New Hire Checklist

Employee Name:	
Paperwork Appt. Date:	
Hire Date:	

	Requirement:	Notes:
	Employment Application	
	Reference Checks Completed (minimum 2)	
	Welcome/Confirmation Letter	
	Payroll Change Form	
	Parent/Guardian Authorization	
	Position Control Updated	
	Fingerprint Background Check Application	
	Fingerprints Completed	
	Fingerprint Results Printed and Filed	
	State W-4	
	Federal W-4	
	I9 Verification with Documentation	
	Direct Deposit Form	
	IDES Report Form	
	Employee Handbook Acknowledgment	
	Benefit Summary	
	Benefit Acknowledgment	
	Benefit Enrollment Forms	
	Daycare – Provide Information and let LPLC know	
	Substance Abuse Policy	
	Pre-Employment Physical Form	
	Position Physical Demands Analysis	
	Hepatitis B Vaccine Acknowledgement	
	Attendance Policy	
	Job Description	
	Driving Record (if applicable, copy of license to Nikki)	
	Conduct Expectations	
	Grievance Policy	
	Disciplinary Action Policy	
	HIPPA/Privacy Acknowledgment	
	Professional Licenses – Copies for File	
	CPR/BLS/ACLS	
	Professional Licenses – Verified and Documented in File	
	Added to License Tracking Spreadsheet	
	OIG Check	
	Add employment on Fingerprint Registry	
	Colleen Processed File	
	Dessie Processed File	
	Pre-Employment Physical Completed	
	Pre-Employment Drug Screen Completed	
	Facility Orientation Completed (documented in file)	
	Follow up on hiring experience, etc.	

Winning Wheels, Inc. Pre-Employment Physical and Drug Screen

Please contact the Morrison Family Care Clinic at 815-772-4003 to schedule. They are open 7 days a week 8:00am-6:00pm. The Morrison Family Care Clinic is located inside the Morrison Community Hospital:

303 N Jackson St.
Morrison, IL 61270

You will need to take the attached drug screen request form and pre-employment physical form. Once you have the forms completed, please return them to Amber Schaefer at the Lyndon Progress Center and you will be scheduled for your first day at the facility.

Amber Schaefer, HR Director
Lyndon Progress Center
501 6th Avenue West
Lyndon, IL 61261
815-778-3683 phone
815-778-4503 fax
aschaefer@aheinco.com

MORRISON COMMUNITY HOSPITAL

303 N. JACKSON ST.

MORRISON, IL 61270

815-772-5536 - LABORATORY

DRUG SCREEN REQUEST FORM

DATE:_____ TIME:_____

CLIENT NAME:_____

_____ PRE-EMPLOYMENT URINE DRUG SCREEN COLLECTION

_____ POST-ACCIDENT URINE DRUG SCREEN COLLECTION

_____ CAUSE FOR SUSPICION URINE DRUG SCREEN COLLECTION

_____ DOT URINE DRUG SCREEN COLLECTION AND PROCESSING ONLY

_____ URINE DRUG SCREEN TEST ON-SITE (REFLEX CONFIRMATION TESTING)

_____ MISC:_____

Above test results are to be billed and sent to:_____

Address:_____

_____

Phone:_____

Fax:_____

Signature of Company Representative:_____

POST-OFFER
PHYSICAL EXAMINATION

Last Name: _____ First Name:_____ Physician:_____ Date:_____

Age:_____ Wt:_____ Ht:_____ Temp:_____ Pulse:_____ Resp:_____

Person Free of Communicable Diseases? ☐Yes ☐No If no, please explain:_____

MEDICAL HISTORY:

Hepatitis	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Mental Illness	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Heart Trouble	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Cancer	☐ Yes	☐ No

If Yes is answered to any of the above conditions, please explain:_____

PHYSICAL EXAMINATION

General Appearance: (Including skin)_____

History of Any Major Medical Conditions ☐ Yes ☐ No If Yes, Explain:_____

History of Mental Illness ☐ Yes ☐ No If Yes, Explain:_____

History of Any Major Surgeries ☐ Yes ☐ No If Yes, Explain:_____

Head (Eyes, Ear, Nose, Throat, Teeth)_____

History of Head Aches ☐ Yes ☐ No If Yes, Explain:_____

Neck_____

History of Neck Pain ☐ Yes ☐ No If Yes, Explain:_____

Back and Spine (Including Test for Flexibility)_____

History of Back or Spine Problems ☐ Yes ☐ No If Yes, Explain:_____

Chronic Back Pain ☐ Yes ☐ No If Yes, Explain:_____

Lungs/Chest_____

Persistent Cough ☐ Yes ☐ No If Yes, Explain:_____

Past Chest X-Ray_____Date Reason:_____

Abdomen_____

History of Hernia(s) ☐ Yes ☐ No If Yes, Explain:_____

History of Abdominal Pain ☐ Yes ☐ No If Yes, Explain:_____

History of Heart Trouble ☐ Yes ☐ No If Yes, Explain:_____

Musculoskeletal_____

Feet_____

History of Any Joint Pain (Wrist, Ankle, Knee) ☐ Yes ☐ No If Yes, Explain:_____

Position specific physical demands analysis reviewed and cleared for employment :

☐ Yes ☐ No If No, Explain:_____

PHYSICIAN SIGNATURE:_____ DATE:_____

WINNING WHEELS PAYROLL CHANGE FORM

HR Director

Employee Name: _____ Clock #: _____

Start Date: _____ Termination Date: _____

Reason for Termination: _____

Type of Change: ◯ New Hire ◯ Re-Hire ◯ Term ◯ Change

Home Address: _____

City, State, Zip: _____

ID Number: _____ Phone Number: _____

Birthdate: _____ SSN: _____

Pay Rate: _____ Department: _____

Status: ◯ Full-Time ◯ Part-Time ◯ Part-Time Insurance ◯ PRN ◯ LOA

INFORMATION FROM FEDERAL W4:

Tax Exempt: ◯ Write "EXEMPT" in the space below 4c

1c: Single, Married Jointly, or Head of Household_____

2c: Box Checked ◯

3: Dependent Amount $_____

4a: Other Income Amount $_____

4b: Deductions Amount $_____

4c: Extra Withholding Amount $_____

INFORMATION FROM STATE W4:

IL ◯ IA ◯

Tax Exempt: ◯

1)Number of Basic Allowances (IL): _____

2)Additional Allowances (IL):_____

3)Additional Amount W/H (IL):$_____

6)Total Allowances (IA):_____

7)Additional Amount W/H (IA):$_____

Date Certified: _____ # Years Certified: _____

NOTES:

Change Requested By: _____ Date: _____

Instructions: Fill in form, choose "FILE" then "SAVE AS", name form as Employee's name. Next, choose "FILE" then "ATTACH TO EMAIL" and send to atopp@aheinco.com, crillie@aheinco.com, and dkpyse@aheinco.com.

State of Illinois
Department of Employment Security

New Hire Reporting Form

Employers must report each new hire within 20 days. **Assistance: 1 800 327-HIRE (4473)**

Please print or type

EMPLOYER NAME AND ADDRESS

Federal Employer ID Number - FEIN 23 - 7136038

Company Name Winning Wheels

Street Address 701 East Third Street

Street Address

City Prophetstown *State* IL *Zip Code* 61277 -

EMPLOYER ADDRESS FOR CHILD SUPPORT WAGE WITHHOLDING ORDERS

Street Address 701 East Third Street

Street Address

City Prophetstown *State* IL *Zip Code* 61277 -

NEW EMPLOYEE NAME AND ADDRESS

Social Security Number Date of Hire (MM-DD-YYYY) - -

First Name *MI* *Last Name*

Street Address

City *State* *Zip Code* -

NEW EMPLOYEE NAME AND ADDRESS

Social Security Number Date of Hire (MM-DD-YYYY) - -

First Name *MI* *Last Name*

Street Address

City *State* *Zip Code* -

Return your completed form either by FAX 1-217-557-1947
or by mail to IDES, P.O. Box 19473, Springfield, IL 62794--9473
or report new hires online at http://www.ides.state.il.us/employer/new-hire.asp

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

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				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

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

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

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
		Regional Director of Human Resources

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
Schaefer	Amber	Winning Wheels, Inc.

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	ZIP Code
701 East 3rd Street	Prophetstown	IL	61277

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. 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. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security
		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		
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				

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

Refer to the instructions for more information about acceptable receipts.

State of Illinois
Illinois Department of Public Health

Health Care Worker Background Check

Authorization and Disclosure for Criminal History Records Information (CHRI) Check

I hereby authorize the Illinois Department of Public Health (the Department), the Department's designee, educational entities that train and/or test health care workers, staffing agencies, my current or potential employer, or a health care facility where I want to volunteer to initiate/request a CHRI check on me. I further authorize the Illinois State Police (ISP) and/or the Federal Bureau of Investigation (FBI) to release information and photographs relative to the existence or nonexistence of any criminal record, which it might have concerning me, to any initiator/requestor solely to determine my suitability for training or testing in a health care training program, employment, continued employment, or to work as a volunteer. I further authorize any entity that maintains criminal records and photographs relating to me, including but not limited to a local unit of government in any State, to release those records and photographs to the ISP, FBI, or the Department. I authorize the Department to provide any health care facility, training program or staffing agency, to which I have provided this authorization and disclosure form, a copy of my ISP CHRI and a determination of eligibility of the FBI CHRI. I certify that the ISP, FBI, any entity that maintains criminal records and photographs, the Department, and any of their employees or officers who furnish this information shall be held harmless from all liability, which may be incurred as a result of releasing such information. I further acknowledge that a educational entity or a health care employer shall not be liable for the failure to hire or retain me as an applicant, student, employee, or volunteer if I have been convicted of committing or attempting to commit one or more of the offenses stated in the Health Care Worker Background Check Act (225 ILCS 46/25).

I understand that any false statements or deliberate omissions on this document may be grounds for disqualification from employment, training, or volunteering, if discovered after employment, training, or volunteering begins, and can result in discipline up to and including my termination of employment, being a volunteer, or a student.

I understand that the information requested below regarding gender, race, height, eye color, hair color, weight, place of birth and date of birth is for the sole purpose of identification and the accurate gathering of the criminal history record information, and that it will not be used to discriminate against me in violation of the law. I understand that the provision of my Social Security number is required by law. A facsimile or photographic copy of this authorization will be as valid as the original.

First Name _____ Full Middle Name _____ Last Name _____

Mailing Address _____ City: _____ State: _____ Zip Code _____

Other Names Used _____ Telephone _____ - _____ - _____

States Where You Have Lived? _____

☐ Male ☐ Female Race _____ Height _____ Weight _____ Date of Birth _____ Social Security Number _____

(Enter a letter from below)

Hair Color _____ Eye Color _____ Place of Birth _____

Race	A	Chinese, Japanese, Filipino, Korean, Polynesian, Indian, Indonesian, Asian Indian, Samoan, or any other Pacific Islander.
	B	Black or African American (Not Hispanic or Latino)
	H	Hispanic or Latino (Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin)
	I	American Indian, Eskimo, or Alaskan native, or a person having origins in any of the 48 contiguous states of the United States or Alaska who maintains cultural identification through tribal affiliation or community recognition.
	U	Of undeterminable race. Of Untold mixture.
	W	Caucasian (not Hispanic or Latino)

Have you ever had an administrative finding of Abuse, Neglect or Theft? ☐ Yes ☐ No If "Yes," give full details and state. Continue on back if more space is needed.

Have you ever been convicted of a criminal offense other than a minor traffic violation (do not include convictions that have been expunged, sealed or adjudicated delinquent)? ☐ Yes ☐ No If "Yes," give full details of each offense and the state in which convicted. Continue on back if more space is needed.

I certify that the above is true and correct and give my consent for my name to appear on Department's Health Care Worker Registry with the results of my criminal history records check.

_____ _____
(Signature) (Date)

As the parent or guardian of the above named individual, who is younger than the age of 17, I give my consent for this named individual to have a criminal history records check.

_____ _____
(Signature of Parent or Guardian when applicable) (Date)

Health Care Worker Registry, 525 W. Jefferson St., Springfield, IL 62761 Phone: 217-785-5133

***** ALL FIELDS MUST BE COMPLETED OR APPLICATION WILL NOT BE PROCESSED*****

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2022

Step 1: Enter Personal Information

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

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

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at *www.irs.gov/W4App*, 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 2022 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 total income will be $200,000 or less ($400,000 or less if married filing jointly):

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

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

Add the amounts above 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)

Illinois Withholding Allowance Worksheet

General Information

Use this worksheet as a guide to figure your total withholding allowances you may enter on your Form IL-W-4.

Complete Step 1.

Complete Step 2 if

- you (or your spouse) are age 65 or older or legally blind, or
- you wrote an amount on Line 4 of the Deductions Worksheet for federal Form W-4.

If you have more than one job or your spouse works, your withholding usually will be more accurate if you claim all of your allowances on the Form IL-W-4 for the highest-paying job and claim zero on all of your other IL-W-4 forms.

You may reduce the number of allowances or request that your employer withhold an additional amount from your pay, which may help avoid having too little tax withheld.

Step 1: Figure your basic personal allowances (including allowances for dependents)

Check all that apply:

☐ No one else can claim me as a dependent.

☐ I can claim my spouse as a dependent.

1 Enter the total number of boxes you checked. 1 _____

2 Enter the number of dependents (other than you or your spouse) you will claim on your tax return. 2 _____

3 Add Lines 1 and 2. Enter the result. This is the total number of basic personal allowances to which you are **entitled.** You are not required to claim these allowances. The number of basic personal allowances that you choose to claim will determine how much money is withheld from your pay. See Line 4 for more information. 3 _____

4 Enter the total number of basic personal allowances you choose to claim on this line and Line 1 of Form IL-W-4 below. This number may not exceed the amount on Line 3 above, however you can claim as few as zero. Entering lower numbers here will result in more money being withheld(deducted) from your pay. 4 _____

Step 2: Figure your additional allowances

Check all that apply:

☐ I am 65 or older. ☐ I am legally blind.

☐ My spouse is 65 or older. ☐ My spouse is legally blind.

5 Enter the total number of boxes you checked. 5 _____

6 Enter any amount that you reported on Line 4 of the Deductions Worksheet for federal Form W-4 plus any additional Illinois subtractions or deductions. 6 _____

7 Divide Line 6 by 1,000. Round to the nearest whole number. Enter the result on Line 7. 7 _____

8 Add Lines 5 and 7. Enter the result. This is the total number of additional allowances to which you are **entitled.** You are not required to claim these allowances. The number of additional allowances that you choose to claim will determine how much money is withheld from your pay. 8 _____

9 Enter the total number of additional allowances you elect to claim on Line 2 of Form IL-W-4, below. This number may not exceed the amount on Line 8 above, however you can claim as few as zero. Entering lower numbers here will result in more money being withheld(deducted) from your pay. 9 _____

IMPORTANT: If you want to have additional amounts withheld from your pay, you may enter a dollar amount on Line 3 of Form IL-W-4 below. This amount will be deducted from your pay in addition to the amounts that are withheld as a result of the allowances you have claimed.

✂ — — — — — — — — Cut here and give the certificate to your employer. Keep the top portion for your records. — — — — — — — — ✂

Illinois Department of Revenue

IL-W-4 Employee's Illinois Withholding Allowance Certificate

___ ___ ___ - ___ ___ - ___ ___ ___ ___
Social Security number

Name

Street address

City State ZIP

Check the box if you are exempt from federal and Illinois Income Tax withholding and sign and date the certificate. ☐

1 Enter the total number of basic allowances that you are claiming (Step 1, Line 4, of the worksheet). 1 _____

2 Enter the total number of additional allowances that you are claiming (Step 2, Line 9, of the worksheet). 2 _____

3 Enter the additional amount you want withheld (deducted) from each pay. 3 _____

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

Your signature Date

Employer: Keep this certificate with your records. If you have referred the employee's federal certificate to the IRS and the IRS has notified you to disregard it, you may also be required to disregard this certificate. Even if you are not required to refer the employee's federal certificate to the IRS, you still may be required to refer this certificate to the Illinois Department of Revenue for inspection. See Illinois Income Tax Regulations 86 Ill. Adm. Code 100.7110.

Printed by the authority of the State of Illinois - PO Number: 2200208 - 500 copies
IL-W-4 (R-05/20)

This form is authorized under the Illinois Income Tax Act. Disclosure of this information is required. Failure to provide information may result in this form not being processed and may result in a penalty.

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

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

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

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

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

STOP *Employer Completes Next Page* STOP

Winning Wheels, Inc.

Direct Deposit Agreement Form

Employee Name _____

☐ Begin Deposit ☐ Change Information ☐ Stop Deposit

Authorization Agreement

I hereby authorize Winning Wheels, Inc. to initiate automatic deposits to my account at the financial institution named below. I also authorize Winning Wheels, Inc. to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold Winning Wheels, Inc. responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until Winning Wheels, Inc. receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Payroll Department.

Account Information

Name of Bank: _____

9 Digit Routing Number: _____

Account Number: _____ ☐ Checking | ☐ Savings

Amount: ☐ Fixed Amount $ _____ ☐ 100% of Net

Name of Bank: _____

9 Digit Routing Number: _____

Account Number: _____ ☐ Checking | ☐ Savings

Amount: ☐ Fixed Amount $ _____ ☐ 100% of Net

Signature

Employee Signature _____ Date: _____

Email Address to Receive Check Stub

Email Address: _____ Date: _____

Please attach a voided check for a checking account or a deposit slip for a savings account and return this form to the Payroll Department.

Winning Wheels

Comprehensive Rehabilitative Care and Independent Living Solutions

Conduct Expectations

As a representative of Winning Wheels, Inc. it is important to conduct yourself in a professional and respectful manner. The purpose of this Code of Expectations is to help ensure that the organization's expectations are clear and staff members are successful in meeting those expectations.

Standards of Conduct:

- Provide quality care and protect the rights of all residents/patients.
- Follow all laws and rules and be ethical, fair and honest.
- Avoid conflicts of interest and make decisions that are in the best interest of the organization and residents/patients.
- Promote a safe environment and appropriate workplace practices.
- Handle all interactions with respect and professionalism.
- Assume goodness in intentions.
- Uphold a culture of accountability.
- Preserve confidentiality and information security.
- Use social media and technology responsibly.
- Record, report and document information accurately and adequately.
- Cooperate with inquiries, audits and investigations.
- Maintain an open mind when discussing opportunities for improvement.
- Handle conflicts with diplomacy and respect.

Examples of Violations of the Conduct Expectations:

- Not following the established grievance policy/chain of command to address concerns.
- Threatening to quit or openly expressing dissatisfaction with a co-worker.
- Taking excessive breaks, leaving work incomplete or dumping work on co-workers.
- Using a tone of voice or demeanor that conveys disrespect or hostility.
- Failing to provide obviously needed assistance.
- Sending an electronic communication that conveys disrespect or hostility towards others.

The Compliance hotline has been established as an avenue for employees or interested parties to report suspected criminal activity, and illegal or unethical conduct occurring within the organization in the event other resolution channels are ineffective or the caller wishes to remain anonymous.

Winning Wheels, Inc. Compliance Hotline: 815-499-9329

Compliance Officer: Robin Landis, C.F.O. / Amber Schaefer Regional Director of HR

I acknowledge understanding and agreement with the Winning Wheels, Inc. conduct expectations:

Employee Signature Date

Winning Wheels, Inc. Employee Computer Usage Agreement

The Information Technology Management (ITM) Policy is the document that guides proper use of information technology (IT) products and services installed and used at Winning Wheels, Inc. facilities. The policy was developed and is maintained by the senior information technology management team. It is implemented by Winning Wheels, Inc. Administration with primary oversight for carrying out this policy delegated to the IT Coordinator. Below are the items all employees should know from the policy:

1. Winning Wheels, Inc. information technology and telecommunications products, equipment, and services may not be used for activities other than approved business.

2. Employees will not reveal their user account password to others nor allow the use of their user account by others. This includes co-workers or family members.

3. Employees will store their data files on the network as opposed to local storage devices (e.g. desktop, flash drives, etc.). Privacy issues prohibit the transporting of facility protected information on removable media.

4. Employees will not change their passwords that allow access to e-mail, network systems, and the internet. Employees will log out of the network when leaving the workstation for more than a very brief period. Employees will not change any screensaver security settings. At the end of each workday, each employee will close out of any open programs, browsers, etc. and log out of their PC. Employees will not shut off their PCs.

5. Employees will not use company-provided devices for nonwork-related purposes such as logging into personal email accounts, Instant Messaging (IM) services, social networking sites, personal shopping and entertainment websites.

6. Employees will not bring personal software or digital electronic equipment to the facility with an intent to make use of facility resources (i.e. flash drives, connecting personal digital camera to work computer, installing software and downloading pictures).

7. Employees will not install or download software programs from any source, including software provided by vendors, the internet, flash drives, compact disks (CDs) or diskette. Software programs refer to applications or executable files either commercially available or free. This includes, but is not limited to, commercial software packages, shareware programs, unauthorized screensavers, free utilities, browser plug-ins, etc.

8. Employees will not provide their work e-mail account when registering on websites, sending greeting cards, ordering on-line, etc. If you require an additional e-mail address, contact the IT department for assistance.

9. Employees who require access to instant messaging or social networking websites for work related purposes or assisting residents, may use the resident computer lab. Please note that other points of the computer usage policy apply to employee use of the resident computer lab.

ACKNOWLEDGEMENT:

- I hereby acknowledge that I have read and understand the Winning Wheels, Inc. Employee Computer Usage Agreement. I understand that all technology resources and all information transmitted by, received from, or stored in these systems is the property of the Winning Wheels, Inc. facility and that I have no expectation of privacy in connection with the use of this equipment or with the transmission, receipt, or storage of information in this equipment.
- I acknowledge the Winning Wheels, Inc. facility's right to monitor my use of technology resources at any time. Such monitoring may include the printing and reading of all electronic transmissions entering, leaving, or stored on the Winning Wheels, Inc. facility's equipment.
- I agree that upon my termination of employment or partnership with the Winning Wheels, Inc. facility that I will not attempt to access any Winning Wheels, Inc. facility data, systems or information.
- I understand that I will be charged the cost of virus/malware removal if it is determined that the infection was a result of a violation of this computer usage agreement.
- I have read and understand all provisions specified in this agreement.

_____

Employee Name Printed Signature Date

SUBJECT: Grievance / Complaint Handling for Clients, Staff and/or Visitors	NO. 136

Purpose: To provide a means to present a grievance or concern to the facility in a manner that can be addressed by the facility and a resolution can be achieved.

Statement: This facility will address grievances in an appropriate manner. A client, employee, or visitor may present complaints on behalf of themselves or person or agency without threat of discharge or reprisal.

Procedure:

1. Anyone may by voice or in writing acknowledge their complaint.

2. The complainant/grievance shall follow a chain of command beginning with the appropriate staff person, to the Director of the Department, then to the Administrator, and then to a member of American Health Enterprises management.

3. Pending the need for further investigation, and/or if the complainant so requests, such a complaint will be investigated by a professional staff person, who shall be a licensed nurse, department supervisor, or an individual appointed by the Administrator. Such person shall conduct a complete investigation not to exceed 2 business days unless extenuating circumstances exist. The individual grievant will receive a written response within 2 business days following the completion of the investigation.

4. The investigator will document such complaint on an investigation form and/or in the resident's medical record as appropriate. A copy of the investigation results shall be retained on file.

5. If the complainant is not satisfied, they may request the Administrator to reinvestigate the situation and a referral to the Quality Assurance Committee may be made at that time. The purpose of the Quality Assurance Committee is to provide resident care that is optimal within available resources and is consistent with the achievable goals for the facility. The reinvestigation will be concluded within 48 hours if possible, and results of same will be communicated to the complainant.

6. If the grievance cannot be resolved, the complainant may file a complaint with the Department of Public Health or American Health Enterprises. Such complaint will be resolved in writing within 30 days of filing.

Employee Name Printed _____ Signature _____ Date _____

Approved:	Effective Date:	Revision Date:	Change No.:	Page:
		8/10; 1/14; 3/17		1 of 1

WINNING WHEELS, INC.
JOB DESCRIPTION

I have read and understand the Winning Wheels, Inc. job description for my position. I understand that I have been delegated the authority, responsibility, and accountability necessary for carrying out my assigned duties. I also understand that my job description is meant to be as complete as possible, but in no way states that the duties listed will be the only required duties to perform. I may be required to perform similar, related or logical assignments for my position which may not be specifically in my job description.

_____ _____

Employee Signature Date

SUBJECT: DISCIPLINARY ACTION GUIDELINES	NO.

In order to work together efficiently and effectively as a team, staff need to observe rules and regulations put in place. Failure to follow rules may require disciplinary action up to and including termination of employment.

Category 1 offenses are most serious and subject the employee to immediate termination without rehire privileges. Under Category 1 offenses, employees can be immediately suspended without pay, subject to investigation. In these cases, suspension is not used as a form of punishment - only to investigate policy or other work rule violation. Administration will investigate the events leading to suspension and the employee will have the right to meet with management to give their side of the story. If discharge is not in order and no lesser offense is found including, but not limited to, Category 2 offenses, the employee will be reinstated with back pay for scheduled days missed while on suspension and documentation will be removed from the personnel file. If a lesser offense is noted, the employee will receive disciplinary action as outlined under Category 2.

The following are Category 1 offenses:

1. Abuse or inconsiderate treatment of a resident
2. Failure to report suspected abuse of a resident
3. Willful negligence
4. Failure to follow appropriate policies or procedures that result in harm or potential harm to a resident or an employee.
5. Possession of alcohol/drugs on facility property; being under the influence of alcohol or drugs while at work; failing to submit to drug/alcohol testing and/or failing said test
6. Sleeping on duty
7. Verbal of physical threats against another employee, the facility, or a resident
8. Possession of a firearm, other weapon, or dangerous device on facility property
9. Misappropriation of facility, resident, or other employee's property
10. Falsification of facility records, or instructing a subordinate to falsify records (including punching another staff members time card or having another staff member punch your time card)
11. Walking off the job or leaving the facility without permission
12. Violation of safety rule that results in injury of a resident, employee or a visitor
13. Failure to report convictions of crimes that would prevent working in a nursing home (Healthcare Workers Background Check Act); making false, misleading, or incomplete statements on your job application or resume that could reasonably be expected to affect the facility's hiring decision.
14. Accepting gifts or gratuities from residents, families or vendors
15. Sexual or other unlawful harassment/discrimination
16. Making a false, misleading, or incomplete statement in a facility investigation and/or refusal to participate in a facility investigation
17. Failure to maintain confidentiality or employee, facility, or resident information
18. Other extreme instances of improper conduct not specifically listed

SUBJECT: DISCIPLINARY ACTION GUIDELINES	NO.

Category 2 offenses are less serious in nature (unless they are reoccurring). Under Category 2 offenses, efforts will be taken to utilize a progressive discipline system. However, occasions may arise where circumstances dictate that progressive discipline is not followed. Violations of conduct or work rules are cumulative and need not be for the same offense.

The following steps are used in the progressive discipline system:

1. Written warning – First violation of any conduct or work rule. This should be in written form with a copy given to the employee and the original retained in the employee file (for specified period of time determined by management)
2. Suspension – Second violation of conduct or work rule. This should be in written form and involve a suspension of a specified number of days from the facility. A copy of the form should be given to the employee and the original retained in the employee file (for a specified period of time determined by management)
3. Termination – Third violation of ay conduct or work rule. This should be in written form with a copy given to the employee and the original retained in the employee file.

The following are Category 2 offenses

1. Failure to report, monitor, or take proper action when there is a significant change in a resident's condition
2. Willful failure to follow a resident's Care Plan, or failure to inform the Care Plan coordinator when the need for changes in a resident's Care Plan have been assessed.
3. Failure to identify or report potential situations of neglect
4. Insubordination or failure to carry out instructions or assignments
5. Excessive absenteeism
6. Tardiness
7. Using abusive or vulgar language to or within earshot of an employee, visitor or resident
8. Failure to attend mandatory inservices or department meetings
9. Time clock violations
10. Leaving work area without permission from supervisor
11. Poor work quality or productivity
12. Posting or removing notices, defacing notices, or writing in any form on notices posted by the facility on bulletin boards and other facility property
13. Creating or contributing to infection control problems
14. Failure to comply with company dress code
15. Making or receiving personal telephone calls that are not emergencies
16. Making false or malicious statements about an employee, resident, visitor or the facility
17. Violation of the company cell phone policy.
18. Failure to follow personnel policies or facility procedures
19. Other instances of improper conduct not specifically listed

SUBJECT: DISCIPLINARY ACTION GUIDELINES	NO.

Employment with the facility is at the mutual consent of the facility and the employee and either party may terminate that relationship, with or without cause, and with or without advance notice.

I have received, read and understand the Winning Wheels, Inc. Disciplinary Action Guidelines.

_____

Name Printed Signature Date

Winning Wheels

Employee Handbook Acknowledgement and Employment-At-Will

I understand the Winning Wheels, Inc. Employee Handbook which describes the company's benefits, policies, and procedures is available online at www.winningwheels.com/employees. I understand that I am responsible for abiding by the policies described in this Handbook during my employment with Winning Wheels, Inc. I also understand that the information contained in it represents guidelines only, and may be modified from time to time.

I understand this is neither a contract of employment nor a warrantee of any particular benefits. I further understand that neither the policies described in it nor any other representations made by a management representative, at the time of hire or at any time during my employment, are to be interpreted as a contract between the Company and me. I further understand that my employment is voluntarily entered into, that I am free to resign at any time and that the Company may terminate the employment relationship whenever it determines that it is in its best interest to do so, and may do so with or without notice or cause. I understand that I am employed at will.

_____

Date

_____

Employee's Signature

_____

Employee's Name

POLICY: SUBSTANCE ABUSE / TESTING POLICY

Winning Wheels prohibits the unlawful use, manufacture, possession, sale or distribution on its premises, facilities or work places of any of the following: alcoholic beverages, intoxicants and narcotics, illegal or unauthorized drugs (including marijuana, or "look-alike" (simulated) drugs) and related drug paraphernalia. Winning Wheels employees must not be at work under the influence of any drug, alcoholic beverage, intoxicant or narcotic or other substance (including legally prescribed drugs and medications) which will in any way adversely affect their working ability, alertness, coordination, response, or jeopardize the safety of others on the job.

Employees and/or prospective employees shall be subject to drug/alcohol testing under the following circumstances:

1. Pre-employment;
2. Following any incident
3. On providing reasonable suspicion of being under the influence of alcohol/unauthorized substances.

PRE-EMPLOYMENT

Any offer of employment made by Winning Wheels shall be made conditionally, pending the outcome of a pre-employment drug/alcohol screening to be conducted as soon as possible after the employment offer is made. Should a prospective employee test positive for any of the substances identified above, the offer of employment shall be withdrawn and further employment consideration will not be given.

POST-INCIDENT

Any employee who has a work-related injury that requires medical treatment beyond first aid will be subject to the taking of blood, urine, or saliva samples for the purpose of testing for the presence of the substances named in this policy. All employees who have work-related injuries are required to report them and complete an incident report by the end of their shift, or will be subject to disciplinary action. Bodily fluid samples will be collected and analyzed at the soonest available opportunity following treatment, at the discretion of the administrator or his/her designee.

REASONABLE SUSPICION

Employees may be required to take a drug or alcohol test at any time that reasonable suspicion presents itself. Examples of reasonable suspicion include, but are not limited to:

-frequent visits to vehicle
-unsteady gait
-smell of alcohol/drugs
-slurred speech
-violent or threatening behavior toward staff or residents
-altered awareness (confusion)
-dialated pupils
-hallucinations
-frequent absence from assigned work area(s)

Specimen collections will take place at the facility under the supervision of designated administrative personnel, specifically trained for this purpose. Such personnel reserve the right to employ those methods deemed necessary to assure the sample is not tampered with.

Any employee who refuses to submit to testing as described in this policy or who is found using, possessing or distributing any of the substances named in this policy, or who is found under the influence of any such substances, is subject to immediate discharge.

Legally prescribed drugs may be permitted on facility premises or work locations provided the drugs are contained in the original prescription container and are prescribed by an authorized medical practitioner for the current use of the person in possession. The facility may, as it deems appropriate, determine if the drug produces hazardous effects. Any valid prescription drug that in the opinion of the facility may produce hazardous effects may be restricted.

Winning Wheels has the right to report use, possession or distribution of any substances named in this policy to law enforcement officials and to turn over to the custody of law enforcement officials any such substance.

Compliance with this policy is mandatory for Winning Wheels employees and is considered a condition of employment.

ACKNOWLEDGEMENTS

This is to acknowledge that I have received a copy of Winning Wheels' Substance Abuse / Testing Policy and that I have read and understand the policy's contents. I agree to abide by all rules and regulations of this policy.

_____
Signed

_____ _____
Date Print Name

_____
Department

(Office Use Only Below This Line)

.....

This will certify that a copy of Winning Wheels' Substance Abuse / Testing Policy was given to the person who signed the above receipt and that training was provided on the contents. It is confirmed that this person understands the policy.

_____
SIGNED – Company Representative

_____
Date

TO BE RETAINED IN PERSONNEL FILE

INFORMED CONSENT FOR INOCULATION
HEPATITIS B VACCINE

I _____, acknowledge that Winning Wheels has made available
(employee's name)
at no personal charge, the Hepatitis B Vaccine. **Winning Wheels has authorized the Whiteside County Health Department to administer the Hepatitis B Vaccine.** The vaccine is available the first and third Wednesdays of each month, from 1 to 4 p.m. Hepatitis B virus is an important cause of viral hepatitis, and there is no specific treatment for this disease. The serious complications of Hepatitis B virus infection include massive hepatic necrosis (death of liver cells), cirrhosis of the liver, chronic active hepatitis and hepatiocellular carcinoma. Transmission of Hepatitis B virus infection is often associated with close interpersonal contact with an individual. Although Hepatitis B virus is usually transmitted through blood and blood products, it has been found in tears, saliva, urine, semen and vaginal secretions. Responsiveness to the vaccine is related to a person's age.

20-39 years old = 95% - 99%
Over 40 years old = 91%

Hepatitis B vaccine will not prevent hepatitis caused by other agents, such as Hepatitis A virus, non-A, non-B Hepatitis viruses, or other viruses known to infect the liver.

ADVERSE REACTIONS

Hepatitis B vaccine is generally well tolerated. No serious adverse reactions attributable to the vaccine have been reported during the course of clinical trails. Fifteen to seventeen percent (15% - 17%) of a trial group of individuals reported some complaints.

The most common of these are:

Injection site soreness
Weakness, headache, fever
Nausea and/or Diarrhea
Dizziness
Sweating, achiness, sense of warmth, chills
Vomiting, Decreases Appetite

The vaccine is administered in three (3) doses:

1st dose within 10 days of employment
2nd dose 1 month later
3rd dose 6 months after first dose

I have read this information and all questions regarding the safety, risk and effectiveness of Hepatitis B vaccine have been answered to my satisfaction.

I hereby, ( ) accept, ( ) decline, *the offer of immunization with Hepatitis B vaccine.
*SEE DECLINATION STATEMENT

If the employee fails to follow through with the administration of the vaccine at the scheduled intervals, such action will signify the employee's decision to decline the vaccine and will release the employer from further obligation.

Signed _____ Date _____

Issued to: _____

Date: _____

COURTESY REMINDER

Our records indicate you have not initiated your pre-exposure Hepatitis B vaccine series. Please initiate the series, or sign the form below and return it to the main office as soon as possible.

HEPATITIS B VACCINE DECLINATION

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Employee Signature: _____

Date: _____

Witness: _____

Quest Information

Have you been positive for Covid-19 prior to hire?

Circle: Yes / No

If yes, please give date of testing: _____

*Please bring in proof of positive testing, employees who have tested postive prior to hire can not test for 90 days after their positive results.

are you vaccinated?: Yes/ No If yes, we will need a copy of your card.

Name: _____
(Last, First, Middle)

DOB: _____

Address: _____
_____
_____

Phone: _____

Primary Insurance: _____
(Name, ID#, Group#) _____
_____

Secondary Insurance: _____
(Name, ID#, Group#) _____
_____

Please return to Megan when finished filling out your personal information
Thank you!

Winning Wheels

Comprehensive Rehabilitative Care and Independent Living Solutions

Benefit Acknowledgement

I have received the benefit plan summaries and reviewed the employment benefit options. I understand to enroll in benefits I must complete the enrollment forms within my first fourteen days of hire. I understand my benefits are effective the first of the month following 90 days of employment, the first of the month following 60 days of employment for health coverage.

Employee Signature

Date