Up To-Date Employment Resources

At Your Fingertips!

www.wwihub.com

Employment Benefit Information

Payroll Information and Forms

Performance Evaluation Information and Forms

Job Descriptions

Policies, Procedures and Handbooks

…. And More!

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*****

www.firmsystems.net

206 S. Sixth Street
Springfield, IL 62701

Phone: 866-721-1203
FAX: 217-753-931

Fee Applicant
Consent Release

Please Print Clearly

Last Name: _____ First Name: _____ MI: _____

Social Security #: _____ Date of Birth: (XX/XX/XXXX) _____

Place of Birth (State or Country, if outside USA): _____ SEX: _____ Race: _____

Address: _____ City: _____ State: _____ Zip: _____

Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____ Phone: _____

Applicant Authorization

Without reservation, I authorize this organization to procure my criminal history record and to furnish this information concerning my criminal history record check or other history as may be required,

Applicant Signature: _____ Date: _____

	Registered Nurse , RN (IDFPR) -
	Licensed Practical Nurse, LPN (IDFPR)
	Security, PERC (IDFPR)
	Massage Therapy (IDFPR)
	Vehicle Dealer (SOS)
	Explosives License (DNR)
	Pyrotechnic License (OSFM)
	Video Gaming Location (IGB)
	Non-Emergency Transport (OIG)
	School Teacher – Name of School:
	School Bus Driver – Name of School:
	Other:

DO NOT WRITE BELOW THIS LINE – For Office Use Only

Proof of Identification: ___ Drivers License, ___ State ID, ____FOID, ____ Passport, ___ Military ID, ___Other

Method of Payment: ___ CASH, ____ Credit/Debit Card, ____ Money Order, ____Company Check ___

Fee Amount: $_____ Billed_____ Collected_____

TCN: _____ Technician Name: _____

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

2025

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 surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

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

Step 3: Claim Dependent and Other Credits

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

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

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

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

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 - web only,1 copy.

IL-W-4 (R-7/23)

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.

IOWA
Department of Revenue

2025 IA W-4
Employee Withholding Allowance Certificate

revenue.iowa.gov

Each employee must file this IA W-4 with their employer. Do not claim more in allowances than necessary or you will not have enough tax withheld. If the amount of allowances you are eligible to claim increases, you may file a new W-4 at any time. If the amount of allowances you are eligible to claim decreases, you must file a new W-4 within 10 days.

Penalties apply for willfully supplying false information or for willful failure to supply information. If you file as exempt from withholding and you incur an income tax liability, you may be subject to a penalty for underpayment of estimated tax.

Filing Status: Other (Including Single) ☐ Head of Household ☐ Married filing jointly or Qualifying Surviving Spouse ☐

If so, does your spouse also have earned income? Yes ☐ No ☐

Print your full name:_____ Social Security Number:_____

Home address: _____

City: _____ State:_____ ZIP: _____

Exemption from withholding

If you do not expect to owe any Iowa income tax and have a right to a full refund of ALL income tax withheld, enter "EXEMPT" here _____ and the year effective here _____ .

Nonresidents may not claim this exemption.

Check this box if you are claiming an exemption from Iowa income tax as a military spouse based on the Military Spouses Residency Relief Act of 2009 or the Veterans Benefits and Transition Act of 2018 and the Veterans Auto and Education Improvement Act of 2022. ..... ☐

If claiming the military spouse exemption, enter your state of domicile or residence here _____

If you are not exempt, complete the following:

1. Personal allowances. See instructions ..... 1.$_____
2. Allowances for dependents. You may claim $40 for each dependent you claim on your Iowa income tax return ..... 2.$_____
3. Allowances for itemized deductions. See instructions ..... 3.$_____
4. Allowances for adjustments to income. Estimate allowable adjustments to income for payments such as an IRA, Keogh, or SEP; penalty on early withdrawal of savings; and student loan interest, which are reflected on the IA 1040. Divide this amount by 15, round to the nearest whole dollar ..... 4.$_____
5. Allowances for child and dependent care credit. See instructions ..... 5.$_____
6. **Total allowances.** Add lines 1 through 5 ..... 6.$_____
7. Additional amount, if any, you want deducted each pay period ..... 7.$_____

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

Employee signature: _____ Date: _____

Employers: The employer must maintain records of the W-4s. If the employee is claiming exemption from withholding when wages are expected to exceed $200 per week, complete the information below and within 90 days send a copy to: **Alcohol & Tax Compliance Division, Iowa Department of Revenue, PO Box 10456, Des Moines, Iowa 50306-0456.**

Employer name: _____

Federal Employer Identification Number (FEIN):_____

Employer address:_____

City: _____ State:_____ ZIP: _____

Questions about Iowa taxes: Call Taxpayer Services at 515-281-3114 or 800-367-3388 or email idr@iowa.gov.

Centralized Employee Registry Reporting Form

To be completed by the employer within 15 days of hire.

New Hire Reporting

An employer doing business in Iowa is required to report newly hired employees, rehires, and contractors to the Centralized Employee Registry. Use one of the following methods to report.

Online Reporting- Online reporting saves time and money and is the preferred method of reporting. Enter employee information or upload data at iowachildsupport.gov.

Fax and Mail Reporting- To report new hires and rehires, submit the following form or an equivalent form. To report contractors by fax or mail, use the Contractor Reporting form found at iowachildsupport.gov.

Magnetic Media- Record layout instructions and media types are available at iowachildsupport.gov.

Employer Information

1. Federal Employer Identification Number (FEIN): .....
2. Employer name: _____
3. Address: _____

   City: _____ State: _____ ZIP: _____
4. Employer contact and phone number: _____
5. Income provider name and address where income withholding and garnishment orders should be sent, if different from above.

   Name: _____

   Address: _____

   City: _____ State: _____ ZIP: _____

Employee Information

6. Is dependent health care coverage available? ..... Yes ☐ No ☐
7. Approximate date this employee qualifies for coverage (MM/DD/YYYY):.....
8. Employee start date (MM/DD/YYYY):.....
9. Employee date of birth (MM/DD/YYYY):.....
10. Employee Social Security Number: .....
11. Last name:_____ First name: _____ Middle initial: _____
12. Address: _____

    City: _____ State:_____ ZIP:_____

Mailing and contact information:

Fax to: 800-759-5881 or 515-281-3749 (local)

Phone: 877-274-2580

Mail to: Centralized Employee Registry
PO Box 10322
Des Moines, IA 50306-0322

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 05/31/2027

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

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

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

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

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

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

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

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

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

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

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

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

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

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

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

First Day of Employment (mm/dd/yyyy):

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

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

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

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.

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

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, Inc.
Acknowledgement of Privacy Obligations

By signing this acknowledgement, I am signifying my understanding that every resident has the right to privacy and confidentiality of protected health information, including information contained in his/her clinical record, as well as any information regarding his/her residency at this facility. Information about a resident may be shared among staff of this facility only insofar as the minimum necessary to ensure optimum treatment of the resident or for the purposes of payment and/or health care operations. No information is to be shared (except as may be required by law) with anyone else except with the informed consent of the resident or of a person authorized to give consent on the resident's behalf. Bona fide students or trainees at the facility by permission are considered facility staff for this purpose and have the same obligation to comply with established privacy practices.

All staff and employees of Winning Wheels are under equal obligation to treat as strictly confidential any information acquired by any means about a resident or ex-resident. Breaches of confidentiality will be regarded as a serious offense and will be grounds for disciplinary action, up to and including termination of employment.

_____ _____

Signature Date

Winning Wheels

Comprehensive Rehabilitative Care and Independent Living Solutions

Benefit Acknowledgment

I acknowledge receipt of the benefit plan summaries and have reviewed the employment benefit options and eligibility offered with employment at Winning Wheels, Inc.

I understand to enroll in, cancel or change benefit elections I must complete the enrollment forms within fourteen days of the qualifying event. Benefits are effective the first of the month following hire date. Cases of qualifying events, enrollments, terminations and changes in benefits are effective the first of the month following the effective date of change. Changes to elections can only be made in the event of qualifying events and during the annual enrollment period.

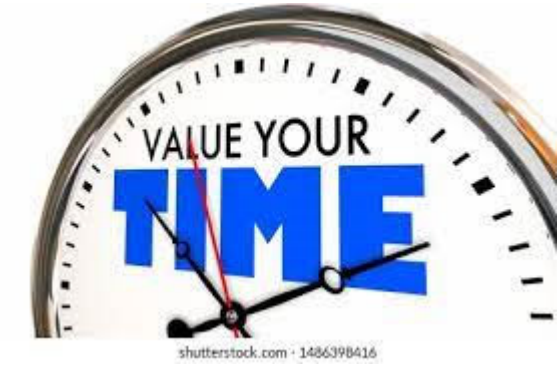
I understand I have access to all current benefit plan information, summaries, eligibility requirements and disclosures at www.wwihub.com or by contacting the Plan Administrator at 815-778-3683.

Team Member Name Printed Signature Date

Winning Wheels

Comprehensive Rehabilitative Care and Independent Living Solutions

Nursing Department Holiday Bonus



Our team is dedicated, provides the best resident care and is all-around awesome! Nursing professionals are often over-worked and stretched to the limit. We value your time and want you to have balance. To do this, Winning Wheels is happy to provide an extra eight hours of paid time every pay period! Work 72 hours and get paid for 80!

Registered Nurses, Licensed Practical Nurses and Certified Nurse Aides regularly working 12 hours shifts, 72 hours per pay period will receive 8 hours of bonus holiday pay each pay period.

Attendance occurrences (late, leaving early or call offs – regardless of reason) during that pay period will forfeit the additional holiday pay. If the team member's payroll hours are less than a total of 72 for the pay period the holiday bonus will not be added to that payroll (the use of non-worked time: vacation, personal, sick or unpaid time off, does not count toward the 72-hour requirement to receive the bonus - it must be 72 hours worked). The 8 hours of holiday pay will not count as hours worked towards overtime calculations or vacation accrual.

Team Member Name (printed) Signature Date

Winning Wheels

Comprehensive Rehabilitative Care and Independent Living Solutions

Nursing Department Emergent Staffing Hourly Bonus Acknowledgement

Winning Wheels, Inc. provides continuous quality care to our residents. In the event of staffing shortages call in bonus pay may be offered to nursing staff in emergent situations as an incentive for our employed team members to pick up the vacant shifts.

Before the call-in bonus pay is offered, all internal staffing options must be exhausted: work load adjustments, other departments covering, volunteers to pick up the shifts, PRN staff coverage, etc. This is intended to be used as a last resort prior to the use of agency staffing and only if our staffing levels will be below state minimums.

If all staffing efforts have been exhausted and documented by nursing administration, staff may be awarded the $10.00/hour call-in bonus for shifts worked that meet the criteria. Team members would not be eligible for the call-in bonus if they have not worked their budgeted status hours for the pay period (hours worked do not include un-paid time off, vacation, sick, bereavement, personal, etc.) or if they have had an attendance occurrence that pay period (late, left early, call off, etc.) for any reason.

Procedure:

To award the call-in bonus nursing administration will designate the shift on the schedule in blue to signify it was an emergent staffing shift and complete a yellow slip for the team member and submit that with payroll. Nursing administration will also provide documentation to support the need for offering the bonus shifts with payroll.

Changes to the emergent staffing bonus program may be implemented by Administration as needed, including discontinuation of the program and will be communicated to staff by the Director of Nursing.

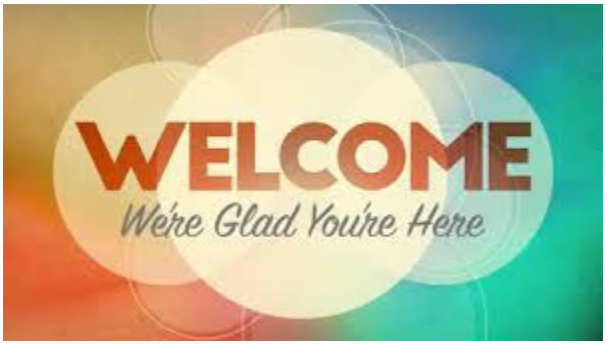
Hourly call-in bonus pay will not be awarded to team members that have not signed this acknowledgement.

I acknowledge the above information was understood and received:

Team Member Name (printed) Signature Date

Winning Wheels

Comprehensive Rehabilitative Care and Independent Living Solutions



Nursing Staff Sign-On Bonus

Winning Wheels, Inc. is proud to honor your commitment to our team by awarding a generous sign-on bonus to qualified nursing staff members joining our team.

Certified Nurse Aide	$10,000.00
Licensed Practical Nurse	$15,000.00
Registered Nurse	$20,000.00

Sign-on bonuses are paid quarterly over the first thirty-six months of employment. Eligible candidates must be full-time status, currently licensed/certified in the State of Illinois and have not been previously employed with Winning Wheels, Inc.

Any changes in employment status or extended leaves will void future sign-on bonus payments and eligibility.

Team Member Signature Date

Winning Wheels

Comprehensive Rehabilitative Care and Independent Living Solutions

Job Description Acknowledgement

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.

I also understand that all job descriptions may be accessed by visiting the team member resource website at www.wwihub.com.

Team Member Signature Date

Winning Wheels

Comprehensive Rehabilitative Care and Independent Living Solutions

Team Member Handbook and Employment at Will/Status Acknowledgment

I understand the Winning Wheels, Inc. Team Member Resource Guide (Handbook) which describes the organization's benefits, policies, and procedures is available online at www.wwihub.com. I understand that I am responsible for abiding by the policies and procedures described in this Handbook while actively employed with Winning Wheels, Inc. I also understand that the information contained in it represents guidelines only, and may be modified as needed.

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 member of administration, at the time of hire or at any time during employment, are to be interpreted as a contract. I further understand that my employment is voluntarily entered into, that I am free to resign at any time and that the organization 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.

Team Member Signature Date

Winning Wheels

Comprehensive Rehabilitative Care and Independent Living Solutions

Informed Consent for Inoculation Hepatitis B Vaccine

Winning Wheels, Inc. provides the Hepatitis B vaccine to all team members at no cost to them.

The Hepatitis B Vaccine is generally well tolerated and administered in three doses. No serious adverse reactions attributable to the vaccine have been reported during the course of clinical trials. Fifteen to seventeen percent of a trial group of individuals reported some of the following complaints:

- Injection site soreness
- Weakness, headache, fever
- Nausea and/or diarrhea
- Dizziness
- Sweating, achiness, sense of warmth, chills
- Vomiting, decrease of appetite

I acknowledge that I have been informed of the effectiveness and risks of the Hepatitis B Vaccine and that it is available to me at no charge as an actively employed Winning Wheels, Inc. team member. If I fail to follow through with the sequence of vaccines at their scheduled intervals will release the employer from further obligation.

Team Member Signature Date

SUBJECT: EMPLOYEE ABSENTEEISM / ATTENDANCE POLICY	NO.

POLICY:
Due to the nature of our work at Winning Wheels, good attendance is imperative to the operation of the facility and to the care of our residents. Winning Wheels applies a no fault attendance policy. If a scheduling conflict arises it is the employee's responsibility to make other arrangements or find a replacement prior to notifying their designated supervisor.

PROCEDURE:

1. If an employee must call off, they need to personally call at least three hours prior to the scheduled start of their shift. A call off after three hours before the start of your shift is considered a late call off. When calling off you must speak directly with your designated supervisor or member of Administration – never leave a call off notice on someone's voicemail, a text message, or a message on a social media platform. If you leave a call off notice on someone's voicemail, text message, or social media platform, it will be counted as a failure to report (no call/no show).
2. Employees will be considered late if they clock in past the scheduled start of their shift.
3. Employees are personally expected to call their supervisor each day until they return to work. Physician documentation will be required to return to work if you are absent from work for three or more consecutive scheduled work days.
4. Supervisors and/or Administration reserve the right to not accept call-offs including, but not limited to, patterns of call offs and staffing compliance.
5. Consecutive call offs for one circumstance will be counted as 1 occurrence. For example, if an employee calls off two regularly scheduled shifts due to an illness, that would be 2 points.
6. A failure to report (no call/no show) is when an employee fails to report their absence before the scheduled start of their shift.
7. If an employee believes that their failure to report was unavoidable due to extenuating circumstances, they may request, within 2 business days, to have their case reviewed by administration. Administration reserves the right to rescind termination and issue a lesser disciplinary action if they determine that there were extenuating circumstances.
8. Personal and Vacation Time must be pre-approved and cannot supplement attendance occurrences. Any attendance occurrence will result in forfeiture of one's bonus pay for that pay period.
9. Absenteeism is tracked using a point system and disciplinary action is administered accordingly:

Late	1 point
Leaving Early	1 point
Call Off	2 points

SUBJECT: EMPLOYEE ABSENTEEISM / ATTENDANCE POLICY	NO.

Points In a Rolling 4 Month Period:

6 Points	Written Warning
10 Points	Suspension
12 Points	Termination of Employment
Failure to Report	Termination of Employment

I have read and understand the Employee Absenteeism / Attendance Policy and agree to abide by it:

Employee Name Printed Signature Date

Winning Wheels

Comprehensive Rehabilitative Care and Independent Living Solutions

Team members are assigned one of three employment statuses:
Full-time
Part-time
PRN
This employment status determines the budgeted hours the team member is required to work as well as the employment benefits they are eligible for.

Nursing staff Scheduled Positions:

Full-time	72-80 hours per pay period
Part-time	48-71 hours per pay period
PRN	There are no guaranteed hours, PRN staff work as needed/as available.
	PRN staff must at a minimum work the following to remain actively employed:

- 4 shifts per quarter (1 of those being a Saturday or Sunday).
- 2 8-hour holidays per year.

PROCEDURE:

1. New team members will be formally offered an employment status upon hire.

2. Managers are responsible for ensuring team members are scheduled for and working hours according to their budgeted status and adjusting that status as deemed appropriate.

3. If team members have a change in employment status, managers need to submit a payroll change form prior to that change with the team member's signature on it to make the necessary adjustments in the payroll and benefit enrollment systems.

Team Member Name Printed Team Member Signature Date

Winning Wheels

Comprehensive Rehabilitative Care and Independent Living Solutions

Tobacco Usage Guidelines

Winning Wheels, Inc. strives to be accommodating to our team members as they spend a significant amount of time at the facility while providing a clean, safe and health environment for everyone. For our team members who choose to use tobacco products while at Winning Wheels, the following guidelines must be followed:

- Tobacco usage (including vaping) is not allowed on facility grounds and must be limited to the designated smoking are on the edge of the rear parking lot.
- Appropriate trash receptacles must be used to dispose of tobacco products and garbage.
- Tobacco usage must be limited to designated break times and not interfere with resident care.

Violation of the above guidelines will result in disciplinary action up to and including termination of employment.

Team Member Name Printed Team Member Signature Date

Winning Wheels

Comprehensive Rehabilitative Care and Independent Living Solutions

QUEST INFORMATION SHEET

Have you been tested for COVID-19 prior to hire? YES NO

If yes, date of most recent test:_____

- Provide documentation of positive testing, team members who have tested positive prior to hire can forfeit testing for ninety days following the positive test result date.

Are you vaccinated for COVID-19? YES NO

- Provide documentation of vaccination.

Name: _____

First Middle Last

Date of Birth: _____

Address:

_____

Street City State Zip Code

Phone Number: _____

Primary Insurance:

_____

Carrier Name ID # Group #

- Provide copy of insurance card.

In the event that the above information changes, please provide appropriate documentation to the front office.