

## FL Participant Direction Option, Florida Community Care Direct Service Worker Information and Attestation

To complete enrollment and be paid, Florida Community Care PDO program must get back all 11 pages of this Worker Information and Attestation form filled out with your information, all questions answered and signed and dated. When all pages are filled out please send to Florida Community Care PDO, through Public Partnerships LLC (PPL), the agency for your participant. Please fax to 1-855-879-7816 or email flfcc-cs@pplfirst.com or mail to: 17 Plaza Drive, Suite 300 Latham, NY 12110

Participant Information			
<b>Participant First Name:</b>		<b>Participant Last Name:</b>	
<b>Designated Representative:</b>			
Direct Service Worker Information			
<b>Worker First Name:</b>	<b>Worker M.I.:</b>	<b>Worker Last Name:</b>	
<b>Have you ever used an Alias?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Worker Maiden/Alias Name(s):</b>		
<b>Date of Birth:</b>	<b>Social Security Number:</b>		<b>Gender:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male
<b>Relationship to Participant:</b> <input type="checkbox"/> Parent/Step-Parent <input type="checkbox"/> Child <input type="checkbox"/> Sibling <input type="checkbox"/> Grandparent			
<input type="checkbox"/> Grandchild <input type="checkbox"/> Spouse <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Non-Relative <input type="checkbox"/> Other			
Physical Address			
<b>Physical Address (do not use P.O. Box):</b>			
<b>Physical Address 2 (apt, bldg., unit, ste.):</b>			
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>	<b>County:</b>
Mailing Address (if different from Physical Address)			
<b>Mailing Address:</b>			
<b>Mailing Address 2 (apt, bldg., unit, ste.):</b>			
<b>City:</b>	<b>State:</b>		<b>Zip Code:</b>

Participant Name	Direct Service Worker Name

Contact Information	
<b>Preferred Method of Contact:</b>	
<input type="checkbox"/> Home Phone Number <input type="checkbox"/> Mobile Phone Number <input type="checkbox"/> Email Address	
<b>Home Phone Number:</b>	<b>Mobile Phone Number:</b>
<b>Florida Community Care PDO program, through Public Partnerships LLC has permission to text me using the mobile phone number above (carrier charges may apply):</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Email Address:</b>	
Emergency Contact Information	
<b>Emergency Contact Name:</b>	<b>Emergency Contact Phone Number:</b>

Criminal Background Check Application Information	
City of Birth: _____ State/Province of Birth: _____ County (if known): _____	
Country of Birth: _____ Country of Citizenship: _____	
Race: <i>(check one)</i>	
<input type="checkbox"/> American Indian and/or Alaskan	<input type="checkbox"/> Asian or Pacific Islander
<input type="checkbox"/> Black	<input type="checkbox"/> Caucasian/Latino
<input type="checkbox"/> Unknown	
Ethnicity: <i>(check one)</i>	
<input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Hispanic
<input type="checkbox"/> Unknown	
Eye Color: <i>(check one)</i>	
<input type="checkbox"/> Black	<input type="checkbox"/> Blue
<input type="checkbox"/> Brown	<input type="checkbox"/> Green
<input type="checkbox"/> Gray	<input type="checkbox"/> Hazel
<input type="checkbox"/> Maroon	<input type="checkbox"/> Pink
<input type="checkbox"/> Multi-Colored	<input type="checkbox"/> Unknown
Hair Color: <i>(check one)</i>	
<input type="checkbox"/> Bald	<input type="checkbox"/> Black
<input type="checkbox"/> Blonde	<input type="checkbox"/> Blue
<input type="checkbox"/> Brown	<input type="checkbox"/> Green
<input type="checkbox"/> Gray	<input type="checkbox"/> Orange
<input type="checkbox"/> Purple	<input type="checkbox"/> Pink
<input type="checkbox"/> Red	<input type="checkbox"/> Sandy
<input type="checkbox"/> White	<input type="checkbox"/> Unknown
Preferred Language: <i>(check one)</i>	
<input type="checkbox"/> English	<input type="checkbox"/> Spanish
Height: _____ Feet _____ Inches	
Weight (Pounds): _____	

Participant Name	Direct Service Worker Name

**Application for Difficulty of Care  
Federal Income Tax Exclusion**

Certain payments received a worker for providing Medicaid services in the participant's home are considered Difficulty of Care payments and federal income tax will not be taken out of your pay for those services. To see if you qualify do the following steps. If you qualify the Florida Community Care PDO program will not report your pay as income and will not take out federal income taxes.

**STEP 1:** Read the information about the Difficulty of Care Federal Income Tax Exclusion. You can read the information at: <https://www.publicpartnerships.com>.

**STEP 2:** Check all that apply:

**I provide services to the participant in my home.**

*(NOTE: The participant receiving care must live in the same home as the participant care provider, regardless of who owns the home.)*

**I do not have a separate home where I reside.**

**This is the home where I reside and regularly perform the routines of private life, including shared meals and holidays with family.**

**STEP 3:** If all the above do not apply, you are not eligible for the Difficulty of Care Federal Income Tax Exclusion.

**STEP 4:** If all the above apply, you are eligible for the Difficulty of Care Federal Income Tax Exclusion.

*Under penalties of perjury, I swear that I am a worker receiving pay from a state Medicaid Home and Community-Based Services program. I live with and provide care to the participant.*

**IMPORTANT:** If you no longer live with the participant you take care of, you must tell the Florida Community Care PDO program through Public Partnerships and you will pay federal taxes on the Difficulty of Care services you do.

Participant Name	Direct Service Worker Name

**Payment Information**  
*(If a payment selection is not checked, the Florida Community Care PDO program will send your payments by debit card)*

**Payment Selection:**  
*(check only one box)*       Direct Deposit       Debit Card

**Direct Deposit**

**Account Type:**  
*(check only one box)*       Checking Account       Savings Account

**Account Information**

1. If you pick **Debit Card**, you do not need to give more information in this section. To learn more about the Debit Card, please refer to the DSW Informational Packet.
2. You can stop direct deposit by calling customer service. If you are changing your bank account information, this form must be sent in.

<b>Banking Institution Name</b>	
<b>Routing Number</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<b>Account Number</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<b>Account Nickname (if desired)</b>	

**Pay Stub/Remittance Advice**

**GO GREEN:** PPL makes your pay stub available on the BetterOnline™ web portal.

**Timesheet Submission**

The best way to submit time worked to the Florida Community Care PDO program is online, using e-Timesheets on the BetterOnline™ web portal or on your smartphone using the Time4Care™ smartphone application.

Submitting time through e-Timesheets or Time4Care™ lets you fill out and submit timesheets online, see the status of payments, and search for timesheets previously entered and paid in the system. All of this can be done at your convenience, so you do not have to call Public Partnerships LLC customer service to see if your timesheet was received.

Participant Name	Direct Service Worker Name

<b>Relationship Questionnaire</b>
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**1. Are you a non-resident alien temporarily in the United States on an F-1, J-1, M-1, or Q-1 visa admitted to the US for providing domestic services?**

- YES**, that description fits my status.  **NO**, that description does not fit my status.

**2. Are you the child of the participant (includes adopted children)?**

- YES**, my employer is my parent (mother or father).  **NO**, my employer is not my parent.

**3. Are you the spouse of the participant?**

- YES**, my employer is my spouse (husband, wife or domestic partner).  **NO**, my employer is not my spouse.

**4. Are you the parent of the participant (includes adopted children)?**

- YES**, my employer is my child (son or daughter).  **NO**, my employer is not my child.

**5. If you answered, "YES," to Question 4, check any of the following that apply.**

- YES**, I also provide care for my grandchild or step-grandchild in my child's home.
- YES**, my grandchild or step-grandchild is under 18, or has a physical or mental condition that requires personal care of an adult for at least four weeks in a row during the calendar quarter in which services are performed.
- YES**, my child (son or daughter) is widowed, divorced, not remarried or living with a spouse who has a mental or physical condition so the spouse cannot care for my grandchild for at least four weeks in a row during the calendar quarter in which services are performed.
- NO**, none of the above apply.

**6. Are you under the age of 18 or do you turn 18 before December 31?**

- YES**, I am under 18 or am turning 18 **before December 31**  **NO**, I am over 18.

*If you answered, "YES," to Question 6, answer the following question. If you answered, "NO," skip the question below.*

**Is this job of performing household services (respite or nursing) your principal occupation?**

**NOTE: Do not answer, "YES," if you are a student.**

- YES**, this is my main job.  **NO**, this is not my main job.

Participant Name	Direct Service Worker Name

<b>Direct Service Worker (DSW) Pay Rate</b> <i>Indicate which services will be provided by checking the boxes that apply.</i>
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ICMC Service Name	Service Code	Hourly Rate
<input type="checkbox"/> <b>Adult Companion Care</b>  Adult companions help with tasks such as meal preparation, laundry, and shopping. They can also provide light housekeeping such as vacuuming, dusting, and sweeping. In addition to helping with tasks in the home, adult companions can go with you to places that you enjoy such as parks, museums, and restaurants.	S5135CG	\$
<input type="checkbox"/> <b>Attendant Nursing Care</b>  Attendant Nursing Care is provided by a licensed nurse for longer periods during the day (usually more than two hours per day). The nurse helps you with medical needs that take a longer time.	S5125CG	\$
<input type="checkbox"/> <b>Homemaker Services</b>  Homemakers provide housekeeping services such as meal preparation, vacuuming, and laundry. They also may provide chore services such as cleaning bathrooms, lawn care, and pest control.	S5130CG	\$
<input type="checkbox"/> <b>Personal Care Services</b>  Personal care workers help with daily tasks such as eating, taking a bath, getting dressed, and using the bathroom. They can also help with preparing meals. Personal care workers can also make your bed, dust, and vacuum.	T1019CG	\$

<input type="checkbox"/> <b>Intermittent-Skilled Nursing (RN)</b>	T1002CG	\$
<input type="checkbox"/> <b>Intermittent-Skilled Nursing (LPN)</b>	T1003CG	\$

Participant Name	Direct Service Worker Name

**Direct Service Worker (DSW) Pay Rate**  
*Indicate which services will be provided by checking the boxes that apply.*

ICMC Service Name	Service Code	Hourly Rate
<input type="checkbox"/> <b>Life Skills Development Level 1</b> Companion services include: <ul style="list-style-type: none"> <li>• Non-medical care,</li> <li>• Supervision, and</li> </ul> Socialization activities provided to recipients age 21 years or older. This service: <ul style="list-style-type: none"> <li>• Must directly relate to achieving the participant’s goals in their support plan,</li> <li>• Provides access to community-based activities that cannot be provided by natural or unpaid supports, and</li> </ul> Can be scheduled on a regular, long-term basis.	S5135UC  S5135UC S2  S5135UC S3	\$
<input type="checkbox"/> <b>Personal Support</b> This service provides assistance and training in activities of daily living, such as: <ul style="list-style-type: none"> <li>• Eating,</li> <li>• Bathing,</li> <li>• Dressing,</li> <li>• Personal hygiene, and</li> <li>• Preparation of meals.</li> </ul> When specified in the support plan, this service can also include heavy household chores to make the home safer, such as: <ul style="list-style-type: none"> <li>• Washing floors, windows and walls,</li> <li>• Tacking down loose rugs and tiles, or</li> <li>• Moving heavy items or furniture.</li> </ul> Services also include non-medical care and supervision.  This service can provide access to community-based activities that cannot be provided by natural or unpaid community supports and are likely to result in an increased ability to access community resources without paid support. Personal supports are designed to encourage community integration. Personal supports in supported living are also designated to teach the recipient about home-related responsibilities.	S5130UC	\$
<b>Skilled Nursing:</b> Providers of skilled nursing services must be: <ul style="list-style-type: none"> <li>• Nurses registered or licensed in accordance with Chapter 464, F.S., and</li> <li>• Within the scope of the Nurse Practitioner Act.</li> </ul> Skilled nursing services cannot be used for ongoing medical oversight and monitoring of direct care staff or caregivers in: <ul style="list-style-type: none"> <li>• The recipient’s own home or family home.</li> <li>• Select the type of Skilled Nursing Service to be provided below:</li> </ul>		\$
<input type="checkbox"/> <b>Private Duty Nursing (PDN) - LPN</b>	T1000UC	\$
<input type="checkbox"/> <b>Private Duty Nursing (PDN) - RN</b>	T1000UC	\$
<input type="checkbox"/> <b>Private Duty Nursing Assessment (PDN) – RN</b>	T1000UC	\$

Participant Name	Direct Service Worker Name

**Intermittent-Skilled Nursing Services**

The scope and nature of these services do not differ from skilled nursing furnished under the State Plan. This service includes the home health benefit available under the Medicaid state plan as well as expanded nursing services coverage under this waiver. Services listed in the plan of care that are within the scope of Florida’s Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the state. Skilled nursing services must be listed in the enrollee’s plan of care and are provided on an intermittent basis to enrollees who either do not require continuous nursing supervision or need is predictable.

**Direct Service Worker Schedule**

As the direct service worker, I know that in the Florida Community Care PDO program my participant will set my schedule for when I can work.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

**Direct Service Worker Qualifications**

As the direct service worker, I know that if I provide services in the Florida Community Care PDO program I must meet the following qualifications.

1. Workers must be at least 18 years old.
2. Certified in CPR and First Aid (if required by your participant’s case manager).
3. Pass a Level 2 background screening pursuant to chapter 435 and section 408.809, F.S.

If I am hired to perform Nursing Services in **Intermittent and Skilled Nursing or Private Duty Nursing**, I must also submit proof of either:

1. Registered Nursing License; in accordance with Chapter 464, F.S.
2. Licensed Practical Nursing License; in accordance with Chapter 464, F.S.

**Mutual Responsibilities**

The parties will be responsible for following the policies and procedures of the Florida Community Care PDO program. The direct service worker and participant or Designated Representative will hold harmless, release, and forever discharge the Florida Community Care PDO program and Public Partnerships LLC from any claims and/or damages that might arise out of any action or omissions by me (the direct service worker, the Participant or the Designated Representative).

**Direct Service Worker (herein referred to as "DSW") Acknowledgement**

I acknowledge the following:

1. I am a DSW of the participant and do not work for Public Partnerships or Florida Community Care PDO program or the state of Florida.
2. This agreement does not promise a certain number of hours of work and does not keep my participant from hiring other DSWs.
3. I cannot work and be paid for more hours than the allowed per day.
4. I can only work for one participant at a time.

Participant Name	Direct Service Worker Name

5. Any information shared with me by my participant or the Florida Community Care PDO program and affiliated agencies must kept private.
6. I will carry out assigned duties and jobs explained to me by my participant
7. I am to be dependable and be at work on time.
8. I can only use my participant's personal things if we both agree it is alright.
9. I must be 18 years or older to work for my participant.
10. I will call my participant as soon as possible if I am sick or will not be at work on time .
11. I will give my participant two weeks' notice if I decide to quit this job.
12. I will let the participant's Case Manager know if I cannot get a hold of my participant.
13. My participant will tell me when I can work and what I will be doing if I am hired and can fire me if they want to.
14. My participant will fire me right away if :
  - (1) I am found on a Disqualification Registry or List maintained by the Florida Community Care PDO program or OIG,
  - (2) I abuse, neglect, or misuse funds or property of the participant,
  - (3) I commit fraud or violate the terms of this Agreement.
15. I will have a Level 2 criminal background check through Florida's Agency for Health Care Administration before I am hired, and the results of the criminal background check may be shared with the Florida Community Care PDO program and/or my participant.
16. I know I cannot start my job until I have passed the criminal background check, and my participant has received a "Good to Go" notice from Florida Community Care PDO program through Public Partnerships.
17. I must report possible neglect, abuse or misuse of funds or property to the participant's Case Manager right away. I can also call the Florida Abuse hotline at 1-800-96-ABUSE (22873).
18. I will be paid by Florida Community Care PDO program through Public Partnerships once every two weeks, after we turn in a true and approved timesheet.
19. I cannot turn in a timesheet if :
  - (1) my participant does not have Medicaid anymore,
  - (2) for jobs or hours not allowed on my participant's care plan, or
  - (3) work before my participant gets "Good-to-Go" notice from Florida Community Care PDO program through Public Partnerships.
20. I will not be paid when my participant is hospitalized, or I do other work not allowed on the participant's care plan.
21. I will let the Florida Community Care PDO program through Public Partnerships know if or when my address or personal information changes or if I want to change how I am paid or change my tax withholdings
22. I know that I am paid with federal and/or state funds. True and correct information is expected. Not doing this is breaking the law.
23. I know that I cannot be paid for work I did not do. I know that if I am I will have to pay it back. The withholding process will be overseen by appropriate law. Florida Community Care PDO program through Public Partnerships will pursue all legal means to recover the amount of overpayment.
24. Medicaid Fraud is a felony and can lead to large penalties and/or jail time. I can report any suspected fraud to the PPL Enrollment Specialist and/or the Florida Medicaid Fraud Unit at 1-888-419-3456.

Participant Name	Direct Service Worker Name

**Participant Acknowledgement**

I acknowledge the following:

1. I know my DSW works for me and does not work for Public Partnerships or the Florida Community Care PDO program or the state of Florida.
2. I must let the Florida Community Care PDO program , through Public Partnerships know if I decide to fire any of my DSWs.
3. I know I must fire my DSW right away if:
  - (1) they are on a Provider Disqualification Registry or List maintained by either the Florida Community Care PDO program or OIG,
  - (2) have committed abuse, neglect, or misuse of my funds or property, or
  - (3) have committed fraud or violated the terms of this Agreement.
4. I must report possible neglect, abuse or misuse of funds or property to my Case Manager right away. I can also call the Florida Abuse hotline at 1-800-96-ABUSE (22873)
5. I know my DSW is not allowed to begin working until they pass the background screening and I have a "Good to Go" notice from the Florida Community Care PDO program, through Public Partnerships.
6. I know the Florida Community Care PDO program , through Public Partnerships will pay my DSW for me once every two weeks, after we turn in a true and approved timesheet.
7. I know that my worker may not turn in timesheets if:
  - (1) I do not have Medicaid anymore,
  - (2) the DSW does any jobs or has hours that are not allowed on my care plan, or
  - (3) the DSW begins working before I get a notice of "Good-to-Pay" from the Florida Community Care PDO program through Public Partnerships
8. I know to notify the Florida Community Care PDO program through Public Partnerships if or when my address or personal information changes.
9. I know my DSW will not be paid when I am in the hospital or for other work not allowed on my care plan.
10. My DSW will not get paid if I no longer have Medicaid. If my DSW is paid, then I will need to pay back the monies that my worker received.
11. I know my DSW is paid with federal and/or state fund. I cannot approve timesheets that are not true. If I am not truthful and it is found out, then I will be charged and prosecuted under the law.
12. Medicaid Fraud is a felony and can lead to large penalties and/or jail time. I can report any suspected fraud to the PPL Enrollment Specialist and/or the Florida Medicaid Fraud Unit at 1-888-419-3456.

**Attestation**

By signing below, my employer and I confirm that:

- We have read and understand all program rules.
- Some wages paid to a worker while working in the worker’s home are “Difficulty of Care” wages. Federal income tax is not collected from these types of wages. Some workers in this program are fit for this “Difficulty of Care” income tax exclusion.

Participant Name	Direct Service Worker Name

- I also agree I filled out the Relationship Questionnaire to show my relationship to my participant. The program will use this to collect my FICA taxes. If wrong data in the Relationship Questionnaire or Difficulty of Care Federal Income Tax Exclusion causes too little tax to be collected, it is my duty to pay the tax due.
- I must sign and return this form to work in Florida Community Care PDO program.
- I know what I will be asked to do, and I have agreed to these terms and conditions.
- I further know and agree that violation of any of the terms and/or conditions may result in termination of this agreement.
- I know that to have this job I must have a level 2 criminal background check and be found Eligible.
- I have completed the USCIS Form I-9, as defined in Instructions for Employment Eligibility Verification by the Department of Homeland Security. The Florida Community Care PDO program, through Public Partnerships provides the Form I-9 in the employment packets, and the participant keep the original Form I-9 and forwards a completed copy to the Florida Community Care PDO program, through Public Partnerships; which Public Partnerships will keep in the worker's files.
- I have made a direct deposit payment selection. I authorize the Florida Community Care PDO program, through Public Partnerships to process payments owed to me for services authorized by the Florida Community Care PDO program. Public Partnerships will deposit my payment directly into my bank account using Automated Clearing House (ACH) transaction.
- If I fail to provide complete and correct information on this form, payment processing may be delayed or made impossible. I certify that I have read and will comply with rules governing payments and electronic transfers.
- I authorize the Florida Community Care PDO program through Public Partnerships to withdraw from my account all amounts deposited electronically in error. If my account is closed or has an insufficient balance to allow withdrawal, then I authorize the Florida Community Care PDO program, through Public Partnerships to withhold any payment owed to me by Public Partnerships until the wrong amounts deposited are paid back. If I decide to change or end this deposit authorization, I know that I must send a notice to the Florida Community Care PDO program, through Public Partnerships.

\_\_\_\_\_  
Participant or Designated Representative Name

\_\_\_\_\_  
Participant or Designated Representative Signature (Date)

\_\_\_\_\_  
Direct Service Worker Name

\_\_\_\_\_  
Direct Service Worker Signature Date



# Employment Eligibility Verification

## Department of Homeland Security

### U.S. Citizenship and Immigration Services

**USCIS**  
**Form I-9**  
OMB No. 1615-0047  
Expires 07/31/2026

**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
<p><b>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.</b></p>	Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):					
	<input type="checkbox"/> 1. A citizen of the United States					
	<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)					
	<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)					
<input type="checkbox"/> 4. A noncitizen (other than <b>Item Numbers 2. and 3.</b> above) authorized to work until (exp. date, if any)						
If you check <b>Item Number 4.</b> , 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)	<p><b>Additional Information</b></p>				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)	<p><input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.</p>				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
<p><b>Certification:</b> 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.</p>					
Last Name, First Name and Title of Employer or Authorized Representative			Signature of Employer or Authorized Representative		First Day of Employment (mm/dd/yyyy):
Employer's Business or Organization Name			Employer's Business or Organization Address, City or Town, State, ZIP Code		
Last Name, First Name and Title of Employer or Authorized Representative			Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)

For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 4.

## LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

\* Documents extended by the issuing authority are considered unexpired.

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

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
<ol style="list-style-type: none"> <li>1. U.S. Passport or U.S. Passport Card</li> <li>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</li> <li>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</li> <li>4. Employment Authorization Document that contains a photograph (Form I-766)</li> <li>5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole:                             <ol style="list-style-type: none"> <li>a. Foreign passport; and</li> <li>b. Form I-94 or Form I-94A that has the following:                                     <ol style="list-style-type: none"> <li>(1) The same name as the passport; and</li> <li>(2) An endorsement of the individual's status or parole 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.</li> </ol> </li> </ol> </li> <li>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</li> </ol>	OR	<ol style="list-style-type: none"> <li>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</li> <li>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</li> <li>3. School ID card with a photograph</li> <li>4. Voter's registration card</li> <li>5. U.S. Military card or draft record</li> <li>6. Military dependent's ID card</li> <li>7. U.S. Coast Guard Merchant Mariner Card</li> <li>8. Native American tribal document</li> <li>9. Driver's license issued by a Canadian government authority</li> <li style="text-align: center;"><b>For persons under age 18 who are unable to present a document listed above:</b></li> <li>10. School record or report card</li> <li>11. Clinic, doctor, or hospital record</li> <li>12. Day-care or nursery school record</li> </ol>	AND	<ol style="list-style-type: none"> <li>1. A Social Security Account Number card, unless the card includes one of the following restrictions:                             <ol style="list-style-type: none"> <li>(1) NOT VALID FOR EMPLOYMENT</li> <li>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</li> <li>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</li> </ol> </li> <li>2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)</li> <li>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</li> <li>4. Native American tribal document</li> <li>5. U.S. Citizen ID Card (Form I-197)</li> <li>6. Identification Card for Use of Resident Citizen in the United States (Form I-179)</li> <li>7. Employment authorization document issued by the Department of Homeland Security                             <p style="margin-left: 20px;">For examples, see <a href="#">Section 7</a> and <a href="#">Section 13</a> of the M-274 on <a href="https://uscis.gov/i-9-central">uscis.gov/i-9-central</a>.</p> <p style="margin-left: 20px;">The Form I-766, Employment Authorization Document, is a List A, <b>Item Number 4.</b> document, not a List C document.</p> </li> </ol>
<p><b>Acceptable Receipts</b></p> <p>May be presented in lieu of a document listed above for a temporary period.</p> <p>For receipt validity dates, see the M-274.</p>				
<ul style="list-style-type: none"> <li>• Receipt for a replacement of a lost, stolen, or damaged List A document.</li> <li>• Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual.</li> <li>• Form I-94 with "RE" notation or refugee stamp issued to a refugee.</li> </ul>	OR	<p>Receipt for a replacement of a lost, stolen, or damaged List B document.</p>	AND	<p>Receipt for a replacement of a lost, stolen, or damaged List C document.</p>

\*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.



# Supplement A, Preparer and/or Translator Certification for Section 1

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

USCIS  
Form I-9  
**Supplement A**  
OMB No. 1615-0047  
Expires 07/31/2026

Last Name ( <i>Family Name</i> ) from <b>Section 1</b> .	First Name ( <i>Given Name</i> ) from <b>Section 1</b> .	Middle initial (if any) from <b>Section 1</b> .
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**Instructions:** This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

**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		Date ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )		Middle Initial ( <i>if any</i> )
Address ( <i>Street Number and Name</i> )	City or Town	State	ZIP Code

**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		Date ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )		Middle Initial ( <i>if any</i> )
Address ( <i>Street Number and Name</i> )	City or Town	State	ZIP Code

**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		Date ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )		Middle Initial ( <i>if any</i> )
Address ( <i>Street Number and Name</i> )	City or Town	State	ZIP Code

**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		Date ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )		Middle Initial ( <i>if any</i> )
Address ( <i>Street Number and Name</i> )	City or Town	State	ZIP Code



# Supplement B, Reverification and Rehire (formerly Section 3)

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

USCIS  
Form I-9  
Supplement B  
OMB No. 1615-0047  
Expires 07/31/2026

Last Name ( <i>Family Name</i> ) from Section 1.	First Name ( <i>Given Name</i> ) from Section 1.	Middle initial (if any) from Section 1.
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**Instructions:** This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the [Handbook for Employers: Guidance for Completing Form I-9 \(M-274\)](#)

Date of Rehire ( <i>if applicable</i> )	New Name ( <i>if applicable</i> )		
Date ( <i>mm/dd/yyyy</i> )	Last Name (Family Name)	First Name (Given Name)	Middle Initial

**Reverification:** If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) ( <i>mm/dd/yyyy</i> )
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**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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.**

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date ( <i>mm/dd/yyyy</i> )
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Additional Information (Initial and date each notation.)

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

Date of Rehire ( <i>if applicable</i> )	New Name ( <i>if applicable</i> )		
Date ( <i>mm/dd/yyyy</i> )	Last Name (Family Name)	First Name (Given Name)	Middle Initial

**Reverification:** If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

**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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.**

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date ( <i>mm/dd/yyyy</i> )
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Additional Information (Initial and date each notation.)

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

Date of Rehire ( <i>if applicable</i> )	New Name ( <i>if applicable</i> )		
Date ( <i>mm/dd/yyyy</i> )	Last Name (Family Name)	First Name (Given Name)	Middle Initial

**Reverification:** If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) ( <i>mm/dd/yyyy</i> )
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**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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.**

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date ( <i>mm/dd/yyyy</i> )
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Additional Information (Initial and date each notation.)

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

# 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.

# 2026

<b>Step 1:</b> <b>Enter Personal Information</b>	(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 <a href="http://www.ssa.gov">www.ssa.gov</a> .
	City or town, state, and ZIP code		
	(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

**Caution:** To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.

**TIP:** Consider using the estimator at [www.irs.gov/W4App](http://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](http://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](http://www.irs.gov/W4App) for the most accurate withholding for this step (and Steps 3-4). If you or your spouse have self-employment income, use this option; **or**

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(b) is more accurate

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

<b>Step 3:</b> <b>Claim Dependent and Other Credits</b>	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly):			
	(a) Multiply the number of qualifying children under age 17 by \$2,200 . . . . .		<b>3(a)</b> \$	
	(b) Multiply the number of other dependents by \$500 . . . . .		<b>3(b)</b> \$	
	Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here . . . . .			<b>3</b>

<b>Step 4:</b> <b>Other Adjustments</b>	(a) <b>Other income (not from jobs).</b> 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 . . . . .	<b>4(a)</b> \$
	(b) <b>Deductions.</b> Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here . . . . .	<b>4(b)</b> \$
	(c) <b>Extra withholding.</b> Enter any additional tax you want withheld each <b>pay period</b> . . . . .	<b>4(c)</b> \$

Exempt from withholding	I claim exemption from withholding for 2026, and I certify that I meet <b>both</b> of the conditions for exemption for 2026. See <i>Exemption from withholding</i> on page 2. I understand I will need to submit a new Form W-4 for 2027 <input type="checkbox"/>
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<b>Step 5:</b> <b>Sign Here</b>	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

<b>Employers Only</b>	Employer's name and address	First date of employment	Employer identification number (EIN)

## General Instructions

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

### Future Developments

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

### Purpose of Form

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

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

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

**When to use the estimator.** Consider using the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App) if you:

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

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

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

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

## Specific Instructions

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

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

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

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



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

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

### Step 4.

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

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

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

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



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

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

**1 Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 5. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** \$ \_\_\_\_\_

**2 Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

**a** Find the amount from the appropriate table on page 5 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** \$ \_\_\_\_\_

**b** Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 5 and enter this amount on line 2b . . . . . **2b** \$ \_\_\_\_\_

**c** Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** \$ \_\_\_\_\_

**3** Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. . . . . **3** \_\_\_\_\_

**4 Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (plus any other additional amount you want withheld) . . . . . **4** \$ \_\_\_\_\_

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



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

1 Deductions for qualified tips, overtime compensation, and passenger vehicle loan interest.
a Qualified tips. If your total income is less than \$150,000 (\$300,000 if married filing jointly), enter an estimate of your qualified tips up to \$25,000
b Qualified overtime compensation. If your total income is less than \$150,000 (\$300,000 if married filing jointly), enter an estimate of your qualified overtime compensation up to \$12,500 (\$25,000 if married filing jointly) of the "and-a-half" portion of time-and-a-half compensation
c Qualified passenger vehicle loan interest. If your total income is less than \$100,000 (\$200,000 if married filing jointly), enter an estimate of your qualified passenger vehicle loan interest up to \$10,000
2 Add lines 1a, 1b, and 1c. Enter the result here
3 Seniors age 65 or older. If your total income is less than \$75,000 (\$150,000 if married filing jointly):
a Enter \$6,000 if you are age 65 or older before the end of the year
b Enter \$6,000 if your spouse is age 65 or older before the end of the year and has a social security number valid for employment
4 Add lines 3a and 3b. Enter the result here
5 Enter an estimate of your student loan interest, deductible IRA contributions, educator expenses, alimony paid, and certain other adjustments from Schedule 1 (Form 1040), Part II. See Pub. 505 for more information
6 Itemized deductions. Enter an estimate of your 2026 itemized deductions from Schedule A (Form 1040). Such deductions may include qualifying:
a Medical and dental expenses. Enter expenses in excess of 7.5% (0.075) of your total income
b State and local taxes. If your total income is less than \$505,000 (\$252,500 if married filing separately), enter state and local taxes paid up to \$40,400 (\$20,200 if married filing separately)
c Home mortgage interest. If your home acquisition debt is less than \$750,000 (\$375,000 if married filing separately), enter your home mortgage interest expense (including mortgage insurance premiums)
d Gifts to charities. Enter contributions in excess of 0.5% (0.005) of your total income
e Other itemized deductions. Enter the amount for other itemized deductions
7 Add lines 6a, 6b, 6c, 6d, and 6e. Enter the result here
8 Limitation on itemized deductions.
a Enter your total income
b Subtract line 4 from line 8a. If line 4 is greater than line 8a, enter -0- here and on line 10. Skip line 9
9 Enter: { \$768,700 if you're married filing jointly or a qualifying surviving spouse; \$640,600 if you're single or head of household; \$384,350 if you're married filing separately }
10 If line 9 is greater than line 8b, enter the amount from line 7. Otherwise, multiply line 7 by 94% (0.94) and enter the result here
11 Standard deduction.
Enter: { \$32,200 if you're married filing jointly or a qualifying surviving spouse; \$24,150 if you're head of household; \$16,100 if you're single or married filing separately }
12 Cash gifts to charities. If you take the standard deduction, enter cash contributions up to \$1,000 (\$2,000 if married filing jointly)
13 Add lines 11 and 12. Enter the result here
14 If line 10 is greater than line 13, subtract line 11 from line 10 and enter the result here. If line 13 is greater than line 10, enter the amount from line 12
15 Add lines 2, 4, 5, and 14. Enter the result here and in Step 4(b) of Form W-4

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

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

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

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

### Married Filing Jointly or Qualifying Surviving Spouse

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

### Single or Married Filing Separately

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

### Head of Household

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



# ATTESTATION OF COMPLIANCE with Background Screening Requirements

**Authority:** This form may be used by **all employees** to comply with:

- the attestation requirements of **section 435.05(2), Florida Statutes**, which state that every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer; **AND**
- the proof of screening within the previous 5 years in **section 408.809(2), Florida Statutes** which requires proof of compliance with level 2 screening standards that have been screened through the Care Provider Background Screening Clearinghouse created under Section 435.12, F.S., or screened within the previous 5 years by the Agency, Department of Health, Department of Elder Affairs, the Agency for Persons with Disabilities, Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S., and in accordance with the standards in Section 408.809(2), F.S., if that agency is not currently implemented in the Care Provider Background Screening Clearinghouse.

***This form must be maintained in the employee's personnel file.*** If this form is used as proof of screening for an administrator or chief financial officer to satisfy the requirements of an **application for a health care provider license**, please attach a copy of the screening results and submit with the licensure application.

**Employee/Contractor Name:**

**Health Care Provider/ Employer Name:**

**Address of Health Care Provider:**

I hereby attest to meeting the requirements for employment and that I have not been arrested for or ~~or~~ and been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty to any offense, or have an arrest awaiting a final disposition prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction:

**Criminal offenses found in section 435.04, F.S.**

- (a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.
- (b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.
- (c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.
- (d) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.
- (e) Section 782.04, relating to murder.

(f) Section 782.07, relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child.

(g) Section 782.071, relating to vehicular homicide

(h) Section 782.09, relating to killing of an unborn quick child by injury to the mother.

(i) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.

(j) Section 784.011, relating to assault, if the victim of the offense was a minor.

(k) Section 784.03, relating to battery, if the victim of the offense was a minor.

(l) Section 787.01, relating to kidnapping.

- (m) Section 787.02, relating to false imprisonment.
- (n) Section 787.025, relating to luring or enticing a child.
- (o) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.
- (p) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.
- (q) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.
- (r) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.
- (s) Section 794.011, relating to sexual battery.
- (t) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.
- (u) Section 794.05, relating to unlawful sexual activity with certain minors.
- (v) Chapter 796, relating to prostitution.
- (w) Section 798.02, relating to lewd and lascivious behavior.
- (x) Chapter 800, relating to lewdness and indecent exposure.
- (y) Section 806.01, relating to arson.
- (z) Section 810.02, relating to burglary.
- (aa) Section 810.14, relating to voyeurism, if the offense is a felony.
- (bb) Section 810.145, relating to video voyeurism, if the offense is a felony.
- (cc) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.
- (dd) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.
- (ee) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.
- (ff) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.
- (gg) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.
- (hh) Section 826.04, relating to incest.
- (ii) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child
- (jj) Section 827.04, relating to contributing to the delinquency or dependency of a child.
- (kk) Former s. 827.05, relating to negligent treatment of children.
- (ll) Section 827.071, relating to sexual performance by a child.
- (mm) Section 843.01, relating to resisting arrest with violence.
- (nn) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.
- (oo) Section 843.12, relating to aiding in an escape.
- (pp) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.
- (qq) Chapter 847, relating to obscene literature.
- (rr) Section 874.05(1), relating to encouraging or recruiting another to join a criminal gang.
- (ss) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.
- (tt) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.
- (uu) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.
- (vv) Section 944.40, relating to escape.
- (ww) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.
- (xx) Section 944.47, relating to introduction of contraband into a correctional facility.
- (yy) Section 985.701, relating to sexual misconduct in juvenile justice programs.
- (zz) Section 985.711, relating to contraband introduced into detention facilities.
- (3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

**Criminal offenses found in section 408.809(4), F.S.**

- (a) Any authorizing statutes, if the offense was a felony.
- (b) This chapter, if the offense was a felony.
- (c) Section 409.920, relating to Medicaid provider fraud.
- (d) Section 409.9201, relating to Medicaid fraud.
- (e) Section 741.28, relating to domestic violence.
- (f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.
- (g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.
- (h) Section 817.234, relating to false and fraudulent insurance claims.
- (i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.
- (j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.
- (k) Section 817.505, relating to patient brokering.
- (l) Section 817.568, relating to criminal use of personal identification information.

- (m) Section 817.60, relating to obtaining a credit card through fraudulent means.
- (n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.
- (o) Section 831.01, relating to forgery.
- (p) Section 831.02, relating to uttering forged instruments.
- (q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.
- (r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.
- (s) Section 831.30, relating to fraud in obtaining medicinal drugs.
- (t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony.
- (u) Section 895.03, relating to racketeering and collection of unlawful debts.
- (v) Section 896.101, relating to the Florida Money Laundering Act.

**I have been granted an Exemption from Disqualification through the Agency for Healthcare Administration (AHCA).**

*Date of Decision:* \_\_\_\_\_

**I have been granted an Exemption from Disqualification through the Florida Department of Health.**

*Date of Decision:* \_\_\_\_\_

**\*\*A copy of the Exemption from Disqualification decision letter must be attached\*\***

If you are also using this form to provide evidence of prior Level 2 screening (fingerprinting) in the last 5 years and have not been unemployed for more than 90 days, please provide the following information. **A copy of the prior screening results must be attached.**

Purpose of Prior Screening: \_\_\_\_\_

Screening conducted by: \_\_\_\_\_ Date of Prior Screening: \_\_\_\_\_

- Agency for Healthcare Administration
- Department of Health
- Agency for Persons with Disabilities

- Department of Elder Affairs
- Department of Financial Services
- Department of Children and Family Services

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## Attestation

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Under penalty of perjury, I, \_\_\_\_\_, hereby swear or affirm that I meet the requirements for qualifying for employment in regards to the background screening standards set forth in Chapter 435 and section 408.809, F.S. In addition, I agree to immediately inform my employer if arrested or convicted of any of the disqualifying offenses while employed by any health care provider licensed pursuant to Chapter 408, Part II F.S.

\_\_\_\_\_  
Employee/Contractor Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date



## PRIVACY POLICY ACKNOWLEDGEMENT FORM

I acknowledge that I have received a copy of the privacy policies from the Florida Department of Law Enforcement and the Federal Bureau of Investigation, which describe the exchange of information where criminal record results will become part of the Care Provider Background Screening Clearinghouse.

I understand and agree that I will read and comply with the guidelines contained in the privacy policies.

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Employee/Contractor Name (Printed)

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Employee/Contractor Signature

---

Date

## FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORD RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING CLEARINGHOUSE

### NOTICE OF:

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record that may pertain to you to the Specified Agency or Agencies from which you are seeking approval to be employed, licensed, work under contract, or to serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes. "Specified agency" means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Persons with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearinghouse will be notified if FDLE receives Florida arrest information on you.

Your Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies' duties in distinguishing your identity from that of other persons whose identification information may be the same as or similar to yours.

Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of the record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in s. 943.056, F.S., and Rule 11C8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.

Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

The FBI's Privacy Statement follows on a separate page and contains additional information.

**US Department of Justice**  
Federal Bureau of Investigation  
*Criminal Justice Information Services Division*



## **FBI PRIVACY ACT STATEMENT**

### **Authority:**

The FBI's acquisition, preservation, and exchange of information requested by this form is generally authorized under 28 U.S.C.534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub.L. 92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L. 94-29; Pub.L. 101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion or approval of your application.

### **Social Security Account Number (SSAN).**

Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal agencies to use this number to help identify individuals in agency records.

### **Principal Purpose:**

Certain determinations, such as employment, security, licensing, and adoption, may be predicated on fingerprint-based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as may be relevant to the activity for which this application is being submitted, the FBI may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

### **Routine Uses:**

The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as may be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice/FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement, counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law, treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing this application, they may have additional routine uses.

### **Additional Information:**

The requesting agency and/or the agency conducting the application-investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice in the Federal Register describing any system(s) of records in which that agency may also maintain your records, including the authorities, purposes, and routine uses for the system(s).