allowances that you are entitled to. Your withholding will better match your total tax if you claim all of your allowances at your higher-paying job and zero allowances at the lower-paying job. In addition, to make sure that you have enough tax withheld, if you are a single taxpayer or head of household with two or more jobs, and your combined wages from all jobs are under \$107,650, reduce the number of allowances by seven on line 1 and line 2 (if applicable) on the certificate you file with your higher-paying job employer. If you arrive at negative allowances (less than zero), see *Withholding allowances* above.

If you are a single or a head of household taxpayer, and your combined wages from all of your jobs are between \$107,650 and \$2,263,265, use the chart(s) in Part 7 and enter the additional withholding dollar amount from the chart on line 3.

If you are a married taxpayer, and your combined wages from all of your jobs are \$107,650 or more, use the chart(s) in Part 6 and enter the additional withholding dollar amount from the chart on line 3 (Substitute the words *Higher-paying job for Higher earner's wages* within the chart).

Dependents – If you are a dependent of another taxpayer and expect your income to exceed \$3,100, you should reduce your withholding allowances by one for each \$1,000 of income over \$2,500. This will ensure that your employer withholds enough tax.

Following the above instructions will help to ensure that you will not owe additional tax when you file your return.

Heads of households with only one job – If you will use the head-of-household filing status on your state income tax return, mark the *Single or Head of household* box on the front of the certificate. If you have only one job, you may also wish to claim two additional withholding allowances on line 15.

Additional dollar amount(s)

You may ask your employer to withhold an additional dollar amount each pay period by completing lines 3, 4, and 5 on Form IT-2104. In most instances, if you compute a negative number of allowances and your employer cannot accommodate a negative number, for each negative allowance claimed you should have an additional \$1.85 of tax withheld per week for New York State withholding on line 3, and an additional \$0.80 of tax withheld per week for New York City withholding on line 4. Yonkers residents should use 16.75% (.1675) of the New York State amount for additional withholding for Yonkers on line 5.

Note: If you are requesting your employer to withhold an additional dollar amount on lines 3, 4, or 5 of this allowance certificate, the additional dollar amount, as determined by these instructions or by using the chart(s) in Part 6 or Part 7, is accurate for a weekly payroll. Therefore, if you are not paid on a weekly basis, you will need to adjust the dollar amount(s) that you compute. For example, if you are paid biweekly, you must double the dollar amount(s) computed.

Avoid underwithholding

Form IT-2104, together with your employer's withholding tables, is designed to ensure that the correct amount of tax is withheld from your pay. If you fail to have enough tax withheld during the entire year, you may owe a large tax liability when you file your return. The Tax Department must assess interest and may impose penalties in certain situations in addition to the tax liability. Even if you do not file a return, we may determine

that you owe personal income tax, and we may assess interest and penalties on the amount of tax that you should have paid during the year.

Employers

Box A – If you are required to submit a copy of an employee's Form IT-2104 to the Tax Department because the employee claimed more than 14 allowances, mark an **X** in box A and send a copy of Form IT-2104 to: **NYS Tax Department, Income Tax Audit Administrator, Withholding Certificate Coordinator, W A Harriman Campus, Albany NY 12227-0865**. If the employee is also a new hire or rehire, see **Box B** instructions. See Publication 55, *Designated Private Delivery Services*, if not using U.S. Mail.

Due dates for sending certificates received from employees claiming more than 14 allowances are:

Quarter	Due date	Quarter	Due date
January – March	April 30	July – September	October 31
April – June	July 31	October – December	January 31

Box B – If you are submitting a copy of this form to comply with New York State's New Hire Reporting Program, mark an **X** in box B. Enter the first day any services are performed for which the employee will be paid wages, commissions, tips and any other type of compensation. For services based solely on commissions, this is the first day an employee working for commissions is eligible to earn commissions. Also, mark an **X** in the *Yes* or *No* box indicating if dependent health insurance benefits are available to this employee. If *Yes*, enter the date the employee qualifies for coverage. Mail the completed form, within 20 days of hiring, to: **NYS Tax Department, New Hire Notification, PO Box 15119, Albany NY 12212-5119**. To report newly-hired or rehired employees online instead of submitting this form, go to <https://www.nynewhire.com>.

(continued)

Worksheet**See the instructions before completing this worksheet.****Part 1 – Complete this part to compute your withholding allowances for New York State and Yonkers (line 1).**

6	Enter the number of dependents that you will claim on your state return (<i>do not include yourself or, if married, your spouse</i>)	6	_____
For lines 7, 8, and 9, enter 1 for each credit you expect to claim on your state return.			
7	College tuition credit	7	_____
8	New York State household credit	8	_____
9	Real property tax credit	9	_____
For lines 10, 11, and 12, enter 3 for each credit you expect to claim on your state return.			
10	Child and dependent care credit	10	_____
11	Earned income credit	11	_____
12	Empire State child credit	12	_____
13	New York City school tax credit: If you expect to be a resident of New York City for any part of the tax year, enter 2	13	_____
14	Other credits (<i>see instructions</i>)	14	_____
15	Head of household status and only one job (<i>enter 2 if the situation applies</i>)	15	_____
16	Enter an estimate of your federal adjustments to income, such as deductible IRA contributions you will make for the tax year. Total estimate \$ _____. Divide this estimate by \$1,000. Drop any fraction and enter the number	16	_____
17	If you expect to be a covered employee of an employer who elected to pay the employer compensation expense tax in 2020, complete Part 3 below and enter the number from line 29	17	_____
18	If you made contributions in 2019 to a New York Charitable Gifts Trust Fund (the Health Charitable Account or the Elementary and Secondary Education Account), complete Part 4 below and enter the amount from line 32	18	_____
19	If you expect to itemize deductions on your state tax return, complete Part 2 below and enter the number from line 24. All others enter 0	19	_____
20	Add lines 6 through 19. Enter the result here and on line 1. If you have more than one job, or if you and your spouse both work, see instructions for <i>Taxpayers with more than one job</i> or <i>Married couples with both spouses working</i>	20	_____

Part 2 – Complete this part only if you expect to itemize deductions on your state return.

21	Enter your estimated NY itemized deductions for the tax year (<i>see Form IT-196 and its instructions; enter the amount from line 49</i>)	21	_____
22	Based on your federal filing status, enter the applicable amount from the table below	22	_____

Single (cannot be claimed as a dependent)	\$ 8,000	Qualifying widow(er)	\$16,050
Single (can be claimed as a dependent)	\$ 3,100	Married filing jointly	\$16,050
Head of household	\$11,200	Married filing separate returns	\$ 8,000

23	Subtract line 22 from line 21 (<i>if line 22 is larger than line 21, enter 0 here and on line 19 above</i>)	23	_____
24	Divide line 23 by \$1,000. Drop any fraction and enter the result here and on line 19 above	24	_____

Part 3 – Complete this part if you expect to be a covered employee of an employer that has elected to participate in the Employer Compensation Expense Program (line 17).

25	Expected annual wages and compensation from electing employer in 2020	25	_____
26	Line 25 minus \$40,000 (if zero or less, stop)	26	_____
27	Line 26 multiplied by .03	27	_____
28	Line 27 multiplied by .935	28	_____
29	Divide line 28 by 65. Drop any fraction and enter the result here and on line 17 above	29	_____

Part 4 – Complete this part if you made contributions in 2019 to the Health Charitable Account or the Elementary and Secondary Education Account (line 18).

30	Contributions to these funds in 2019	30	_____
31	Multiply line 30 by 85% (.85)	31	_____
32	Divide line 31 by 60. Drop any fraction and enter the result here and on line 18 above	32	_____

Part 5 – Complete this part to compute your withholding allowances for New York City (line 2).

33	Enter the amount from line 6 above	33	_____
34	Add lines 15 through 19 above and enter total here	34	_____
35	Add lines 33 and 34. Enter the result here and on line 2	35	_____

Part 6 – These charts are only for married couples with both spouses working or married couples with one spouse working more than one job, and whose combined wages are between \$107,650 and \$2,263,265.

Enter the additional withholding dollar amount on line 3.

The additional dollar amount, as shown below, is accurate for a weekly payroll. If you are not paid on a weekly basis, you will need to adjust these dollar amount(s). For example, if you are paid biweekly, you must double the dollar amount(s) computed.

[illegible][illegible]

		Combined wages between \$1,185,400 and \$1,724,299									
Higher earner's wages		\$1,185,400	\$1,239,250	\$1,293,200	\$1,347,050	\$1,400,950	\$1,454,850	\$1,508,700	\$1,562,550	\$1,616,450	\$1,670,400
		\$1,239,249	\$1,293,199	\$1,347,049	\$1,400,949	\$1,454,849	\$1,508,699	\$1,562,549	\$1,616,449	\$1,670,399	\$1,724,299
\$592,650	\$646,499	\$5	\$8								
\$646,500	\$700,399	\$5	\$8	\$11	\$14						
\$700,400	\$754,299	\$5	\$8	\$11	\$14	\$18	\$21				
\$754,300	\$808,199	\$5	\$8	\$11	\$14	\$18	\$21	\$24	\$27		
\$808,200	\$862,049	\$5	\$8	\$11	\$14	\$18	\$21	\$24	\$27	\$30	\$33
\$862,050	\$915,949	\$32	\$8	\$11	\$14	\$18	\$21	\$24	\$27	\$30	\$33
\$915,950	\$969,899	\$28	\$36	\$11	\$14	\$18	\$21	\$24	\$27	\$30	\$33
\$969,900	\$1,023,749	\$23	\$31	\$39	\$14	\$18	\$21	\$24	\$27	\$30	\$33
\$1,023,750	\$1,077,549	\$29	\$26	\$34	\$42	\$18	\$21	\$24	\$27	\$30	\$33
\$1,077,550	\$1,131,499	\$33	\$30	\$28	\$36	\$43	\$19	\$22	\$25	\$28	\$32
\$1,131,500	\$1,185,399	\$21	\$33	\$30	\$28	\$36	\$43	\$19	\$22	\$25	\$28
\$1,185,400	\$1,239,249	\$9	\$21	\$33	\$30	\$28	\$36	\$43	\$19	\$22	\$25
\$1,239,250	\$1,293,199		\$9	\$21	\$33	\$30	\$28	\$36	\$43	\$19	\$22
\$1,293,200	\$1,347,049			\$9	\$21	\$33	\$30	\$28	\$36	\$43	\$19
\$1,347,050	\$1,400,949				\$9	\$21	\$33	\$30	\$28	\$36	\$43
\$1,400,950	\$1,454,849					\$9	\$21	\$33	\$30	\$28	\$36
\$1,454,850	\$1,508,699						\$9	\$21	\$33	\$30	\$28
\$1,508,700	\$1,562,549							\$9	\$21	\$33	\$30
\$1,562,550	\$1,616,449								\$9	\$21	\$33
\$1,616,450	\$1,670,399									\$9	\$21
\$1,670,400	\$1,724,299										\$9

		Combined wages between \$1,724,300 and \$2,263,265									
Higher earner's wages		\$1,724,300	\$1,778,150	\$1,832,050	\$1,885,950	\$1,939,800	\$1,993,700	\$2,047,600	\$2,101,500	\$2,155,350	\$2,209,300
		\$1,778,149	\$1,832,049	\$1,885,949	\$1,939,799	\$1,993,699	\$2,047,599	\$2,101,499	\$2,155,349	\$2,209,299	\$2,263,265
\$862,050	\$915,949	\$36	\$39								
\$915,950	\$969,899	\$36	\$39	\$42	\$46						
\$969,900	\$1,023,749	\$36	\$39	\$42	\$46	\$49	\$52				
\$1,023,750	\$1,077,549	\$36	\$39	\$42	\$46	\$49	\$52	\$55	\$58		
\$1,077,550	\$1,131,499	\$35	\$38	\$41	\$44	\$47	\$50	\$53	\$56	\$490	\$906
\$1,131,500	\$1,185,399	\$32	\$35	\$38	\$41	\$44	\$47	\$50	\$53	\$487	\$906
\$1,185,400	\$1,239,249	\$28	\$32	\$35	\$38	\$41	\$44	\$47	\$50	\$484	\$903
\$1,239,250	\$1,293,199	\$25	\$28	\$32	\$35	\$38	\$41	\$44	\$47	\$481	\$900
\$1,293,200	\$1,347,049	\$22	\$25	\$28	\$32	\$35	\$38	\$41	\$44	\$477	\$897
\$1,347,050	\$1,400,949	\$19	\$22	\$25	\$28	\$32	\$35	\$38	\$41	\$474	\$894
\$1,400,950	\$1,454,849	\$43	\$19	\$22	\$25	\$28	\$32	\$35	\$38	\$471	\$891
\$1,454,850	\$1,508,699	\$36	\$43	\$19	\$22	\$25	\$28	\$32	\$35	\$468	\$888
\$1,508,700	\$1,562,549	\$28	\$36	\$43	\$19	\$22	\$25	\$28	\$32	\$465	\$885
\$1,562,550	\$1,616,449	\$30	\$28	\$36	\$43	\$19	\$22	\$25	\$28	\$462	\$881
\$1,616,450	\$1,670,399	\$33	\$30	\$28	\$36	\$43	\$19	\$22	\$25	\$459	\$878
\$1,670,400	\$1,724,299	\$21	\$33	\$30	\$28	\$36	\$43	\$19	\$22	\$456	\$875
\$1,724,300	\$1,778,149	\$9	\$21	\$33	\$30	\$28	\$36	\$43	\$19	\$453	\$872
\$1,778,150	\$1,832,049		\$9	\$21	\$33	\$30	\$28	\$36	\$43	\$449	\$869
\$1,832,050	\$1,885,949			\$9	\$21	\$33	\$30	\$28	\$36	\$474	\$866
\$1,885,950	\$1,939,799				\$9	\$21	\$33	\$30	\$28	\$466	\$890
\$1,939,800	\$1,993,699					\$9	\$21	\$33	\$30	\$458	\$882
\$1,993,700	\$2,047,599						\$9	\$21	\$33	\$461	\$875
\$2,047,600	\$2,101,499							\$9	\$21	\$464	\$877
\$2,101,500	\$2,155,349								\$9	\$451	\$880
\$2,155,350	\$2,209,299									\$235	\$438
\$2,209,300	\$2,263,265										\$14

Note: These charts do not account for additional withholding in the following instances:

- a married couple with both spouses working, where one spouse's wages are more than \$1,131,632 but less than \$2,263,265, and the other spouse's wages are also more than \$1,131,632 but less than \$2,263,265;
- married taxpayers with only one spouse working, and that spouse works more than one job, with wages from each job under \$2,263,265, but combined wages from all jobs is over \$2,263,265.

If you are in one of these situations and you would like to request an additional dollar amount of withholding from your wages, please contact the Tax Department for assistance (see *Need help?* on page 7).

Part 7 – These charts are only for single taxpayers and head of household taxpayers with more than one job, and whose combined wages are between \$107,650 and \$2,263,265.

Enter the additional withholding dollar amount on line 3.

The additional dollar amount, as shown below, is accurate for a weekly payroll. If you are not paid on a weekly basis, you will need to adjust these dollar amount(s). For example, if you are paid biweekly, you must double the dollar amount(s) computed.

Combined wages between \$107,650 and \$538,749											
Higher wage	\$107,650 \$129,249	\$129,250 \$150,749	\$150,750 \$172,299	\$172,300 \$193,849	\$193,850 \$236,949	\$236,950 \$280,099	\$280,100 \$323,199	\$323,200 \$377,099	\$377,100 \$430,949	\$430,950 \$484,899	\$484,900 \$538,749
\$53,800 \$75,299	\$13	\$18									
\$75,300 \$96,799	\$12	\$20	\$27	\$26							
\$96,800 \$118,399	\$8	\$17	\$24	\$27	\$28						
\$118,400 \$129,249	\$2	\$11	\$18	\$21	\$26	\$35					
\$129,250 \$139,999		\$4	\$14	\$17	\$22	\$39					
\$140,000 \$150,749		\$2	\$10	\$13	\$19	\$39	\$38				
\$150,750 \$161,549			\$3	\$10	\$15	\$38	\$36				
\$161,550 \$172,499			\$1	\$7	\$13	\$38	\$38	\$36			
\$172,500 \$193,849				\$3	\$10	\$36	\$42	\$38	\$37		
\$193,850 \$236,949					\$11	\$31	\$44	\$42	\$42	\$25	
\$236,950 \$280,099						\$9	\$18	\$29	\$25	\$28	\$15
\$280,100 \$323,199							\$7	\$17	\$27	\$22	\$26
\$323,200 \$377,099								\$8	\$18	\$27	\$22
\$377,100 \$430,949									\$8	\$18	\$27
\$430,950 \$484,899										\$8	\$18
\$484,900 \$538,749											\$8

		Combined wages between \$538,750 and \$1,185,399											
Higher wage		\$538,750 \$592,649	\$592,650 \$646,499	\$646,500 \$700,399	\$700,400 \$754,299	\$754,300 \$808,199	\$808,200 \$862,049	\$862,050 \$915,949	\$915,950 \$969,899	\$969,900 \$1,023,749	\$1,023,750 \$1,077,549	\$1,077,550 \$1,131,499	\$1,131,500 \$1,185,399
\$236,950	\$280,099	\$9											
\$280,100	\$323,199	\$9	\$8										
\$323,200	\$377,099	\$26	\$8	\$8	\$8								
\$377,100	\$430,949	\$22	\$26	\$8	\$8	\$8	\$8						
\$430,950	\$484,899	\$27	\$22	\$26	\$8	\$8	\$8	\$8	\$8				
\$484,900	\$538,749	\$18	\$27	\$22	\$26	\$8	\$8	\$8	\$8	\$8	\$8		
\$538,750	\$592,649	\$8	\$18	\$27	\$22	\$26	\$8	\$8	\$8	\$8	\$8	\$236	\$451
\$592,650	\$646,499		\$8	\$18	\$27	\$22	\$26	\$8	\$8	\$8	\$8	\$236	\$451
\$646,500	\$700,399			\$8	\$18	\$27	\$22	\$26	\$8	\$8	\$8	\$236	\$451
\$700,400	\$754,299				\$8	\$18	\$27	\$22	\$26	\$8	\$8	\$236	\$451
\$754,300	\$808,199					\$8	\$18	\$27	\$22	\$26	\$8	\$236	\$451
\$808,200	\$862,049						\$8	\$18	\$27	\$22	\$26	\$236	\$451
\$862,050	\$915,949							\$8	\$18	\$27	\$22	\$254	\$451
\$915,950	\$969,899								\$8	\$18	\$27	\$250	\$470
\$969,900	\$1,023,749									\$8	\$18	\$255	\$465
\$1,023,750	\$1,077,549										\$8	\$246	\$471
\$1,077,550	\$1,131,499											\$123	\$233
\$1,131,500	\$1,185,399												\$14

(Part 7 continued on page 8)

Privacy notification

See our website or Publication 54, *Privacy Notification*.

Need help?



Visit our website at **www.tax.ny.gov**

- get information and manage your taxes online
- check for new online services and features

Telephone assistance

Automated income tax refund status: 518-457-5149

Personal Income Tax Information Center: 518-457-5181

To order forms and publications: 518-457-5431

Text Telephone (TTY) or TDD
equipment users

Dial 7-1-1 for the
New York Relay Service

[illegible][illegible]



Fairview Nursing Care Center

69-70 Grand Central Parkway, Forest Hills, New York 11375
Tel: 718.263.4600 Fax: 718.575.8945

Health Examination Report - Page 1

Employee Name: (Please PRINT) _____ Age: _____

B.P.: _____ Pulse: _____ Weight: _____ Height: _____

General Appearance: _____

Eyes: _____ Orthopedic (Musculoskeletal): _____

ENT: _____ Neurological (Reflexes): _____

Neck: _____ Mental Status: _____

Heart: _____ Disabilities/Handicaps: _____

Lungs: _____ Present Medication: _____

I understand that the information disclosed on this health report is for the use of my employer and the health examination, which I am having the date indicated above, is not intended to be relied upon by me as an indication of my general state of health. I have read the above and declare that I have had no illness or ailment other than as noted above. Any falsification or misrepresentation will be sufficient grounds for my release from employment.

Employee's Signature: _____ Date: _____



Based upon available date, the above named employee is free from any health impairment or chemical dependence, which if of potential risk to patients or residents, or that may interfere with performance of his/her duties.

If no, explain: _____

Physician Name: _____ License #: _____ Date: _____

Physician Signature: _____



Fairview Nursing Care Center

69-70 Grand Central Parkway, Forest Hills, New York 11375
Tel: 718.263.4600 Fax: 718.575.8945

Health Examination Report - Page 2

Employee Name: _____ Date: _____

Mantoux Test (PPD):

Date Given Brand Lot # Signature of Individual Giving the Test

Date Read Results in MM Signature of Individual Reading the Test

- Results of PPD Test must be recorded in mm. If no reaction, record 0.
- If Positive, chest x-ray required.
- Positive Mantoux test must be reported to the Director of Nursing

Chest X-Ray Results: Date: _____ (Please attach X-Ray results)

Immunizations:

Measles	Circle: Immunization / Titer	_____ Date Done	_____ Results
Mumps	Circle: Immunization / Titer	_____ Date Done	_____ Results
Rubella	Circle: Immunization / Titer	_____ Date Done	_____ Results
Hepatitis B	Circle: Immunization / Titer	_____ Date Done	_____ Results
Influenza	Circle: Immunization / Titer	_____ Date Done	_____ Results
Varicella	Circle: Immunization / Titer	_____ Date Done	_____ Results

Physician's name Physician's Signature Date