COMMUNITY BEHAVIORAL HEALTH

www.communitybehavioralhealth.net

Phone: (844) 224-5264

Human Resources Fax (443) 230-4324 **Main Fax: (888) 509-0010** **Billing/Financial Fax (410) 824-1323**

Dear Potential New Staff,

Thank you for considering Community Behavioral Health, LLC as your new place of employment.

Before you join CBH, the Human Resources Department can aid you in filling out the paperwork and determine a start date: Please complete the background check as soon as possible. Orientation cannot be scheduled without clearance.

1. CJIS Background Check (Federal and State)
2. Physical Check Form signed by a medical provider.
3. PPD / TB Test Results
4. Flu Vaccination Form
5. Three professional references
6. Health Internship In-take form
7. Unpaid Internship Contract (you can start to fill this out but will be complete by HR)

All forms to be sent to HR@cbh.clinic

Best wishes,

Human Resources

426 Dorchester Ave
Cambridge, MD 21613

30519 Prince William Street
Princess Anne, MD 21853

809, 811, 817 & 821 Eastern Shore Drive
Salisbury, MD 21804

10774 & 10810 Hickory Ridge Road
Columbia, MD 21044

138 Coursevall Drive
Centreville, MD 21617

300 Scheeler Rd
Chestertown, MD 21620

STATE OF MARYLAND
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES
CRIMINAL JUSTICE INFORMATION SYSTEMS – CENTRAL REPOSITORY

LIVESCAN PRE-REGISTRATION APPLICATION

APPLICANT INFORMATION *(PLEASE TYPE OR PRINT CLEARLY)*

Name:

Date of birth: | SSN: | Gender: ☐ Male ☐ Female *(Please check)*

Height: ft. inches | Weight: lbs. | Eye Color: | Hair Color:

Race: ☐ Black ☐ White ☐ Asian/Pacific Islander ☐ Native American ☐ Other *(Please check)*

Place of Birth: | Citizenship:

Current address:

City: | State: | ZIP Code: -

Daytime Phone: | Evening Phone: ———— | Driver's License #:

AGENCY INFORMATION

Agency Authorization #: 1100007451

ORI # (if required): | Reason fingerprinted? Background Check

Position Applied for:

Request Type: *(Choose one ONLY)*

- ☐ Adult Dependent Care
- ☐ Attorney/Client
- ☒ Child care
- ☐ Criminal Justice
- ☐ Gold Seal/ Adoption
- ☐ Gold Seal/Letter/VISA
- ☐ Government Employment
- ☐ Government Licensing or Certification
- ☐ Immigration/VISA
- ☐ Individual Challenge
- ☐ Individual Review
- ☐ MSP Licensing
- ☐ Private Party Petition
- ☐ Public Housing

Mail Response to:
(Mailing option only available for Visa Gold Seal and/or Individual Review)

Name: _____

Address: _____

City, State, Zip code: _____

COMMUNITY BEHAVIORAL HEALTH

426 Dorchester Ave.
Cambridge, MD 21613
Phone: 410-228-3929
Fax: 410-228-3810

821 Eastern Shore Dr.
Salisbury, MD 21801
Phone: 410-334-6687
Fax: 410-334-6700

142 Coursevall Dr.
Centreville, MD 21617
Phone: 410-758-1787
Fax: 410-758-1789

Background Checks – CJIS Approved Sites:

3M Cogent Fingerprinting Services c/o Anne Arundel County Community College Department of Public Safety	Central Services Building 101 College Parkway Arnold, Maryland 21012	410.777.2440
3M Cogent Fingerprinting Services c/o Bay Shore Services, Inc.	1235 Pemberton Dr. Salisbury, MD 21801	410.341.0307 x106
3M Cogent Fingerprinting Services Main-One (M-1) Solutions, Inc	4300 Forbes Blvd. Suite 220 Lanham, MD 20706	301.702.7200
3M Cogent Fingerprinting Services c/o Fairmount Heights Police Department	6100 Jost Street Fairmount Heights, MD 20743	301.883.9472
3M Cogent Fingerprinting Services c/o Xecutive Security Investigations Group	821 E. Baltimore St. Baltimore, MD 21202	410.800.8844
911 Security & Investigations, LLC	850 Sligo Avenue #502D Silver Springs, MD 20910	301.755.6138
Absolute Investigative Service	604 E. Joppa Road Towson, MD 21286	410.828.6460
Absolute Investigative Services, Inc.	139 N. Main Street #103 Bel Air, Maryland 21014	410.420.6923
Allied Barton Security Services	7939 Honeygo Blvd. Suite 203 Nottingham, MD 21236	410.931.5061 (by appointment only)
All American Protective Services, LLC	6701 Democracy Blvd. Suite 110 Bethesda, MD 20817	301.296.4499
All American Protective Services, LLC	12501 Prosperity Drive Suite 200 Silver Spring, MD 20904	240.670.7952
All American Protective Services, LLC	7361 Calhoun Place Suite 485 Rockville, MD 20855	301.296.4499
American Fingerprinting Services	7272 Wisconsin Avenue Suite 300 Bethesda, MD 20814	301.941.1916
Apex Investigative Services	1916 Crain Hwy S. Ste. 11	410.590.3700

	Glen Burnie, MD 21061	
Biometrics Identity Verification System	5010 Sunnyside Avenue #300 Beltsville, Maryland 20705	301.477.3210
Biometrics Identity Verification System	6214 Reisterstown Road Baltimore, MD 21215	443.213.8245 443.213.8625 (f)
Broadway Services, Inc.	3709 E. Monument St. Baltimore, Maryland 21205	410.563.6949
E House Executive Security Professionals, Inc	4710 Auth Pl Suite 420 Suitland, MD 20746	301.899.2828
Elite People Protective Services	5602 Baltimore National Pike Catonsville, MD 21228	410.788.0111
Essential Support Services	2030 Liberty Road Unit #10 Eldersburg, MD 21784	443.223.2080
FYI Fingerprints	3696 Park Avenue Ellicott City, MD 21043	410.418.4657
Grand Mission Consult	7515 Annapolis Rd #203 Hyattsville, MD 20784	301.429.0525
Hughes Barney Investigations	9315 Largo Drive West Suite 210 Largo (Upper Marlboro), MD 20774	301.333.1728
Inquiries, Inc.	129 N. West Street Easton, MD 21601	866.987.3767
Inquiries, Inc. c/o Pinkerton	11019 McCormick Rd Ste 200 Hunt Valley, MD 21031	800.635.1649
MorphoTrust USA (L-1) c/o ABCO Investigations	10545 Friendship Road Berlin, MD 21811	877.467.9215
MorphoTrust USA (L-1) c/o BITHGROUP Technologies	113 Monument Street Baltimore, MD 21201	877.467.9215
MorphoTrust USA (L-1) c/o Securitas Security Services	1101 Opal Court Suite 211 Hagerstown, MD 21740	877.467.9215
MorphoTrust USA (L-1) c/o Securitas Security Services	7004 Security Boulevard Suite 200 Baltimore, MD 21244	877.467.9215
Maryland Livescan, Inc.	The Empire Towers Building 7310 Ritchie Hwy. Suite 610 Glen Burnie, MD 21061-3290	410.761.6700
Mid-Atlantic Regional Investigations, LLC	1202 West Street Annapolis, MD 21401	888.320.7775
Optimal Health Care	6 West Washington Street Hagerstown, MD 21740	301.790.4962
Positive I.D., Inc.	103 Sudbrook Lane #4 Pikesville, MD 21208	410.602.2479
Prevent First	3710 Riviera Street #1A Temple Hills, MD 20748	301.423.5414
Quick Fingerprints	11605 Crossroads Circle Suite F Middle River, MD 21220	855.463.7226
Renoxx Group, LLC	ID Solutions 9500 Annapolis RD	301.850.1148

	Suite B2 Lanham, MD 20706	
Scotty's Investigations, Inc.	515 Regina Avenue Cumberland, MD 21502	301.777.0232
Securpros	9300 Annapolis Road #103 Lanham, MD 20706	301.459.8322
Thomas Security	1325 Mt. Hermon Road Salisbury, MD 21804	410.548.5029
Three Brothers	3061 Frederick Avenue Baltimore, MD 21223	410.566.9112
United Security & Communications, Inc.	5415 Southern Maryland Blvd. Wayson's Corner (Lothian), MD 20711	301.952.8724
Worldwide Investigations, LLC	312 N.Charles Street Suite # 300	410.244.1756
Worth-A-Shot, Inc.	8424 Veterans Highway #5 Millersville, MD 21108	443.688.6521

Aflac®

An Independent Agent Representing Aflac

Congratulations on your employment with Community Behavioral Health. As a new employee, you have access to AFLAC Supplemental Insurance Policies. AFLAC insurance can assist you with your high deductibles and out of pocket expenses.

We can assist you with:

24-hour Accident coverage
Hospital
Cancer
Critical Care
Additional Dental and Vision coverage
Short Term Disability
Whole Life
Term Life
Juvenile Life

Policies start as low as $6.00 per week. We can custom-tailor a benefit package for you and your family's needs.

All AFLAC insurance premiums, **EXCEPT** those for Short Term Disability and Life Insurance policies, are deducted on a pre-tax basis.

Please contact John Allen at 302-245-5612 or email j2_allen@us.aflac.com to schedule an appointment.

Employment Application

Thank you for interest in applying for a position with us. Community Behavioral Health, LLC is and Equal Opportunity Employer. We consider all applications without regard to race, color, religion, sex, national origin, age, disability, veteran's status, marital status, or actual or perceived sexual orientation or any other characteristic protected by federal, state, or local law.

APPLICANT INFORMATION				
Last Name	First		M.I.	Date
Street Address			Apartment/Unit #	
City	State		ZIP	
Phone	E-mail Address			
Date Available	Social Security No.		Desired Salary	
Position Applied for				
Are you a citizen of the United States?	YES ☐	NO ☐	If no, are you authorized to work in the U.S.?	YES ☐ NO ☐
Have you ever worked for this company?	YES ☐	NO ☐	If so, when?	
Have you ever been convicted of a felony?	YES ☐	NO ☐	If yes, explain	
Have you ever been convicted of healthcare fraud or listed by a governmental agency as excluded, debarred or otherwise ineligible to participate in government funded healthcare program?	YES ☐	NO ☐	If yes, explain	
Are you physically able to perform the duties of the position that you are applying for?	YES ☐	NO ☐	If no, explain	

EDUCATION				
High School/GED	Address			
	Did you graduate?	YES ☐	NO ☐	Degree
College	Address			
	Did you graduate?	YES ☐	NO ☐	Degree
Other	Address			
	Did you graduate?	YES ☐	NO ☐	Degree

REFERENCES	
Please list three professional references.	
Full Name	Relationship

Company	Phone ( )
Address	
Full Name	Relationship
Company	Phone ( )
Address	
Full Name	Relationship
Company	Phone ( )
Address	

PREVIOUS EMPLOYMENT

Company	Phone ( )	
Address	Supervisor	
Job Title	Starting Salary $	Ending Salary $
Responsibilities		
From To	Reason for Leaving	
May we contact your previous supervisor for a reference?	YES ☐	NO ☐
Company	Phone ( )	
Address	Supervisor	
Job Title	Starting Salary $	Ending Salary $
Responsibilities		
From To	Reason for Leaving	
May we contact your previous supervisor for a reference?	YES ☐	NO ☐
Company	Phone ( )	
Address	Supervisor	
Job Title	Starting Salary $	Ending Salary $
Responsibilities		
From To	Reason for Leaving	
May we contact your previous supervisor for a reference?	YES ☐	NO ☐

MILITARY SERVICE

Branch	From To
Rank at Discharge	Type of Discharge

If other than honorable, explain

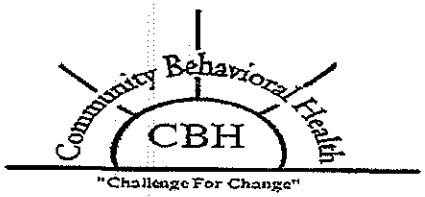
DISCLAIMER AND SIGNATURE

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

Signature

Date



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PRE-HIRE DRIVING RECORD RELEASE

I _____ (*print your name*) authorize Community Behavioral Health (CBH) to pull my drivers record as part of the pre hiring process. I also understand that the position I am applying for requires an annual driving record check on file with CBH as part of the requirement of employment of the position being offered to me. I will provide a clear copy of my Valid and current Driver's license to CBH with this release for them to process my pre hire paperwork as needed.

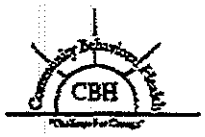
Last 4 Digits of SSN: _____

Driver Licence No: _____

Signature : _____

Print Name : _____

Date : _____



COMMUNITY BEHAVIORAL HEALTH

Applicant Reference Release

I hereby authorize **COMMUNITY BEHAVIORAL HEALTH** ("the Company") to contact any company, person, or educational institution I listed as a reference on my employment application. I hereby allow any company, person, or educational institute I listed as a reference on my employment application to disclose any information they may have regarding my qualifications for employment, including but not limited to employment dates, descriptions of jobs performed, salary and wage rates and personal attributes.

I agree to release and discharge _____ successors, employees, officers, and directors as well as any company, person or educational institution I have listed as a reference for all claims, liabilities, and causes of action, known or unknown, fixed or contingent, for providing or receiving any information regarding my qualifications for employment. This release includes, but is not limited to, claims of defamation, libel, slander, negligence, or interference with contract or profession.

_____

Print Name

_____

Signature

_____

Date

COMMUNITY BEHAVIORAL HEALTH

PROFESSIONAL REFERENCE CHECK FORM

Please provide us with at least 3 professional references per details below. Your employment with CBH is contingent upon a clear reference and background check.

PROFESSIONAL REFERENCE

1	Name	
	Title of Reference	
	Phone	
	E-mail	
	Years Known	
	Relationship To You	

2	Name	
	Title of Reference	
	Phone	
	E-mail	
	Years Known	
	Relationship To You	

3	Name	
	Title of Reference	
	Phone	
	E-mail	
	Years Known	
	Relationship To You	

Candidate Name _____

Candidate Signature _____

COMMUNITY BEHAVIORAL HEALTH

PROFESSIONAL REFERENCE CHECK FORM

Date _____

Candidate Address _____

Contact (Phone & E-mail) _____

_____

HR Department Notes : _____

AGENCY PRIVACY REQUIREMENTS FOR NONCRIMINAL JUSTICE APPLICANTS

Authorized governmental and non-governmental agencies/officials that conduct a national fingerprint-based criminal history record check on an applicant for a noncriminal justice purpose (such as employment or a license, immigration or naturalization matter, security clearance, or adoption) are obligated to ensure the applicant is provided certain notice and other information and that the results of the check are handled in a manner that protects the applicant's privacy. These obligations are pursuant to the Privacy Act of 1974, Title 5, United States Code (U.S.C.) Section 552a, and Title 28, Code of Federal Regulations (CFR), Section 50.12, among other authorities.

- **Officials must provide to the applicant written notification[1] that his/her fingerprints will be used to check the criminal history records of the FBI.**
- **Officials must ensure that an applicant receives and acknowledges receipt of, an adequate Privacy Act Statement when the applicant submits his/her fingerprints and associated personal information.[2]**
- **Officials using the FBI criminal history record (if one exists) to make a determination of the applicant's suitability for the employment, license, or other benefit must provide the applicant the opportunity to complete or challenge the accuracy of the information in the record.**
- **Officials must advise the applicant that procedures for obtaining a change, correction, or update of an FBI criminal history record are set forth at 28 CFR 16.34.**
- **Officials should not deny the employment, license, or other benefit based on information in the criminal history record until the applicant has been afforded a reasonable time to correct or complete the record or has declined to do so.**
- **Officials must use the criminal history record solely for the purpose requested and cannot disseminate the record outside the receiving department, related agency, or other authorized entity.[3]**

The FBI has no objection to officials providing a copy of the applicant's FBI criminal history record to the applicant for review and possible challenge when the record was obtained based on positive fingerprint identification. If agency policy permits, this courtesy will save the applicant the time and additional FBI fee to obtain his/her record directly from the FBI by following the procedures found at 28 CFR 16.30 through 16.34. It will also allow the officials to make a more timely determination of the applicant's suitability.

Each agency should establish and document the process/procedures it utilizes for how/when it gives the applicant notice, what constitutes "a reasonable time" for the applicant to correct or complete the record, and any applicant appeal process that is afforded the applicant. Such documentation will assist State and/or FBI auditors during periodic compliance reviews on use of criminal history records for noncriminal justice purposes.

Name_____ Date_____

[1] Written notification includes electronic notification, but excludes oral notification.
[2] See https://www.fbi.gov/services/cjis/compact-council/privacy-act-statement
[3] See 5 U.S.C. 552a(b); 28 U.S.C. 534(b); 42 U.S.C. 14616, Article IV(c); 28 CFR 20.21(c), 20.33(d), 50.12(b) and 906.2(d).

COMMUNITY BEHAVIORAL HEALTH

EMPLOYEE PHYSICAL FITNESS FORM

FULL NAME	DATE OF BIRTH SOC.SEC. #	AGE
ADDRESS: (STREET #, CITY, STATE, ZIP)		SEX
HAVE YOU EVER HAD , OR HAVE YOU NOW, ANY OF THE FOLLOWING (check all that apply)		

_____ HEADACHE	_____ HEART PROBLEMS
_____ DIZZINESS	_____ HIGH BLOOD PRESSURE
_____ UNCONSCIOUSNESS	_____ STOMACH PROBLEMS
_____ EYE TROUBLE	_____ KIDNEY STONE (BLOOD IN URINE)
_____ ALLERGIES	_____ ASTHMA
_____ DIABETES	
_____ TEETH/GUM TROUBLE	_____ CONVULSIONS
_____ HERNIA	_____ BACK TROUBLE
_____ ARTHRITIS (RHEUMATISM)	_____ ANXIETY DISORDER
_____ DRUG/ALCOHOL DEPENDENCY	_____ DEPRESSION
_____ SKIN PROBLEMS	_____ TYPHOID FEVER
_____ SMOKER	_____ VENEREAL DISEASE
_____ SURGERY	_____ PROBLEM PREGNANCY
_____ HIGH CHOLESTEROL	_____ MENSTRUAL PROBLEMS
_____ PROSTATE PROBLEMS	_____ OTHER

DESCRIBE ANY ITEMS CHECKED ABOVE

_____

_____

_____

NAME OF PERSONAL PHYSICIAN: ADDRESS OF PHYSICIAN:

LIST MEDICATIONS YOU ARE CURRENTLY TAKING:

HEIGHT: WEIGHT: PULSE: BLOOD PRESSURE:

PPD RESULTS:

PHYSICAL EXAMINATION RESULTS:

HEENT _____ CHEST _____

CV _____ ABD _____

M/S _____ EXT _____

EMPLOYEE PRESENTS TO BE FREE OF HEALTH, EMOTIONAL, OR PSYCHOLOGICAL IMPAIRMENTS WHICH WOULD ENDANGER THE PHYSICAL AND PSYCHOLOGICAL WELL BEING OF CHILDREN:

_____ YES, QUALIFIED FOR EMPLOYMENT

_____ NO, DISQUALIFIED

RECOMMENDATIONS:

_____

_____

MEDICAL EXAMINER'S SIGNATURE:

PRINT EXAMINER'S NAME:

EXAM DATE :

Tuberculosis Skin Test Form

Healthcare Professional/Patient Name: _____

Testing Location: _____

Date Placed: _____

Site: ☐ Right ☐ Left

Lot#: _____ Expiration Date: _____

Signature (administered by): _____

☐ RN ☐ MD Other: _____

Date Read (within 48-72 hours from date placed): _____

Induration (please note in mm): _____mm

PPD (Mantoux) Test Result: ☐ Negative ☐ Positive

Signature (results read/reported by): _____

☐ RN ☐ MD Other: _____

Declination of Influenza Vaccination

Community Behavioral Health has recommended that I receive influenza vaccination to protect the patients I serve.

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands of people in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare workers to protect this facility's patients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.
- If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't change, my immunity declines over time. This is why vaccination against influenza is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including
    - all patients in this healthcare facility
    - my co-workers
    - my family
    - my community

Despite these facts, I am choosing to decline influenza vaccination right now for the following reasons: _____

_____

I understand that I can change my mind at any time and accept influenza vaccination, if vaccine is still available.

I have read and fully understand the information on this declination form.

Signature: _____ Date: _____

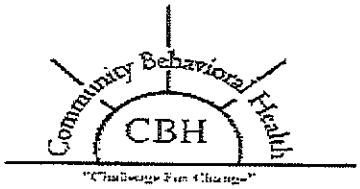
Name (print): _____

Department: _____

Reference: CDC. Prevention and Control of Influenza with Vaccines— Recommendations of ACIP at www.cdc.gov/flu/professionals/acip/index.htm

Technical content reviewed by the Centers for Disease Control and Prevention, October 2011.

www.immunize.org/catg.d/p4068.pdf • Item #P4068 (10/11)



Flu Vaccine Confirmation Form

Healthcare Professional/Patient Name:

Testing Location:

Date Placed:

Sight: Left or Right?

Lot#:

Expiration Date:

Signature (administered by):

Qualification of administrator:

COMMUNITY BEHAVIORAL HEALTH

NEW EMPLOYEE ORIENTATION

Human Resource / Finance Department Onboarding Checklist

Employee Name : _____

Position : _____

Start Date : _____

Oriented to	Orientation Date	Oriented by (Name & Initial)	Comment / Follow Up
Agency Mission & Philosophy			
Organizational Chart			
Job Description			
Time Reporting			
Employee Rights - Grievance			
Employee Rights - Complaints			
Confidentiality & HIPAA			
Emergency Procedures			
Env. of care (if applicable)			
Emergency Evacuation Infestation Policy Infection Polity			

Employee Handbook (Policies & Proc)			
ADP Training			
E-mail ID			
Ringcentral Extns.			
Open EMR Logins & Access			
CBH ID Badge			
Gas Card			
Travel / Vehicle Policy			
Provider Connect Login / Access			

Employee Signature : _____

Print Name : _____

Date : _____

COMMUNITY BEHAVIORAL HEALTH

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Payroll Information & Emergency Contact Form

PERSONAL INFORMATION

First Name : _____

Middle Name : _____

Last Name : _____

SSN No : _____ - _____ - _____

Date of Birth : _____ / _____ / _____ (MM/DD/YYYY)

Are you a Tobacco User ? Yes / No *(Please circle one. Data required by our insurance company)*

Do you have Medicare ? _____

Do You Have Medicaid ? _____

Your Current Address : _____

_____

City _____ State _____ Zip _____

Your Permanent Address : _____

_____

City _____ State _____ Zip _____

Home Phone No: _____ - _____ - _____ / _____ - _____ - _____

Cell Phone Nos : _____ - _____ - _____ / _____ - _____ - _____

Your working personal Email Address : _____

VOLUNTARY SELF IDENTIFICATION

Gender : Male ☐ Female ☐ Do not wish to identify ☐ Other _____

Marital Status : _____

Race / Ethnicity :

- ☐ Hispanic/Latino ☐
- ☐ Black/African American ☐
- ☐ White ☐
- ☐ American Indian/Alaskan Native ☐
- ☐ Asian ☐
- ☐ Native Hawaiian or Other Pacific Islander ☐
- ☐ Two or More Races (Not Hispanic or Latino) ☐
- ☐ Do Not Wish to Identify ☐

Race/Ethnic Definitions:

• *Hispanic/Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.*

• *Black/African American (not Hispanic or Latino): A person having origins in any of the black racial groups of Africa.*

• *White (not Hispanic or Latino): A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.*

• *American Indian/Alaskan Native (not Hispanic or Latino): A person having origins in any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment.*

• *Asian (not Hispanic or Latino): A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.*

• *Native Hawaiian or Other Pacific Islander (not Hispanic or Latino): A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.*

• *Two or More Races (not Hispanic or Latino): A person who identifies with two or more race categories named above.*

Are you a Veteran ? Yes / No *(Circle One)*

OR select the box(s) that apply to your veteran status.

I am not a veteran. (I did not serve in the military.) ☐

I belong to the following classifications of protected veterans (Choose all that apply):

DISABLED VETERAN ☐

RECENTLY SEPARATED VETERAN ☐

Military Discharge Date (MM/DD/YYYY): _____/_____/_____

ACTIVE WARTIME OR CAMPAIGN BADGE VETERAN ☐

ARMED FORCES SERVICE MEDAL VETERAN ☐

I am NOT a protected veteran. (I served in the military but do not fall into any veteran categories listed above.) ☐

I choose not to identify my veteran status. ☐

EMERGENCY CONTACTS :

Name of Primary Emergency Contact : _____

Relationship to Primary Emergency Contact : _____

Primary Emergency Contact's Address : _____

_____ City _____ State _____ Zip _____

Primary Emergency Contact's Working Phone Numbers : _____ - _____ - _____ (Home)

_____ - _____ - _____ (Cell 1)

_____ - _____ - _____ (Cell 2)
(Put N/A if not applicable)

Primary Contact's Email Address : _____
(please provide a personal working email for your secondary emergency contact)

Name of Secondary Emergency Contact : _____

Relationship to Secondary Emergency Contact : _____

Secondary Emergency Contact's Address : _____

_____ City _____ State _____ Zip _____

Secondary Emergency Contact's Phone Numbers : _____ - _____ - _____ (Home)

_____ - _____ - _____ (Cell 1)

_____ - _____ - _____ (Cell 2)
(Put N/A if not applicable)

Secnodary Contact's Email Address : _____
(please provide a personal working email for your secondary emergency contact)

DIRECT DEPOSIT :

Do you wish to enroll in Direct Deposit ? Yes ☐ / No ☐

If yes Please fill out the ADP Direct Deposit form.

Do you wish to receive Health / Dental / Vision Coverage ? Yes ☐ / No ☐

Do you wish to receive Supplemental Coverage (AFLAC) ? Yes ☐ / No ☐

DECLARATION :

I solemnly affirm that the information provided above is true and accurate to the best of my knowledge. I understand that CBH requires this information on file to be used in emergency and contingent situations.

I further agree that it is my responsibility to update the payroll and HR department with changes to any information requested in this form within 15 working days. Deviation to the 15 day rule will require written waiver from my supervisor and/or Dr. Mr. or Mrs. Jani.

In the event of my failure to provide updated information regarding changes to my personal information to the CBH Payroll and HR department as soon as reasonably possible, I understand that CBH and its personnel or successors will not be held liable in any circumstances that may result out of my non compliance.

Employee Signature: _____ **Date:** _____

For Official Use Only

Employee Name : _____

First date of employment: _____/_____/_____ (MM / DD / YYYY)

Wage Type :	Salaried	☐	Other *(Pl. Specify)*: _____
	Hourly	☐	
	Guaranteed Pay	☐	
	Fee for Service	☐	
Status :	Full Time	☐	Other *(Pl. Specify)*: _____
	Part Time	☐	
	Fee for Service	☐	

Signature Finance Director: _____ Date: _____ / _____ / _____

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

2020

Step 1: Enter Personal Information

(a) First name and middle initial | Last name | (b) Social security number

Address

City or town, state, and ZIP code

▶ 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*.

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ▶ ☐

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

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

Step 3: Claim Dependents

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

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

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

Add the amounts above and enter the total here . . . . . 3 $

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

▶ _____ ▶ _____

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

Employers Only

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

General Instructions

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 **and** you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2020 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 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, 2021.

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

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

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

1. Expect to work only part of the year;

2. Have dividend or capital gain income, or are subject to additional taxes, such as the additional Medicare tax;

3. Have self-employment income (see below); or

4. Prefer the most accurate withholding for multiple job situations.

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

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

Specific Instructions

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

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

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

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

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

Step 3. Step 3 of Form W-4 provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2020 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

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

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . 1 $ _____

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

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . 2a $ _____

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . 2b $ _____

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

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

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

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

1 Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . 1 $ _____

2 Enter:
- $24,800 if you're married filing jointly or qualifying widow(er)
- $18,650 if you're head of household
- $12,400 if you're single or married filing separately

. . . . . 2 $ _____

3 If line 1 is greater than line 2, subtract line 2 from line 1. If line 2 is greater than line 1, enter "-0-" . . 3 $ _____

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040 or 1040-SR)). See Pub. 505 for more information 4 $ _____

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . 5 $ _____

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

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

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

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

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$220	$850	$900	$1,020	$1,020	$1,020	$1,020	$1,020	$1,210	$1,870	$1,870
$10,000 - 19,999	220	1,220	1,900	2,100	2,220	2,220	2,220	2,220	2,410	3,410	4,070	4,070
$20,000 - 29,999	850	1,900	2,730	2,930	3,050	3,050	3,050	3,240	4,240	5,240	5,900	5,900
$30,000 - 39,999	900	2,100	2,930	3,130	3,250	3,250	3,440	4,440	5,440	6,440	7,100	7,100
$40,000 - 49,999	1,020	2,220	3,050	3,250	3,370	3,570	4,570	5,570	6,570	7,570	8,220	8,220
$50,000 - 59,999	1,020	2,220	3,050	3,250	3,570	4,570	5,570	6,570	7,570	8,570	9,220	9,220
$60,000 - 69,999	1,020	2,220	3,050	3,440	4,570	5,570	6,570	7,570	8,570	9,570	10,220	10,220
$70,000 - 79,999	1,020	2,220	3,240	4,440	5,570	6,570	7,570	8,570	9,570	10,570	11,220	11,240
$80,000 - 99,999	1,060	3,260	5,090	6,290	7,420	8,420	9,420	10,420	11,420	12,420	13,260	13,460
$100,000 - 149,999	1,870	4,070	5,900	7,100	8,220	9,320	10,520	11,720	12,920	14,120	14,980	15,180
$150,000 - 239,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,190	16,050	16,250
$240,000 - 259,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,520	17,170	18,170
$260,000 - 279,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	13,120	15,120	17,120	18,770	19,770
$280,000 - 299,999	2,040	4,440	6,470	7,870	9,190	10,720	12,720	14,720	16,720	18,720	20,370	21,370
$300,000 - 319,999	2,040	4,440	6,470	8,200	10,320	12,320	14,320	16,320	18,320	20,320	21,970	22,970
$320,000 - 364,999	2,720	5,920	8,750	10,950	13,070	15,070	17,070	19,070	21,290	23,590	25,540	26,840
$365,000 - 524,999	2,970	6,470	9,600	12,100	14,530	16,830	19,130	21,430	23,730	26,030	27,980	29,280
$525,000 and over	3,140	6,840	10,170	12,870	15,500	18,000	20,500	23,000	25,500	28,000	30,150	31,650

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$460	$940	$1,020	$1,020	$1,470	$1,870	$1,870	$1,870	$1,870	$2,040	$2,040	$2,040
$10,000 - 19,999	940	1,530	1,610	2,060	3,060	3,460	3,460	3,460	3,640	3,830	3,830	3,830
$20,000 - 29,999	1,020	1,610	2,130	3,130	4,130	4,540	4,540	4,720	4,920	5,110	5,110	5,110
$30,000 - 39,999	1,020	2,060	3,130	4,130	5,130	5,540	5,720	5,920	6,120	6,310	6,310	6,310
$40,000 - 59,999	1,870	3,460	4,540	5,540	6,690	7,290	7,490	7,690	7,890	8,080	8,080	8,080
$60,000 - 79,999	1,870	3,460	4,690	5,890	7,090	7,690	7,890	8,090	8,290	8,480	9,260	10,060
$80,000 - 99,999	2,020	3,810	5,090	6,290	7,490	8,090	8,290	8,490	9,470	10,460	11,260	12,060
$100,000 - 124,999	2,040	3,830	5,110	6,310	7,510	8,430	9,430	10,430	11,430	12,420	13,520	14,620
$125,000 - 149,999	2,040	3,830	5,110	7,030	9,030	10,430	11,430	12,580	13,880	15,170	16,270	17,370
$150,000 - 174,999	2,360	4,950	7,030	9,030	11,030	12,730	14,030	15,330	16,630	17,920	19,020	20,120
$175,000 - 199,999	2,720	5,310	7,540	9,840	12,140	13,840	15,140	16,440	17,740	19,030	20,130	21,230
$200,000 - 249,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$250,000 - 399,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$400,000 - 449,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,450	19,940	21,240	22,540
$450,000 and over	3,140	6,230	8,810	11,310	13,810	15,710	17,210	18,710	20,210	21,700	23,000	24,300

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$830	$930	$1,020	$1,020	$1,020	$1,480	$1,870	$1,870	$1,930	$2,040	$2,040
$10,000 - 19,999	830	1,920	2,130	2,220	2,220	2,680	3,680	4,070	4,130	4,330	4,440	4,440
$20,000 - 29,999	930	2,130	2,350	2,430	2,900	3,900	4,900	5,340	5,540	5,740	5,850	5,850
$30,000 - 39,999	1,020	2,220	2,430	2,980	3,980	4,980	6,040	6,630	6,830	7,030	7,140	7,140
$40,000 - 59,999	1,020	2,530	3,750	4,830	5,860	7,060	8,260	8,850	9,050	9,250	9,360	9,360
$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,780	10,980	11,180	11,580	12,380
$80,000 - 99,999	1,900	4,300	5,710	7,000	8,200	9,400	10,600	11,180	11,670	12,670	13,580	14,380
$100,000 - 124,999	2,040	4,440	5,850	7,140	8,340	9,540	11,360	12,750	13,750	14,750	15,770	16,870
$125,000 - 149,999	2,040	4,440	5,850	7,360	9,360	11,360	13,360	14,750	16,010	17,310	18,520	19,620
$150,000 - 174,999	2,040	5,060	7,280	9,360	11,360	13,480	15,780	17,460	18,760	20,060	21,270	22,370
$175,000 - 199,999	2,720	5,920	8,130	10,480	12,780	15,080	17,380	19,070	20,370	21,670	22,880	23,980
$200,000 - 249,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$250,000 - 349,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$350,000 - 449,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,900	25,200
$450,000 and over	3,140	6,840	9,560	12,140	14,640	17,140	19,640	21,530	23,030	24,530	25,940	27,240

MARYLAND
FORM
MW507

Purpose. Complete Form MW507 so that your employer can withhold the correct Maryland income tax from your pay. Consider completing a new Form MW507 each year and when your personal or financial situation changes.

Basic Instructions. Enter on line 1 below, the number of personal exemptions you will claim on your tax return. However, if you wish to claim more exemptions, or if your adjusted gross income will be more than $100,000 if you are filing single or married filing separately ($150,000, if you are filing jointly or as head of household), you must complete the Personal Exemption Worksheet on page 2. Complete the Personal Exemption Worksheet on page 2 to further adjust your Maryland withholding based on itemized deductions, and certain other expenses that exceed your standard deduction and are not being claimed at another job or by your spouse. However, you may claim fewer (or zero) exemptions.

Additional withholding per pay period under agreement with employer. If you are not having enough tax withheld, you may ask your employer to withhold more by entering an additional amount on line 2.

Exemption from withholding. You may be entitled to claim an exemption from the withholding of Maryland income tax if:

a. Last year you did not owe any Maryland income tax and had a right to a full refund of any tax withheld; AND,

b. This year you do not expect to owe any Maryland income tax and expect to have a right to a full refund of all income tax withheld.

If you are eligible to claim this exemption, complete Line 3 and your employer will not withhold Maryland income tax from your wages.

Students and Seasonal Employees whose annual income will be below the minimum filing requirements should claim exemption from withholding. This provides more income throughout the year and avoids the necessity of filing a Maryland income tax return.

Certification of nonresidence in the State of Maryland. Complete Line 4. This line is to be completed by residents of the District of Columbia, Virginia or West Virginia who are employed in Maryland and who do not maintain a place of abode in Maryland for 183 days or more.

Residents of Pennsylvania who are employed in Maryland and who do not maintain a place of abode in Maryland for 183 days or more, should complete line 5 to exempt themselves from the state portion of the withholding tax. These employees are still liable for withholding tax at the rate in effect for the Maryland county in which they are employed, unless they qualify for an exemption on either line 6 or line 7. Pennsylvania residents of York and Adams counties may claim an exemption from the local withholding tax by completing line 6. Pennsylvania residents living in other local jurisdictions which do not impose an earnings or income tax on Maryland residents may claim an exemption by completing line 7. Employees qualifying for exemption under 6 or 7, should also write "EXEMPT" on line 4.

Line 4 is **NOT** to be used by residents of other states who are working in Maryland, because such persons are liable for Maryland income tax and withholding from their wages is required.

If you are domiciled in the District of Columbia, Pennsylvania or Virginia and maintain a place of abode in Maryland for 183 days or more, you become a statutory resident of Maryland and you are required to file a resident return with Maryland reporting your total income. You must apply to your domicile state for any tax credit to which you may be entitled under the reciprocal provisions of the law. If you are domiciled in West Virginia, you are not required to pay Maryland income tax on wage or salary income, regardless of the length of time you may have spent in Maryland.

Under the Servicemembers Civil Relief Act, as amended by the Military Spouses Residency Relief Act, you may be exempt from Maryland income tax on your wages if (i) your spouse is a member of the armed forces present in Maryland in compliance with military orders; (ii) you are present in Maryland solely to be with your spouse; and (iii) you maintain your domicile in another state. If you claim exemption under the SCRA enter your state of domicile (legal residence) on Line 8; enter "EXEMPT" in the box to the right on Line 8; and attach a copy of your spousal military identification card to Form MW507. **In addition, you must also complete and attach Form MW507M.**

Duties and responsibilities of employer. Retain this certificate with your records. You are required to submit a copy of this certificate and accompanying attachments to the Compliance Division, Compliance Programs Section, 301 West Preston Street, Baltimore, MD 21201, when received if:

1. You have any reason to believe this certificate is incorrect;
2. The employee claims more than 10 exemptions;
3. The employee claims an exemption from withholding because he/she had no tax liability for the preceding tax year, expects to incur no tax liability this year and the wages are expected to exceed $200 a week;
4. The employee claims an exemption from withholding on the basis of nonresidence; or
5. The employee claims an exemption from withholding under the Military Spouses Residency Relief Act.

Upon receipt of any exemption certificate (Form MW507), the Compliance Division will make a determination and notify you if a change is required.

Once a certificate is revoked by the Comptroller, the employer must send any new certificate from the employee to the Comptroller for approval before implementing the new certificate.

If an employee claims exemption under 3 above, a new exemption certificate must be filed by February 15th of the following year.

Duties and responsibilities of employee. If, on any day during the calendar year, the number of withholding exemptions that the employee is entitled to claim is less than the number of exemptions claimed on the withholding exemption certificate in effect, the employee must file a new withholding exemption certificate with the employer within 10 days after the change occurs.

FORM
MW507 Employee's Maryland Withholding Exemption Certificate

Print full name	Social Security Number
Street Address, City, State, ZIP	County of residence (Nonresidents enter Maryland county (or Baltimore City) where you are employed.)

☐ Single ☐ Married (surviving spouse or unmarried Head of Household) Rate ☐ Married, but withhold at Single rate

1. Total number of exemptions you are claiming not to exceed line f in Personal Exemption Worksheet on page 2. ..... 1. _____
2. Additional withholding per pay period under agreement with employer. ..... 2. _____
3. I claim exemption from withholding because I do not expect to owe Maryland tax. See instructions above and check boxes that apply.
   - ☐ a. Last year I did not owe any Maryland income tax and had a right to a full refund of all income tax withheld and
   - ☐ b. This year I do not expect to owe any Maryland income tax and expect to have the right to a full refund of all income tax withheld. (This includes seasonal and student employees whose annual income will be below the minimum filing requirements).

   If both a and b apply, enter year applicable _____ (year effective) Enter "EXEMPT" here ..... 3. _____
4. I claim exemption from withholding because I am domiciled in one of the following states. Check state that applies.
   ☐ District of Columbia ☐ Virginia ☐ West Virginia
   I further certify that I do not maintain a place of abode in Maryland as described in the instructions above. Enter "EXEMPT" here. ..... 4. _____
5. I claim exemption from Maryland **state** withholding because I am domiciled in the Commonwealth of Pennsylvania and I do not maintain a place of abode in Maryland as described in the instructions on Form MW507. Enter "EXEMPT" here. ..... 5. _____
6. I claim exemption from Maryland **local** tax because I live in a local Pennsylvania jurisdiction within York or Adams counties. Enter "EXEMPT" here and on line 4 of Form MW507. ..... 6. _____
7. I claim exemption from Maryland **local** tax because I live in a local Pennsylvania jurisdiction that does not impose an earnings or income tax on Maryland residents. Enter "EXEMPT" here and on line 4 of Form MW507. ..... 7. _____
8. I certify that I am a legal resident of the state of _____ and am not subject to Maryland withholding because I meet the requirements set forth under the Servicemembers Civil Relief Act, as amended by the Military Spouses Residency Relief Act. Enter "EXEMPT" here. . . . 8. _____

Under the penalty of perjury, I further certify that I am entitled to the number of withholding allowances claimed on line 1 above, or if claiming exemption from withholding, that I am entitled to claim the exempt status on whichever line(s) I completed.

Employee's signature	Date
Employer's name and address including ZIP code (For employer use only)	Federal Employer Identification Number

Personal Exemptions Worksheet

Line 1

a. Multiply the number of your personal exemptions by the value of each exemption from the table below. (Generally the value of your exemption will be $3,200; however, if your federal adjusted gross income is expected to be over $100,000, the value of your exemption may be reduced. **Do not claim any personal exemptions you currently claim at another job, or any exemptions being claimed by your spouse.** To qualify as your dependent, you must be entitled to an exemption for the dependent on your federal income tax return for the corresponding tax year. **NOTE:** Dependent taxpayers may not claim themselves as an exemption. . . . . a. _____

b. Multiply the number of additional exemptions you are claiming for dependents 65 years old or older by the value of each exemption from the table below. . . . . b. _____

c. Enter the estimated amount of your itemized deductions (excluding state and local income taxes) that exceed the amount of your standard deduction, alimony payments, allowable childcare expenses, qualified retirement contributions, business losses and employee business expenses for the year. Do not claim any additional amounts you currently claim at another job or any amounts being claimed by your spouse. **NOTE:** Standard deduction allowance is 15% of Maryland adjusted gross income with a minimum of $1,500 and a maximum of $2,000. . . . . c. _____

d. Enter $1,000 for additional exemptions for taxpayer and/or spouse at least 65 years old and/or blind. . . . . d. _____

e. Add total of lines **a** through **d**. . . . . e. _____

f. Divide the amount on line e by $3,200. **Drop any fraction. Do not round up.** This is the **maximum** number of exemptions you may claim for withholding tax purposes. . . . . f. _____

If Your federal AGI is		**If you will file your tax return**	
		Single or Married Filing Separately **Your Exemption is**	Joint, Head of Household or Qualifying Widow(er) **Your Exemption is**
$100,000 or less		**$3,200**	**$3,200**
Over	**But not over**		
$100,000	**$125,000**	**$1,600**	**$3,200**
$125,000	**$150,000**	**$800**	**$3,200**
$150,000	**$175,000**	**$0**	**$1,600**
$175,000	**$200,000**	**$0**	**$800**
In excess of $200,000		**$0**	**$0**

FEDERAL PRIVACY ACT INFORMATION

Social Security Numbers must be included. The mandatory disclosure of your Social Security Number is authorized by the provisions set forth in the Tax-General Article of the Annotated Code of Maryland. Such numbers are used primarily to administer and enforce the individual income tax laws and to exchange income tax information with the Internal Revenue Service, other states and other tax officials of this state. Information furnished to other agencies or persons shall be used solely for the purpose of administering tax laws or the specific laws administered by the person having statutory right to obtain it.

Employee Direct Deposit Enrollment Form

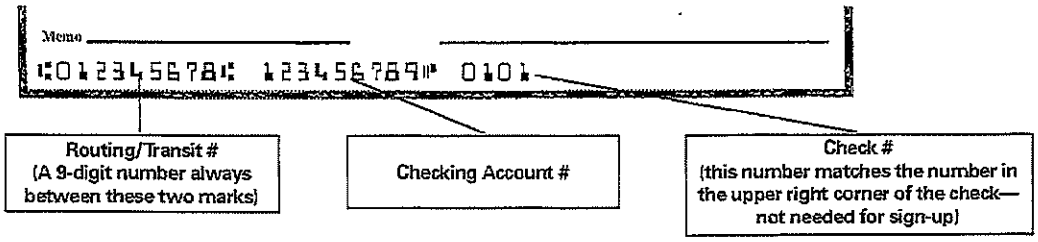
Payroll Manager—Please complete this section.

Company Code: _____ Company Name: _____ Date: _____

Payroll Mgr. Name: _____ Payroll Mgr. Signature: _____

To enroll in Full Service Direct Deposit, simply fill out this form and give it to your payroll manager. Attach a voided check for each checking account – not a deposit slip. If depositing to a savings account, ask your bank to give you the Routing/Transit Number for your account. It isn't always the same as the number on a savings deposit slip. This will help ensure that you are paid correctly.

Below is a sample check MICR line, detailing where the information necessary to complete this form can be found.



Important! Please read and sign before completing and submitting.

I hereby authorize my employer (hereinafter "Company") to deposit any amounts owed me by initiating credit entries to my accounts at the financial institutions (hereinafter "Bank") indicated on this form. Further, I authorize Bank to accept and to credit any credit entries indicated by Company to my accounts. Unless prohibited by applicable law, in the event that Employer deposits funds erroneously into my account, I authorize Employer, either directly or through its payroll service provider, to debit my account for an amount not to exceed the original amount of the erroneous credit.

This authorization is to remain in full force and effect until Company and Bank have received written notice from me of its termination in such time and in such manner as to afford Company and Bank reasonable opportunity to act on it.

Employee Name: _____

Employee Signature: _____ Date: _____

Account Information

The last item must be for the remaining amount owed to you. To distribute to more accounts, please complete another form.
Make sure to indicate what kind of account, along with amount to be deposited, if less than your total net paycheck.

1. Bank Name/City/State: _____

Routing/Transit #: _ _ _ _ _ _ _ _ _ Account Number: _____

☐ Checking ☐ Savings ☐ Other I wish to deposit: $ _____ . ____ or ☐ Entire Net Amount

2. Bank Name/City/State: _____

Routing/Transit #: _ _ _ _ _ _ _ _ _ Account Number: _____

☐ Checking ☐ Savings ☐ Other I wish to deposit: $ _____ . ____ or ☐ Entire Net Amount

3. Bank Name/City/State: _____

Routing/Transit #: _ _ _ _ _ _ _ _ _ Account Number: _____

☐ Checking ☐ Savings ☐ Other I wish to deposit: $ _____ . ____ or ☐ Entire Net Amount

ATTENTION PAYROLL MANAGER:
Employers must keep each original employee enrollment form on file as long as the employee is using FSDD, and for two years thereafter.

Employment Eligibility Verification

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

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

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

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

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

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

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

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

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

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

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

Additional Information

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

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

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

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

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	ZIP Code

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

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

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

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

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

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

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

Refer to the instructions for more information about acceptable receipts.

COMMUNITY BEHAVIORAL HEALTH

426 Dorchester Ave. Cambridge, MD 21613
821 Eastern Shore Dr. Salisbury, MD 21804
142 Coursevall Dr. Centreville, MD 21617
10774 Hickory Ridge Rd. Columbia, MD 21044
Ph: (844) 224-5264 Fax: (888) 509-0010

AUTO INSURANCE COVERAGE SUGGESTION/INFORMATION FOR EMPLOYEES USING PERSONAL VEHICLES FOR COMPANY BUSINESS

1. OBTAIN THE MAXIMUM AMOUNT OF LIABILITY COVERAGE THAT YOUR INSURANCE PROVIDER WILL ALLOW (I.E 250,000/300,000).

2. IN THE EVENT OF AN ACCIDENT WHILE DOING COMPANY BUSINESS OR TRANSPORTING CLIENTS IN PERSONAL VEHICLE, CONTACT THE LOCAL POLICE IMMEDIATELY.

3. FILE CLAIM WITH YOUR INSURANCE PROVIDER (RULE: CLAIM FOLLOWS THE TITLE HOLDER OF THE VEHICLE THAT'S IN FAULT)

4. IF THE CLAIM EXCEEDS THE LIMIT OF THE TITLE HOLDERS INSURANCE COVERAGE, THE EMPLOYER'S AUTO UMBRELLA COVERAGE WILL GO INTO EFFECT.

5. IF NECESSARY, CONTACT HUMAN RESOURCES / FINANCE DEPARTMENT FOR COMPANY AUTO INSURANCE INFORMATION.

EMPLOYEE NAME : _____

EMPLOYEE SIGNATURE: _____

DATE : _____

COMMUNITY BEHAVIORAL HEALTH

www.communitybehavioralhealth.net
Phone: (844) 224-5264 ; Fax: (888) 509-0010

ANNUAL DRIVING RECORD RELEASE

I _____ authorize Community Behavioral Health (CBH) to perform and pull my drivers record check annually during the term of my employment with CBH. I understand that CBH requires an annual driving record check on each employee's Human Resources file as a part of the position requirement, at which I am currently employed. I release CBH from all liability and authorize it to pull my driving records annually till the last date of my employment.

Driving License No : _____

Expiration Date: _____

Date of Birth : _____

Social Security No : _____

State of DL Issuance : _____

Signature : _____

Print Name : _____

Date : _____

Company Property Acknowledgement

Records removed/transported from any CBH facility for any reason must be properly secured in a HIPAA compliant safety box and never left alone or outside in vehicles! To ensure adequate security and to protect records against weather, light, pollution and other potential hazards and dangers, vehicles must be:

- covered
- locked at all times when not in use
- attended to at all times by the employee; and,
- not used for transporting dangerous and hazardous materials, such as chemicals, flammable materials that may pose risk to the records.

Your company's and your patients' PHI (personal health information) must be well protected at all times! Should you ever experience a loss of medical records or other sensitive documents, you must immediately report it to your supervisor or the medical director.

I understand that the HIPPA compliant lock box has been issued to me is to be used for transporting any information about a client, client PHI, or business related materials and belongs to CBH. It is expected that reasonable care be taken when operating company property so as to be able to return it in good operating condition. I further understand, acknowledge, and authorize CBH, to deduct for the value of the equipment up to $100 dollars from my paycheck, including my final one if I fail to return it, lose it, or damage it. I understand the lock code has been set and cannot be changed. I also understand that if I do not comply with these provisions, my access to company property may be revoked at any time, and I may be subject to disciplinary action up to and including discharge.

I understand if I have any concerns or questions, I will contact my immediate supervisor.

Employee Printer Name_____

Employee Signature_____ Date_____

PART B: information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)	
COMMUNITY BEHAVIORAL HEALTH	80-0900370	
5. Employer address	6. Employer phone number	
426 DORCHESTER AVE	410-334-6687	
7. City	8. State	9. ZIP code
CAMBRIDGE	MD	21613
10. Who can we contact about employee health coverage at this job?		
HUMAN RESOURCES / FINANCE		RUTH HOPPES
11. Phone number (if different from above)	12. Email Address	
844-224-5264		RHOPPES@COMMUNITYBEHAVIORALHEALTH.NET

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  ☑ Some employees. Eligible employees are:

  After 90 days of employment.

  Full time employees-employer subsidized.

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  ☑ We do offer coverage. Eligible dependents are:

  Spouse and/or child(ren)-0% employer subsidy.

  ☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to

determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

ACKNOWLEDGEMENT

Employee Name : _____

Employee Signature: _____

Date: _____

COMMUNITY BEHAVIORAL HEALTH
Phone: 844-224-5264
Fax: 888-509-0010

KEY/CODE RECEIVING CONTRACT

All employees who receive office keys to any location will be responsible for their keys. The keys are- DO NOT DUPLICATE-keys. Distribution of keys to an employee is at the manager's discretion according to the need and job responsibilities.

By signing below, you accept responsibility for the set of key(s) in your possession. Upon resignation or termination, you must return your key(s) to either your Supervisor or the Medical Director Dr. Mrs. Sushma Jani, Facilities Management, or to the Human Resource department. If you fail to turn in your key(s) from leaving employment, the cost of lock replacement will be deducted from your final check. Management also reserves the right to ask for any key(s) to be turned in at any time, at their discretion, without any reason given. All keys are the sole property of COMMUNITY BEHAVIORAL HEALTH LLC.

Thank you,
COMMUNITY BEHAVIORAL HEALTH

I received key(s) to the following office(s): Please mark a X next to clinic location

Cambridge: Easton: Centreville: Salisbury : Princess Anne: Snow Hill: Columbia :

_____ _____
Date **Employee Signature**

_____
Employee Printed Name

_____ _____
Date **Witness Printed Name**

Arbitration Agreement
Effective: May 1, 2019

This Arbitration Agreement is made effective on May 1, 2019 between _____ and Community Behavioral Health (hereinafter "CBH"). The undersigned hereby voluntarily agree to submit any dispute with CBH to binding arbitration.

WHEREAS, disputes and differences have arisen between the parties;

AND WHEREAS, the parties recognize that litigation in court can be time consuming and expensive;

NOW IT IS AGREED BETWEEN THE PARTIES HERETO AS FOLLOWS:

Any controversy or claim arising out of or relating to employment at CBH shall be settled by arbitration administered by an arbitrator selected by CBH. The number of arbitrators shall be one. The arbitrator need not disclose any information related to interest in either party. No depositions may be done other than those of expert witnesses. The burden of proof shall at all times be on the party seeking relief.

The place of arbitration shall be Columbia, MD. Maryland law shall apply in any arbitration proceedings, without regard to principles of conflict of law. Judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. Except as may be required by law, neither a party nor its representatives may disclose the existence, content, or results of any arbitration hereunder without the prior written consent of both you and CBH. The cost of the arbitration proceeding and any proceeding in court to confirm or to vacate any arbitration award, as applicable (including, without limitation, reasonable attorney's fees and costs), shall be borne by the unsuccessful party, as determined by the arbitrators, and shall be awarded as part of the arbitrator's award. It is specifically understood and agreed that either party may enforce any award rendered by bringing suit in any court of competent jurisdiction. **No claims may be arbitrated on a class or collective basis** unless required by applicable law.

You, the employee and party to the arbitration, and CBH agree that the arbitrator shall have authority to grant injunctive or other forms of equitable relief to any party. The party bringing the action shall pay arbitrator fees and expenses and the arbitration fees and any associated costs, including required prepayment of arbitrator fees unless the arbitrator waives the payment of such fees based on financial hardship of the party. The arbitrator shall be entitled to award the foregoing arbitration and administrative fees and expenses as damages in his or her discretion.

Arbitration Agreement
Effective: May 1, 2019

This Agreement shall survive the termination or cancellation of any employment contracts, guidelines, rules, handbooks, or other documents between yourself and CBH. Any arbitration proceeding under this Agreement must be instituted within one (1) year from the date the dispute first arose.

This arbitration agreement is in effect from: **May 1, 2019**

UNDERSTOOD, AGREED, AND ACCEPTED: My signature on this document acknowledges that I understand the above Arbitration Agreement and agree to abide by its conditions. I also acknowledge that I understand my employment is at-will and may be terminated at any time, with or without reason, by either Community Behavioral Health or myself. I agree that arbitration shall be the exclusive forum for resolving all disputes arising out of or involving my employment with Community Behavioral Health or the termination of that employment.

Signature: _____

Full Name: _____

Date: _____

Acknowledgement of Receipt of Community Behavioral Health Personnel Policy and Procedure Handbook

I acknowledge that I have received a copy of the Community Behavioral Health "Personnel Policy and Procedure Handbook." I understand that I am responsible for reading and abiding by all the policies and procedures in this handbook, as well as other policies and procedures of the organization.

I also understand that the purpose of this handbook is to inform me of the organization's policies and procedures, and this is not a contract of employment. Nothing in this handbook provides entitlement to me or to any organization employee, nor is it intended to create contractual obligation of any kind. I understand that the organization has the right to Change any provision of this handbook at anytime and that I will be bound by any such changes.

I also understand and agree that my employment is for an indefinite term and is terminable at any time at the will of either myself or Community Behavioral Health for any reason. I understand that severance of this employment relationship at any time, by either party, for any reason not prohibited by law will not constitute a violation of any express or implied covenant.

I also understand that this policy manual is easily accessible and available on all internal websites of the organization for reference at any time, and I am responsible for keeping myself updated.

I HAVE READ THE ABOVE STATEMENTS AND I HAVE READ AND UNDERSTAND THE PERSONNEL POLICIES AND PROCEDURES HANDBOOK.

Signature : _____ ***Date :*** _____

Full Name : _____
(Please Print)

Please sign and date one copy of the acknowledgement and return to the Human Resource Department. Retain a second copy for your reference.

Acknowledgement of Receipt of Community Behavioral Health Cybersecurity Handbook

I acknowledge that I have received a copy of the Community Behavioral Health Cybersecurity Handbook. I understand that I am responsible for reading and abiding by all the policies in this handbook, as well as other policies and procedures of the organization.

I also understand that the purpose of this handbook is to inform me of the organization's cybersecurity policies, and this is not a contract of employment. Nothing in this handbook provides entitlement to me or to any organization employee, nor is it intended to create contractual obligation of any kind. I understand that the organization has the right to change any provision of this handbook at any time and that I will be bound by any such changes.

I also understand that this policy manual is easily accessible and available on the internal website of the organization for reference at any time, and I am responsible for keeping myself updated.

I also understand that it is my responsibility to abide by the policies and requirements set forth in the Cybersecurity Handbook. I am aware that I can seek additional guidance from the Chief Operating Administrator.

I HAVE READ THE ABOVE STATEMENTS AND I HAVE READ AND UNDERSTAND THE CYBERSECURITY HANDBOOK.

Signature : _____ ***Date :*** _____

Full Name : _____
(Please Print)

Please sign and date one copy of the acknowledgement and return to the Human Resource Department. Retain a second copy for your reference.

COMMUNITY BEHAVIORAL HEALTH

www.communitybehavioralhealth.net

Phone: (844) 224-5264

Human Resources Fax (443) 230-4324 **Main Fax: (888) 509-0010** **Billing/Financial Fax (410) 824-1323**

Annual Safety and Cultural Competency Training

- Safety Orientation for Healthcare (21 minutes)
- Workplace Bloodborne Pathogens for Healthcare (16 minutes)
- HIPAA Privacy and Security Awareness (14 minutes)
- Workplace Violence (17 minutes)
- Conflicts in the Workplace (17 minutes)
- Driving Safety (28 minutes)
- Harassment and Diversity Training (15 minutes)

I have attended the annual OSHA-Compliant safety training.
I have attended the annual cultural competency training.

Name: _____ Date: _____

MARYLAND'S LAW
ON CHILD ABUSE, CHILD NEGLECT, DISCIPLINE

In Maryland, the child abuse and neglect law requires that all persons, including all professionals, make a report as soon as possible to the Department of Social Services, when they SUSPECT a child has been or is being mistreated. (In cases of child abuse, a report may be made to Social Services or the police department).

Any professional who knowingly fails to make a required report of child abuse may be subjected to certain professional sanctions. The professionals identified in Maryland Law include: health practitioners, police officers, educators and human service workers.

Child Abuse is defined as he physical injury of a child by any parent or other person who has permanent or temporary care or custody or responsibility for supervision of a child or by any household or family member, under circumstances that indicate that the child's health or welfare is significantly harmed or at risk of being significantly harmed or sexual abuse of a child, whether physical injuries are sustained or not. Sexual abuse means any act that involves sexual molestation or exploitation of a child and includes: fondling, incest, rape or sexual offense in any degree, sodomy and unnatural or perverted practices.

Child Neglect is defined as the failure to give proper care and attention to a child including leaving the child unattended by the child's parents, guardian or custodian under circumstances that indicate that the child's health or welfare is significantly harmed or placed at risk of significant harm.

Discipline is an essential aspect of child rearing. It should be viewed as a learning experience so that the child will develop accepted patters of behavior and an understanding of responsibility as well as accepted rules of control and character which will enable him/her to become a mature and responsible adult and should be administered within the context of a positive, caring relationship.

Corporal punishment has limited value as a disciplinary method. Any type of corporal punishment has the potential of doing physical damage t the child and it therefore prohibited.

I have read, understand and agree to adhere to the above stated policies in reference to child abuse, neglect and discipline.

Name: _____

Signature: _____

Position: _____

Date: _____

INFECTION CONTROL
AND
BIOHAZARD SPILL CLEAN UP
PROCEDURE

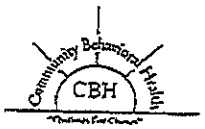
1. WEAR GLOVES. Gown, mask or goggles may also be necessary if splashing of blood or body fluids is likely.
2. DO NOT pick up glassware by hand. Use a brush and dust pan, tong or forceps.
3. WIPE UP THE SPILL with a disposable towel and dispose of the towel in a leak proof plastic bag marked with a biohazard symbol.
4. DECONTAMINATE THE SPILL AREA BY APPLYING A MIXTURE OF:
   - 1 part bleach to 10 parts water, or
   - An EPA approved antimicrobial

   Apply until surface is glistening wet.
5. PLACE A CAUTION sign over the wet area and allow the surface to air dry completely.
6. DISPOSE OF GLOVES and any contaminated materials in a leak proof plastic bag marked with a biohazard symbol.
7. WASH YOUR HANDS thoroughly using hand soap.

I, _____ have read and understand the Infection Control and Biohazard Spill Clean Up Procedure.

_____ _____

SIGNATURE DATE



COMMUNITY BEHAVIORAL HEALTH

HIPAA Training Acknowledgment Form

I, _____ am a user of one or more Community Behavioral Health's information technology devices or systems that may include electronic Protected Health Information (ePHI).

I hereby certify That:

1. I have viewed the CBH "HIPAA Privacy Training and Security Awareness Training" DVD.
2. I have received the CBH "HIPAA Policy".
3. I agree to abide by the CBH policies and procedures as explained in the "HIPAA Privacy Training and Security Awareness Training" DVD and the HIPAA Policy.
4. I recognize the importance of maintaining the confidentiality and integrity of the ePHI that I work with for my job duties.
5. I understand that, by not following Community Behavioral Health policies and procedures on HIPAA, I could be subject to disciplinary actions or civil or criminal penalties.

My signature on this form acknowledges my completion of HIPAA Privacy Training and Security Awareness Training Program, and that I have received information pertaining to HIPAA and Corporate Compliance that are applicable to Community Behavioral Health.

I agree to maintain the policies and standards of HIPAA Compliance.

_____ _____

Signature Date

Community Behavioral Health
HIPAA Confidentiality Agreement

SUMMARY OF HIPAA PRIVACY RULES FOR EMPLOYEES/CONTRACTORS

The Department of Health and Human Services has adopted privacy regulations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). These "Privacy Rules" require most doctors, hospitals and health insurers ("Covered Entities") to develop procedures to limit the use and disclosure of patients' protected health information ("PHI") as well as notify patients of their rights with respect to such information.

Confidentiality and Privacy Agreement:

Employees, contractors and partners of the practice will have access to confidential information, both written and oral, in the course of their employment and job responsibilities. It is imperative that this information is not disclosed to any unauthorized individuals to maintain the integrity of the patient information. An unauthorized individual would be any person that is not currently an employee of the practice. Any other disclosures may only occur at the direction of the patient by authorization.

This obligation of this Agreement shall remain in effect even after my time at Community Behavioral Health has ended.

Acknowledgement
I have read and understand the practice's policies with regards to privacy and security of personal health information. I agree to maintain confidentiality of all information obtained in the course of my time at Community Behavioral Health including, but not limited to, financial, technical, or proprietary information of the organization and personal and sensitive information regarding patients, employees, and vendors.

Printed Name_____

Signature_____ Date_____

NON-DISCLOSURE AGREEMENT

This Non-Disclosure Agreement covers financial and proprietary information belonging to Community Behavioral Health, LLC with a principal place of business at 426 Dorchester Avenue, Cambridge MD 21613-2446 ("Disclosing Party") that is currently made available to the party signing this agreement ("Receiving Party"). This Agreement is created for the purpose of preventing the unauthorized disclosure of the confidential, financial, and proprietary information regarding the finances, methods, and workflow of Disclosing Party providing psychiatry services so as to protect the business goodwill, business interests, and proprietary rights of Disclosing Party as a growing business. In no way does this Agreement supersede or discharge Receiving Party's obligations and responsibilities to protect patient protected health information as defined by the Health Insurance Portability and Accountability Act of 1996 ("PHI").

For the purposes of this Agreement, the term "Confidential Information" shall include, but not be limited to, PHI, business plans, financial statements, customers or users, economic and business analyses, models, strategies, projections, promotion methods, trade secrets, blueprints, supplier lists, works-in-progress, analytical data, software products, software source code or any related codes in all formats, documentation, and correspondences that have not otherwise been made publicly available. However, Confidential Information does not include: (1) information generally available to the public; (2) widely used programming practices or algorithms; (3) information rightfully in the possession of the parties to this Agreement prior to signing this Agreement; (4) information independently developed without the use of any of the provided Confidential Information; and (5) information approved for release by written authorization of an officer or representative of the Disclosing Party.

Disclosing Party shall have sole ownership and control of the Confidential Information with the Receiving Party being prohibited from disclosing, manipulating, transferring, or destroying confidential, financial, and proprietary information learned from Receiving Party's time working at Disclosing Party in consideration of Receiving Party's continued at-will employment. This Agreement neither alters the Receiving Party's at-will status nor imposes any obligation on Disclosing Party or Receiving Party regarding continued employment other than Receiving Party's obligations specifically set forth in the confidentiality agreement.

Receiving Party agrees to hold and maintain the Confidential Information in the strictest of confidence at all times. Receiving Party shall have the obligation to not use the Confidential Information for any personal gain or detrimentally to Disclosing Party. Receiving Party shall have the obligation to take all steps necessary to protect the Confidential Information from disclosure and to implement internal procedures to guard against such disclosure. If any such Confidential Information shall reach a third party or become public, all liability will be on the Party that is responsible. Receiving Party shall not publish, copy, or use the Confidential Information for their sole benefit without the written approval of Disclosing Party. If requested, Receiving Party shall be bound to return any and all materials to the Disclosing Party within three (3) business days.

In the event that Receiving Party receives a request or if required, by deposition, interrogatory, request for documents, subpoena, civil investigative demand, or similar process, to disclose all or any part of the Confidential Information, Receiving Party agrees, if legally permissible, to: (1) promptly notify Disclosing Party of the existence, terms, and circumstances surrounding such request or requirements; (2) consult with Disclosing Party of the advisability of taking legally available steps to resist or narrow such request or requirement; and (3) assist Disclosing Party in seeking a protective order or other appropriate remedy; provided however, that Receiving Party shall not be required to take any action in violation of applicable laws. In the event that such protective order or other remedy is not obtained or that Disclosing Party waives compliance with the provisions hereof, Receiving Party shall not be liable for such disclosure unless disclosure to any such tribunal was caused by or resulted from a previous disclosure by Receiving Party not permitted by this Agreement.

Receiving Party's obligation not to disclose information stated in this Agreement shall remain in effect in perpetuity, or to the greatest extent permitted by law if indefinite time periods are no longer allowed due to changes in the law, even after Receiving Party's time or work at Disclosing Party has ended. If future law renders

the time period of this Agreement not to exist in perpetuity, Receiving Party shall immediately return all documents and other tangible objects, both originals and copies, containing or representing Confidential Information which are in the possession of the Receiving Party as all objects thereof are and shall remain the property of Disclosing Party.

This Agreement is personal in nature, and neither party of this Agreement may directly or indirectly assign this Agreement or any rights or obligations under it, without prior written consent by both parties, and any attempt to do so is void; and neither grants the other any licenses under any patents or copyrights. Any provision of this Agreement held or determined by a court or other legal authority of competent jurisdiction to be illegal, invalid, or unenforceable in any jurisdiction shall be deemed separate, distinct, and independent, and shall be ineffective to the extent of such holding or determination without: (1) invalidating the remaining provisions of this Agreement in that jurisdiction; or (2) affecting the legality, validity, or enforceability of such provision in any other jurisdiction.

Receiving Party acknowledges and agrees that due to the unique and sensitive nature of the Confidential Information, any breach of this Agreement would cause irreparable harm for which damages and equitable relief may be sought including, but not limited to, injunctive relief, liquidated damages, attorney's fees, and disciplinary action. Such relief shall include the Disclosing Party enjoining Receiving Party in a court of equity for violating or threatening to violate this Agreement. Receiving Party must inform prospective future employers that Receiving Party is subject to a confidentiality agreement, but may only disclose the existence that such Agreement exists. The harmed Party shall be entitled to all remedies available at law. This Agreement shall be governed under the laws in the State of Maryland, the United States, and any applicable international law.

Receiving Party acknowledges and understands this Agreement and further acknowledges that Receiving Party has had full opportunity to have counsel of their choosing review this Agreement. Any modifications to this Agreement must be in a signed writing by both parties to this Agreement.

DISCLOSING PARTY

RECEIVING PARTY