Wheels On The Bus, INC.

Please bring a copy of everything listed below as well as the attached packet, fully completed. If you have any questions, please feel free to contact us. Thank you!

	Resume/Application
	Driver's License
	Fingerprint card (app# _____ _____)
	Copy of Social Security card or Birth Certificate
	Copy of Auto Insurance
	Criminal History (*must be notarized)*
	Article 9 (class scheduled for: (_____ @ _____)
	CPR (class scheduled for: (_____ @ _____)
	First Aid (class scheduled for: (_____ @ _____)
	Driving Record (*Instructions included in packet*)

Wheels on the Bus, Inc

Employment Application

Applicant Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

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 yes, when? _____

Have you ever been convicted of a felony? YES ☐ NO ☐

If yes, explain: _____

Education

High School: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Diploma:: _____

College: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____

Other: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____

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 ☐

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: _____

Form W-4 (2014)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2014 expires February 17, 2015. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,000 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity iincome, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2014. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A**	
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	**B**	
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C**	
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D**	
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	**E**	
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F**	
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $65,000 ($95,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to six eligible children or **less** "2" if you have seven or more eligible children. • If your total income will be between $65,000 and $84,000 ($95,000 and $119,000 if married), enter "1" for each eligible child	**G**	
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▶	**H**	

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

Separate here and give Form W-4 to your employer. Keep the top part for your records.

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2014

1	Your first name and middle initial	Last name	**2** Your social security number
	Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
	City or town, state, and ZIP code	**4** If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ ☐	

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2014, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▶	**7**	

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

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

8	Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1 Enter an estimate of your 2014 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1950) of your income, and miscellaneous deductions. For 2014, you may have to reduce your itemized deductions if your income is over $305,050 and you are married filing jointly or are a qualifying widow(er); $279,650 if you are head of household; $254,200 if you are single and not head of household or a qualifying widow(er); or $152,525 if you are married filing separately. See Pub. 505 for details . . . . 1 $

2 Enter: { $12,400 if married filing jointly or qualifying widow(er); $9,100 if head of household; $6,200 if single or married filing separately } . . . . . 2 $

3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" . . . . . 3 $

4 Enter an estimate of your 2014 adjustments to income and any additional standard deduction (see Pub. 505) 4 $

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2014 Form W-4* worksheet in Pub. 505.) . . . . . 5 $

6 Enter an estimate of your 2014 nonwage income (such as dividends or interest) . . . . . 6 $

7 **Subtract** line 6 from line 5. If zero or less, enter "-0-" . . . . . 7 $

8 **Divide** the amount on line 7 by $3,950 and enter the result here. Drop any fraction 8

9 Enter the number from the **Personal Allowances Worksheet,** line H, page 1 9

10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 10

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) 1

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3" 2

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet 3

Note. If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet 4

5 Enter the number from line 1 of this worksheet 5

6 **Subtract** line 5 from line 4 6

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . 7 $

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . 8 $

9 Divide line 8 by the number of pay periods remaining in 2014. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2014. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 $

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $6,000	0	$0 - $6,000	0
6,001 - 13,000	1	6,001 - 16,000	1
13,001 - 24,000	2	16,001 - 25,000	2
24,001 - 26,000	3	25,001 - 34,000	3
26,001 - 33,000	4	34,001 - 43,000	4
33,001 - 43,000	5	43,001 - 70,000	5
43,001 - 49,000	6	70,001 - 85,000	6
49,001 - 60,000	7	85,001 - 110,000	7
60,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $74,000	$590	$0 - $37,000	$590
74,001 - 130,000	990	37,001 - 80,000	990
130,001 - 200,000	1,110	80,001 - 175,000	1,110
200,001 - 355,000	1,300	175,001 - 385,000	1,300
355,001 - 400,000	1,380	385,001 and over	1,560
400,001 and over	1,560		

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 who claims no withholding allowances; 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.

ARIZONA FORM
A-4

Employee's Arizona Withholding Election

2014

Type or print your Full Name		Your Social Security Number
Home Address – number and street or rural route		
City or Town	State	ZIP Code

Choose either box 1 or box 2:

☐ **1** Withhold from gross taxable wages at the percentage checked **(check only one percentage)**:

☐ 0.8% ☐ 1.3% ☐ 1.8% ☐ 2.7% ☐ 3.6% ☐ 4.2% ☐ 5.1%

☐ Check this box and enter an extra amount to be withheld from each paycheck ..... $

☐ **2** I elect an Arizona withholding percentage of zero, and I certify that I expect to have no Arizona tax liability for the current taxable year.

I certify that I have made the election marked above.

SIGNATURE _____ DATE _____

Employee's Instructions

Arizona law requires your employer to withhold Arizona income tax from your wages for work done in Arizona. This amount is applied to your Arizona income tax due when you file your tax return. The amount withheld is a percentage of your gross taxable wages of every paycheck. You may also have your employer withhold an extra amount from each paycheck. Complete this form to select a percentage and any extra amount to be withheld from each paycheck.

What are my "Gross Taxable Wages"?

For withholding purposes, your "gross taxable wages" are the wages that will generally be in box 1 of your federal Form W-2. It is your gross wages less any pretax deductions, such as your share of health insurance premiums.

New Employees

Complete this form in the first five days of employment to select an Arizona withholding percentage. You may also have your employer withhold an extra amount from each paycheck. If you do not file this form, the department requires your employer to withhold 2.7% of your gross taxable wages.

Current Employees

If you want to change the current amount withheld, you must file this form to change the Arizona withholding percentage or change the extra amount withheld.

What Should I do With Form A-4?

Give your completed Form A-4 to your employer.

Electing a Withholding Percentage of Zero

You may elect an Arizona withholding percentage of zero if you expect to have no Arizona income tax liability for the current year. Arizona tax liability is gross tax liability less any tax credits, such as the family tax credit, school tax credits, or credits for taxes paid to other states. If you make this election, your employer will not withhold Arizona income tax from your wages for payroll periods beginning after the date you file the form. Zero withholding does not relieve you from paying Arizona income taxes that might be due at the time you file your Arizona income tax return. If you have an Arizona tax liability when you file your return or if at any time during the current year conditions change so that you expect to have a tax liability, you should promptly file a new Form A-4 and choose a percentage that applies to you.

Voluntary Withholding Election by Certain Nonresident Employees

Compensation earned by nonresidents while physically working in Arizona for temporary periods is subject to Arizona income tax. However, under Arizona law, compensation paid to certain nonresident employees is not subject to Arizona income tax withholding. These nonresident employees need to review their situations and determine whether they should elect to have Arizona income taxes withheld from their Arizona source compensation. Nonresident employees may request that their employer withhold Arizona income taxes by completing this form to elect Arizona income tax withholding.

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire 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 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	E-mail Address	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):

☐ A citizen of the United States

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

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

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

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date *(mm/dd/yyyy)*:

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

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

Signature of Preparer or Translator:			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 examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

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)*:				

3-D Barcode
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	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Last Name *(Family Name)* First Name *(Given Name)*		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)* Last Name *(Family Name)* First Name *(Given Name)* Middle Initial	**B.** Date of Rehire *(if applicable) (mm/dd/yyyy)*:

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current 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:	Date *(mm/dd/yyyy)*:	Print 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 Birth Abroad issued by the Department of State (Form FS-545)
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.** Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
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.** Native American tribal document
		6. Military dependent's ID card		**6.** U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		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:		
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		**10.** School record or report card		**8.** Employment authorization document issued by the Department of Homeland Security
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.

Direct Deposit Authorization

Full Legal Name: _____

Bank Name/Branch: _____

Account Number 1: _____

Checking _____ Savings _____

Account Number 2: _____

Checking _____ Savings _____

Routing Number: _____

Check the appropriate item:

____ Direct Deposit

The undersigned hereby requests and authorizes the entire amount of my paycheck each pay period to be deposited directly into the bank account(s) named above.

____ I would like to cancel my deposit authorization.

The undersigned hereby cancels the authorization for direct deposit or payroll deduction deposited previously submitted.

_____ _____

Employee Signature Date

LCR-1034A FORNA (7-14)
Previous versions not accepted

ARIZONA DEPARTMENT OF ECONOMIC SECURITY

CRIMINAL HISTORY SELF DISCLOSURE AFFIDAVIT

Your fingerprints will be submitted to the Arizona Department of Public Safety (DPS) and the Federal Bureau of Investigation (FBI) for a criminal history check. Your self-disclosure on this affidavit and the information provided by your criminal history check will be used, as authorized by Public Law and Arizona Revised Statues, to help us determine your fitness to have unsupervised access to vulnerable persons. **Your failure to disclose true and accurate information on this affidavit will be sufficient grounds to end your employment or to deny, suspend, or revoke your license and may be referred to the State Attorney General's Office for prosecution.**

Be sure that you go over all five (5) pages of the self-disclosure affidavit.

You have the right to obtain a copy of any background check report and challenge the accuracy or completeness of information contained in the report. If you challenge the information, you also have a right to prompt determination as to the validity of your challenge. To obtain a copy of your background check report, contact the DPS Records Unit, ACJIS Division at (602) 223-2222.

YOUR NAME *(First, Middle, Last)*	DATE OF BIRTH *(MM/DD/YY)*

ADDRESS *(No., Street, Apt. No., City, State, ZIP)*

Check one of the following and provide information as directed:

☐ I have not been convicted of nor am I under pending indictment for any crimes.

☐ I have been convicted of or I am under pending indictment for the following crime(s) *(Provide dates, location/jurisdiction, circumstances and outcome. Attach additional pages as needed)*:

ALSO – Check one of the following:

☐ I am not subject to registration as a sex offender in Arizona or in any other jurisdiction.

☐ I am subject to registration as a sex offender in Arizona or in any other jurisdiction. *(If you are subject to registration as a sex offender in this state or any other jurisdiction, DPS will deny you a Level 1 Fingerprint Clearance Card and you **WILL NOT** be eligible to appeal the decision.)*

I certify that I understand this affidavit. My self-disclosure is true, accurate, and complete to the best of my knowledge.

Your Signature _____ Date _____

Notary Public

State of Arizona, County of _____

Subscribed and sworn or affirmed and acknowledged before me this _____ day of _____ , 20 _____

Commission Expiration date _____ Notary Public's Signature _____

Non-Appealable Offenses

Are you awaiting trial for or have you ever been convicted of committing, attempting to commit, soliciting or facilitating or conspiring to commit one or more of these crimes in this state or a similar crime in another jurisdiction? Mark "Yes" or "No" as applicable.

If you are subject to registration as a sex offender in this state or any other jurisdiction, or awaiting trial on or been convicted of committing, attempting to commit, soliciting or facilitating, or conspiring to commit one or more of the crimes in this section DPS will deny you a Level 1 Fingerprint Clearance Card and you **WILL NOT** be eligible to appeal the decision.

Expunged convictions from any court other than juvenile court must be identified.

YES	NO	
☐	☐	1. Sexual abuse of vulnerable adult
☐	☐	2. Incest
☐	☐	3. Homicide, including first or second-degree murder, manslaughter and negligent homicide
☐	☐	4. Sexual assault
☐	☐	5. Sexual exploitation of a minor or vulnerable adult
☐	☐	6. Commercial sexual exploitation of a minor or vulnerable adult
☐	☐	7. Child prostitution as prescribed in A.R.S. § 13-3212
☐	☐	8. Child abuse
☐	☐	9. Felony child neglect
☐	☐	10. Sexual conduct with a minor
☐	☐	11. Molestation of a child or vulnerable adult
☐	☐	12. Dangerous crime against children as defined in A.R.S. § 13-705
☐	☐	13. Exploitation of minors involving drug offenses
☐	☐	14. Taking a child for the purposes of prostitution as defined in A.R.S. § 13-3206
☐	☐	15. Neglect or abuse of a vulnerable adult
☐	☐	16. Sex trafficking
☐	☐	17. Sexual abuse
☐	☐	18. Production, publication, sale, possession and presentation of obscene items as prescribed in A.R.S. § 13-3506
☐	☐	19. Furnishing harmful items to minors as prescribed in A.R.S. § 13-3506
☐	☐	20. Furnishing harmful items to minors by internet activity as prescribed in A.R.S. § 13-3506.01
☐	☐	21. Obscene or indecent telephone communications to minors for commercial purposes as prescribed in A.R.S. § 13-3512
☐	☐	22. Luring a minor for sexual exploitation
☐	☐	23. Enticement of persons for purposes of prostitution
☐	☐	24. Procurement by false pretenses of persons for purposes of prostitution
☐	☐	25. Procuring or placing persons in a house of prostitution
☐	☐	26. Receiving earnings of a prostitute
☐	☐	27. Causing one's spouse to become a prostitute
☐	☐	28. Detention of persons in a house of prostitution for debt
☐	☐	29. Keeping or residing in a house of prostitution or employment in prostitution
☐	☐	30. Pandering
☐	☐	31. Trafficking of persons for forced labor or services as defined in A.R.S. § 13-1308
☐	☐	32. Transporting persons for the purpose of prostitution, polygamy and concubinage
☐	☐	33. Portraying adult as a minor as prescribed in A.R.S. § 13-3555
☐	☐	34. Admitting minors to public displays of sexual conduct as prescribed in A.R.S. § 13-3558
☐	☐	35. Any felony offense involving contributing to the delinquency of a minor
☐	☐	36. Unlawful sale or purchase of children
☐	☐	37. Child bigamy
☐	☐	38. Any felony offense involving domestic violence as defined in A.R.S. § 13-3601, except for a felony offense only involving criminal damage in an amount more than $250, but less than $1000 if the offense was committed before June 29, 2009.
☐	☐	39. Felony indecent exposure
☐	☐	40. Felony public sexual indecency
☐	☐	41. Felony driving under the influence, driving under the extreme influence or aggravated driving under the influence if committed within 5 years of the date you apply for a Level 1 Clearance Card.
☐	☐	42. Terrorism
☐	☐	43. Any offense involving a violent crime as defined in A.R.S. § 13-901.03

Appealable 5 Years After Conviction

The following **felony** offenses are non-appealable if committed within 5 years before the date you apply for a Level 1 Fingerprint Clearance Card. If you have been convicted of committing, attempting to commit, soliciting or facilitating or conspiring to commit one or more of the crimes in this section *within 5 years* of applying for a Level 1 Fingerprint Clearance Card, DPS will deny you a Level 1 Fingerprint Clearance Card and you **WILL NOT** be eligible to appeal the denial.

If the conviction was *more than 5 years* before you apply for a Level 1 Fingerprint Clearance Card, DPS will deny you a Level 1 Fingerprint Clearance Card, but you will be eligible to appeal the denial to the Arizona Board of Fingerprinting.

Mark "Within 5 Years," "Over 5 Years" or "No" as applicable.

WITHIN 5 YEARS	OVER 5 YEARS	NO	
☐	☐	☐	1. Endangerment
☐	☐	☐	2. Threatening or intimidating
☐	☐	☐	3. Assault
☐	☐	☐	4. Aggravated assault
☐	☐	☐	5. Unlawfully administrating intoxicating liquors, narcotic drugs or dangerous drugs
☐	☐	☐	6. Dangerous or deadly assault by prisoner or juvenile
☐	☐	☐	7. Prisoners who commit assault with intent to incite to riot or participate in riot
☐	☐	☐	8. Assault by vicious animals
☐	☐	☐	9. Drive by shooting
☐	☐	☐	10. Assaults on public safety employees or volunteers and state hospital employees
☐	☐	☐	11. Discharging a firearm at a structure
☐	☐	☐	12. Prisoner assault with bodily fluids
☐	☐	☐	13. Aiming a laser pointer at a peace officer
☐	☐	☐	14. Possession and sale of peyote
☐	☐	☐	15. Possession and sale of a vapor-releasing substance containing a toxic substance
☐	☐	☐	16. Selling or giving nitrous oxide to underage persons
☐	☐	☐	17. Sale of regulated chemicals
☐	☐	☐	18. Sale of precursor chemicals
☐	☐	☐	19. Production or transportation of marijuana
☐	☐	☐	20. Possession, use or sale of marijuana, dangerous drugs or narcotic drugs
☐	☐	☐	21. Possession, use, administration, acquisition, sale, manufacture or transportation of prescription-only drugs
☐	☐	☐	22. Administration, acquisition, manufacture or transportation of dangerous drugs or narcotic drugs
☐	☐	☐	23. Manufacturing methamphetamine under circumstances that cause physical injury to a minor under the age of 15
☐	☐	☐	24. Involving or using minors in drug offenses
☐	☐	☐	25. Possession, use, sale or transfer of marijuana, peyote, prescription drugs, dangerous drugs, or narcotic drugs or manufacture of dangerous drugs in a drug-free school zone
☐	☐	☐	26. Possession, manufacture, delivery and advertisement of drug paraphernalia
☐	☐	☐	27. Use of wire communication or electronic communication in drug-related transactions
☐	☐	☐	28. Using a building for sale or manufacture of dangerous or narcotic drugs
☐	☐	☐	29. Manufacture or distribution of prescription-only drug
☐	☐	☐	30. Manufacture, distribution, possession, or possession with intent to use imitation controlled substances, imitation prescription-only drugs or imitation over-the-counter drugs
☐	☐	☐	31. Manufacture of certain substances and drugs by certain means

Appealable Offenses

Are you awaiting trial for or have you ever been convicted of committing, attempting to commit, soliciting or facilitating or conspiring to commit one or more of these crimes in this state or a similar crime in another jurisdiction? Mark "Yes" or "No" as applicable.

If you are awaiting trial on or been convicted of committing, attempting to commit, soliciting or facilitating or conspiring to commit one or more of these crimes, DPS will deny you a Level 1 Fingerprint Clearance Card, but you will be eligible to appeal the decision to the Arizona Board of Fingerprinting.

YES	NO	
☐	☐	1. Theft
☐	☐	2. Theft by extortion
☐	☐	3. Shoplifting
☐	☐	4. Forgery
☐	☐	5. Criminal possession of a forgery device
☐	☐	6. Obtaining a signature by deception
☐	☐	7. Criminal impersonation
☐	☐	8. Theft of a credit card or obtaining a credit card by fraudulent means
☐	☐	9. Receipt of anything of value obtained by fraudulent use of a credit card
☐	☐	10. Forgery of a credit card
☐	☐	11. Fraudulent use of a credit card
☐	☐	12. Possession of any machinery, plate or other contrivance or incomplete credit card
☐	☐	13. False statements as to financial condition or identity to obtain a credit card
☐	☐	14. Fraud by persons authorized to provide goods or services
☐	☐	15. Credit card record theft
☐	☐	16. Misconduct involving weapons
☐	☐	17. Misconduct involving explosives
☐	☐	18. Depositing explosives
☐	☐	19. Misconduct involving simulated explosives
☐	☐	20. Concealed weapon violation
☐	☐	21. Misdemeanor indecent exposure
☐	☐	22. Misdemeanor public sexual indecency
☐	☐	23. Aggravated criminal damage
☐	☐	24. Adding poison or other harmful substance to food, drink or medicine
☐	☐	25. A criminal offense involving criminal trespass and burglary under Title 13, Chapter 15
☐	☐	26. A criminal offense involving organized crime or fraud as prescribed in Title 13, Chapter 23, except terrorism
☐	☐	27. Misdemeanor offenses involving child neglect
☐	☐	28. Misdemeanor offenses involving contributing to the delinquency of a minor
☐	☐	29. Misdemeanor offenses involving domestic violence as defined in A.R.S. § 13-3601
☐	☐	30. Felony offenses involving domestic violence if the offense only involved criminal damage in the amount of $250 but less than $1000 and the offense was committed before June 29, 2009.
☐	☐	31. Arson
☐	☐	32. Criminal damage
☐	☐	33. Misappropriation of charter school monies as prescribed in A.R.S. § 13-1818
☐	☐	34. Taking identity of another person or entity
☐	☐	35. Aggravated taking identity of another person or entity
☐	☐	36. Trafficking in the identity of another person or entity
☐	☐	37. Cruelty to animals
☐	☐	38. Prostitution as described in A.R.S. § 13-3214
☐	☐	39. Sale or distribution of material harmful to minors through vending machines as prescribed in A.R.S. § 13-3513
☐	☐	40. Welfare fraud
☐	☐	41. Kidnapping
☐	☐	42. Robbery, aggravated robbery or armed robbery
☐	☐	43. Misdemeanor endangerment
☐	☐	44. Misdemeanor threatening or intimidating
☐	☐	45. Misdemeanor assault

YES	NO	
☐	☐	46. Misdemeanor aggravated assault
☐	☐	47. Misdemeanor unlawfully administering intoxicating liquor, narcotic drugs or dangerous drugs
☐	☐	48. Misdemeanor dangerous or deadly assault by prisoner or juvenile
☐	☐	49. Misdemeanor prisoners who commit assault with intent to incite riot or participate in riot
☐	☐	50. Misdemeanor assault by vicious animals
☐	☐	51. Misdemeanor drive-by shooting
☐	☐	52. Misdemeanor assaults on public safety employees or volunteers and state hospital employees
☐	☐	53. Misdemeanor discharging a firearm at a structure
☐	☐	54. Misdemeanor prisoner assault with bodily fluids
☐	☐	55. Misdemeanor aiming a laser pointer at a peace officer
☐	☐	56. Misdemeanor possession and sale of peyote
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☐	☐	58. Misdemeanor selling or giving nitrous oxide to underage persons
☐	☐	59. Misdemeanor sale of regulated chemicals
☐	☐	60. Misdemeanor sale of precursor chemicals
☐	☐	61. Misdemeanor production or transportation of marijuana
☐	☐	62. Misdemeanor possession, use or sale of marijuana, dangerous drugs or narcotic drugs
☐	☐	63. Misdemeanor possession, use, administration, acquisition, sale, manufacture or transportation of prescription-only drugs
☐	☐	64. Misdemeanor administration, acquisition, manufacture or transportation of dangerous drugs or narcotic drugs
☐	☐	65. Misdemeanor manufacturing methamphetamine under circumstances that cause physical injury to a minor under the age of 15
☐	☐	66. Misdemeanor involving or using minors in drug offenses
☐	☐	67. Misdemeanor possession, use, sale or transfer of marijuana, peyote, prescription drugs, dangerous drugs, or narcotic drugs or manufacture of dangerous drugs in a drug-free school zone
☐	☐	68. Misdemeanor possession, manufacture, delivery and advertisement of drug paraphernalia
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☐	☐	70. Misdemeanor using a building for sale or manufacture of dangerous or narcotic drugs
☐	☐	71. Misdemeanor manufacture or distribution of prescription-only drug
☐	☐	72. Misdemeanor manufacture, distribution, or possession with intent to use imitation controlled substances, imitation prescription-only drugs or imitation over-the-counter drugs
☐	☐	73. Misdemeanor manufacture of certain substances and drugs by certain means

DD-403-FF (12-05)
(Refer to A.A.C. R6-6-1504
(Replaces DD-403-A,B,C,D)

ARIZ(\ DEPARTMENT OF ECONOMIC SECURI
Division of Developmental Disabilities
Home and Community Based Services (HCBS)

REFERENCE REQUEST

APPLICANT

This reference request should be provided to a person who has personal knowledge about your employment history, education or character and can attest to your ability to provide services. Two references should be from former/current employers. References **CANNOT** be from family members. Please fill in your name below and give to the person you are requesting a reference from. Instruct the person to mail this Reference Request back to the Division of Developmental Disabilities (DDD).

APPLICANT'S NAME *(Last, First, M.I.)*

APPLICANT'S ADDRESS *(No., Street, City, State, ZIP)* | APPLICANT'S PHONE NO. ( )

PERSON PROVIDING REFERENCE

Please complete the questions listed below keeping in mind that Home and Community Based Services (HCBS) may be performed unsupervised in the home of the person with developmental disabilities or in the residence/facility of the applicant. Your time and effort in completing this form is appreciated and strict confidentiality in regard to your responses will be observed within the provisions of the law.

This reference request **MUST** be returned to the HCBS local office listed on the reverse. If mailing, fold this form in half with the DES/DDD address on the outside, seal lower edge ***(NO STAPLES)***, attach stamp and mail.

PRINT PERSON'S NAME PROVIDING REFERENCE *(Last, First, M.I.)*

ADDRESS *(No., Street, City, State, ZIP)*

DAYTIME PHONE NO. ( ) | EVENING PHONE NO. ( )

STATE THE LENGTH OF TIME YOU HAVE KNOWN THE APPLICANT

Years: Months:

TYPE OF ACQUAINTANCE *(Check all that apply)*

☐ Supervised applicant ☐ Worked with applicant ☐ Friend ☐ Neighbor ☐ Other:

INDICATE YOUR FEELINGS ON HOW YOU BELIEVE THE APPLICANT WILL RELATE TO INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES. DESCRIBE YOUR KNOWLEDGE OF ANY CHARACTERISTICS AND/OR SPECIAL TRAINING/EDUCATION THAT THE APPLICANT MAY HAVE FOR WORKING WITH THESE INDIVIDUALS.

INDICATE IF YOU HAVE ANY REASON TO BELIEVE THAT THE APPLICANT WOULD NOT BE SUITED TO PROVIDE SERVICES TO INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES.

IF THE APPLICANT WAS A FORMER EMPLOYEE, WOULD YOU REHIRE THIS PERSON?

☐ No ☐ Yes ☐ N/A If no, why not?

ADDITIONAL COMMENTS WHICH WILL HELP IN EVALUATING THIS APPLICANT

PERSON'S SIGNATURE PROVIDING REFERENCE | DATE

FOR OFFICE USE ONLY

INTERVIEWED BY PHONE ☐ No ☐ Yes | DATE

PRINT INTERVIEWER'S NAME *(Last, First, M.I.)* | INTERVIEWER'S SIGNATURE

DD-403-FF (12-05)
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STATE THE LENGTH OF TIME YOU HAVE KNOWN THE APPLICANT

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TYPE OF ACQUAINTANCE *(Check all that apply)*

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PERSON'S SIGNATURE PROVIDING REFERENCE | DATE

FOR OFFICE USE ONLY

INTERVIEWED BY PHONE | DATE

☐ No ☐ Yes

PRINT INTERVIEWER'S NAME *(Last, First, M.I.)* | INTERVIEWER'S SIGNATURE

Certifications

** You may obtain Article 9, CPR, and First Aid from any certified company you wish. **Online certifications are not accepted by the state or Wheels on the Bus**. CPR and First Aid must be an "infant and adult healthcare professional" certification. Here are a few companies we recommend. **

For Article 9 training:

1. Maguire Consulting: Mesa & Peoria offer more classes/times. 480.236.8811

Mesa Training Center:
737 W Guadalupe Rd
Suite 114
Mesa, AZ 85210

Phoenix Training Center:
2320 N. 20th Street
Phoenix, AZ 85006

Peoria Training Center:
15396 N. 83rd Ave
Suite A100
Peoria, AZ 85382

2. ACE Training: 623-932-7979

Avondale Training Center
1039 East Van Buren Street
Suite B-101
Avondale, Arizona 85323

Scottsdale Training Center
10799 N. 90th Street
Scottsdale, AZ 85260

Peoria Training Center
9299 W. Olive Avenue,
Suite 604
Peoria, AZ 85345

Goodyear Training Center
Estella Professional Center
15655 W. Roosevelt St. Suite 140
Goodyear, AZ. 85338

CPR and First Aid:

1. Maguire Consulting: Mesa & Peoria offer more classes/times. 480.236.8811

Mesa Training Center:
737 W Guadalupe Rd
Suite 114
Mesa, AZ 85210

Phoenix Training Center:
2320 N. 20th Street
Phoenix, AZ 85006

Peoria Training Center:
15396 N. 83rd Ave
Suite A100
Peoria, AZ 85382

2. East Valley: http://queencreekcpr.com/

3. ACE Training: 623-932-7979

Avondale Training Center
1039 East Van Buren Street
Suite B-101
Avondale, Arizona 85323

Scottsdale Training Center
10799 N. 90th Street
Scottsdale, AZ 85260

Peoria Training Center
9299 W. Olive Avenue,
Suite 604
Peoria, AZ 85345

Goodyear Training Center
Estella Professional Center
15655 W. Roosevelt St. Suite 140 Goodyear, AZ 85338

4. West Valley: ABC's of CPR Training Center (also offers Spanish) 623.328.8990

I have received, read and understand the full 47-page Policies and Procedures manual as well as the 5-page Disciplinary Policies and Procedures and understand that I am responsible for fulfilling and upholding it's contents. I also understand that these documents are available to me online at www.wheelspediatrictherapy.com for me to reference at any time.

_____ _____

Employee/Contractor Signature **Date**

CLIENT POLICIES
WHEELS ON THE BUS, INC.
Client Rights

As a client cared for by Wheels on the Bus, Inc., you have the rights including but not limited to the following:

1. To have access to services regardless of race, color, religion, sex, age, gender preference, national origin, handicap or decision regarding advanced directives.
2. To be fully informed at the time of admission of these rights and responsibilities. Information shall be communicated to you in language you can reasonably understand.
3. To be fully informed, orally and in writing, prior to or at the time of admission of services available in the agency, of related charges and if you will be responsible for payment.
4. To be informed of financial benefit, if any, to the referring organization when he/she is referred to another organization, service or individual.
5. To be informed, orally and in writing, of any charge and/or payment responsibility.
6. To be fully informed in advance about the care to be provided by the agency (unless contraindicated), to be fully informed in advance of any changes in the care to be provided by the agency, and to participate in the planning the care.
7. To refuse treatment and to be informed of the possible consequences of such refusal.
8. To be assisted, along with your family, to carry out physician's instructions about you illness so that you/your family can understand and assist in the care provided.
9. To be assured of confidentiality regarding your care. We may submit information to third parties, only with your approval.
10. To be treated with consideration, respect and full recognition of dignity and individuality.
11. To have your communication needs met.
12. To be assured that personnel who provide care are qualified through education and/or experience to provide the services for which they are responsible, and to be assured that these personnel work under qualified supervision.
13. To voice grievances with respect to care that is (or fails to be) furnished, to be involved in the resolving of ethical issues, or to recommend changes to the agency, the patient/family may contact:

Agency Administration: (480) 242-5903
Se habla espanol

_____ _____

Provider Signature **Date**

Respite
Job Description

All caregivers will report to Wheels on the Bus, Inc.'s management and will be accountable to care for the client in such a way that he/she can live with security and independence while maintaining their dignity.

This service provides short-term care and supervision in accordance with the person's Individual Support Plan. The goal of the service is to provide a "break" for the caregiver. This service can be provided in the person or the provider's home, or in the community.

Duties may include:

- Providing for the social, emotional and physical needs of the person
- Ensuring medication is taken as prescribed
- Providing appropriate first aid or attention to an illness or injury
- Providing appropriate food
- Following the person's Individual Support Plan
- Assist in all goals as required and identified by the client's Care Plan
- Offer conversation and companionship whenever needed in order to engage the client, but will avoid topics of conversation as discussed in the employee handbook. For example: will avoid talking about personal lives/problems, religion, politics, or any other subject that can be upsetting to the client and/or family
- At all times be aware of the Client's Rights and to treat all clients with respect and dignity

Documentation and other responsibilities include:

1. Caregiver is responsible for maintaining his/her personnel file and will submit renewals to the agency in a timely manner. Failing to maintain and up-to-date personnel file will result in suspension and/or termination.

Signature of Employee

Habilitation
Job Description

Habilitation provides a variety of support designed to increase a person's independence. The goals of this service include supporting a person to gain knowledge and skills, assisting in learning socialization skills and appropriate behavior as well as gaining and maintaining a quality life. This support may occur in the person's home or in the community. Based on the Person's specific needs, as identified through the Individual Support Plan process, some of the tasks related to Habilitation may include:

- Assistance and training related to personal and physical needs
- Routine daily living skills
- Implementing strategies to address behavioral concerns
- Ensuring health needs are being met
- Implementing therapy recommendations
- Training in mobility or alternative or adaptive communication
- Assisting in learning to use community transportation
- Assist in all goals as required and identified by the client's Care Plan
- Offer conversation and companionship whenever needed in order to engage the client, but will avoid topics of conversation as discussed in the employee handbook. For example: will avoid talking about personal lives/problems, religion, politics, or any other subject that can be upsetting to the client and/or family
- At all times be aware of the Client's Rights and to treat all clients with respect and dignity

Documentation and other responsibilities include:

1. Caregiver must complete a daily activity log which is equivalent to their time sheet for payroll. Separate instructions are given on how to complete this form during the hiring and orientation.
2. Caregiver must complete a monthly progress note/report for each client. The progress report may be a monthly report with daily notes to be checked off. Progress notes should be completed for each individual client and a daily activity log to support it ***Activity logs must be submitted to the agency on a bi-monthly basis in order to process payroll and timely client billing.**
3. Caregiver is responsible for maintaining his/her personnel file and will submit renewals to the agency in a timely manner. Failing to maintain and up-to-date personnel file will result in suspension and/or termination.
4. Caregiver has a responsibility to maintain ongoing communication with the agency whenever changes in the client's condition or care have occurred.

Signature of Employee Date

Wheels On The Bus, INC.

(Time Records/ Non-Authorized work)

Accurately recording time worked is the responsibility of every Wheels On The Bus, Inc. employee. Federal and state laws require Wheels On The Bus, INC. to keep an accurate record of time worked in order to calculate employee pay. Time worked is defined as authorized work performed by Wheels On The Bus, INC, employee. Time records submitted for non-authorized hours are subject to non-payment. Employees should not sign in or start work prior to their scheduled starting time not continue to work after there scheduled stop time without expressed, prior authorization from their supervisor. Altering, falsifying, tampering with time records, or recording time on another employee's time record may result in disciplinary action, up to and including termination of employment. Time records should be completed in ink with no white out (correction fluid). If a spouse or other adult is signing on behalf of a client to validate hours worked they should either A) sign their own name or B) sign the client's name as such: "on behalf of 'client's name' by 'signer's name". Should be crossed out and initialed. Employees providing in home services to Wheels On The Bus, Inc. clients/ consumers are not authorized to work if:

- Client/consumer is admitted to the hospital or other care facility
- Client/consumer DDD authorization is expired and employee receives notice either the consumer, Wheels or from the support coordinator at DDD.

Time records submitted under for non-authorized work are subject to non-payment unless authorized by immediate supervisor. Continued submission of non-authorized work hours may result in disciplinary action up to and including termination.

My signature below serves as verification of my review and understanding of this policy. I was given an opportunity to ask questions and/or request more information.

Employee Signature: _____

_____ _____

Employee: **Date:**

_____ _____

Wheels On The Bus, INC Representative **Date:**

Wheels on the Bus, Inc.
ORIENTATION ACKNOWLEDGEMENT

The intentional misuse, abuse, distribution, theft or misappropriation of company or client property will be grounds for immediate dismissal.

The intentional interference with another employee's performance of his/her job or task will be grounds for immediate dismissal.

Client's confidentiality must be maintained at all times.

I HAVE READ AND UNDERSTOOD THE AGENCY'S POLICIES AND PROCEDURES STATED IN THE HANDBOOK.

Signature of Employee Date

WHEELS ON THE BUS, INC.
EMERGENCY PLAN

Wheels on the Bus, Inc. is committed to the health and safety of its staff and consumers. Wheels on the Bus, Inc. will cooperate with all national, state and local public safety agencies in the event of local or national emergency.

Fire, Flood, or other Natural Disaster

Wheels on the Bus, Inc. and its staff understand its moral, ethical and contractual responsibility as it relates to providing care to its consumers. In the event of an emergency (Fire, Flood, Natural or otherwise) staff are required to do the following:

I. Contact emergency personnel and request assistance as appropriate, i.e. fire, rescue, law enforcement (911)

II. Contact immediate supervisor or on call personnel to report emergency and provide current status of emergency situation.

III. Immediate supervisor or on call personnel must ensure the consumer's family (if applicable) and DDD personnel are contacted to report incident and status of situation.

IV. Staff must remain on site and **attend to consumer**, even if the consumer is being attended to by emergency personnel unless instructed by said emergency personnel to stand back; staff must maintain the consumer in their visual field at all times if at all possible. In the event the staff member is instructed to leave by anyone other than Wheels on the Bus, Inc. management, he or she must contact their immediate supervisor or on-call personnel immediately.

V. Wheels on the Bus, Inc. staff are expected to remain with consumer(s) even if the emergency or disaster requires evacuation or relocation.

VI. In the event communication with Wheels on the Bus, Inc. is not possible, staff are to remain with the consumers at all times and contact immediate supervisor or call on call personnel as communication becomes available.

VII. Staff are expected to advocate for consumers and make emergency personnel aware of the consumer's needs.

It is a serious violation of Wheels on the Bus, Inc.'s policy to leave a consumer unattended during an emergency and under certain circumstances could be considered abuse and neglect punishable by law.

I have read and understand Wheels on the Bus, Inc.'s emergency plan and agree to abide by the policies and procedures within the plan.

_____

Print Name

_____ Date_____

Signature

Due to the nature of our business, direct care of a disabled person, telecommuting ins not an option for respite and habilitation providers. If the provider needs to miss work due to a pandemic episode, he/she is not entitled to compensation for missed hours. There is no guarantee that his/her client will wait for him/her to be able to return to work. There is no guarantee that his/her client will not choose another caregiver or provider; his/her right to choose has precedence in all cases.

Colette Marotto, named lead for pandemic episodes, can be reached at 480-242-5903 or Colette@wheelspediatrictherpay.com.

It is a serious violation of Wheels on the Bus, Inc.'s policy to leave a consumer unattended during an emergency and under certain circumstances could be considered abuse and neglect punishable by law.

I have read and understand Wheels on the Bus, Inc,'s emergency plan and agree to abide by the policies and procedures within the plan.

_____

Print Name

_____ _____

Signature Date

EXPECTATIONS

(Respite/Habilitation providers)

1. **Attendance**
    a. Tardiness
        i. Complaints of tardiness from consumers/responsible parties will commence in disciplinary actions beginning with oral warnings. Tardiness is defined as more than 5 minutes past scheduled start time.
    b. Excused Absences
        i. Absences called in 24 hours or more in advance of start times are considered excused. Calls must be made both to consumer's responsible party and management staff. If therapy sessions are rescheduled within the same week, it shall be considered a re-schedule and not an absence. More than 3 "excused" absences in one quarter may trigger regular disciplinary actions at management staff's discretion.
    c. Other Absences (No shows)
        i. Three (3) consecutive absences without appropriate notification will be considered "abandonment of position."
        ii. One (1) absence without appropriate notification will trigger disciplinary action starting with a written warning.
    d. Vacations
        i. Vacation requests must be submitted via email or in writing to management staff for approval at least 14 days prior to requested vacation start date.
2. **Reports**
    a. Habilitation Reports
        i. Habilitation Reports shall be submitted no less than at the end of each month that habilitation is billed, but will be accepted twice a month with each time sheet.
        ii. **No billing shall be processed** unless hab reports have been submitted for each consumer.
        iii. Time sheets should be separated by the 1st-15th and 16th-last day of the month. Do not overlap months on one time sheet.
        iv. **All items with client information must be sent by <u>secure</u> email or fax only**.

3. **Communication**
    a. Communication with Management Staff
        i. Email
            1. Email shall be the primary means of communication unless otherwise requested by the employee or independent contractor.
            2. Emails should be returned within 2 business days to avoid triggering disciplinary actions beginning with an oral warning.
        ii. Phone calls/Text messages
            1. Phone calls shall be returned within one (1) business day or 24 hours. Failure to do so may result in disciplinary actions beginning with an oral warning.
        iii. <u>If three (3) phone calls or emails are not returned, this will be considered abandonment of position. Communication with management staff is a requirement of employment.</u>

    b. Communication with Consumers/Responsible Parties
        i. Phone calls
            1. Phone calls shall be the primary means of communication unless requested by the **client's responsible party.**
            2. Phone calls from consumers/responsible parties must be returned **within 24 hours**. Business days do not apply.
        ii. Email/Text messages
            1. Email and text messaging may only be used if requested by the **client's responsible party** and is not an acceptable form notification for calling in an "excused" absence unless some physical ailment or limitation does not allow for a phone call.

Employee Signature _____ Date _____

Witness _____ Date _____

WHEELS ON THE BUS, INC.

PAYROLL INSTRUCTIONS

Paydays are Bi-Monthly. You will receive your paycheck no later than the 8th and 23nd of each month. The ultimate responsibility is YOURS to get your timesheet/billing and progress notes to Wheels on the Bus, Inc. by the dates specified. The following is the procedure for getting paid on those days:

You must **fax or scan and email** your time sheets **NO LATER THAN 9AM ON THE 16TH OF THE MONTH TO RECEIVE A CHECK BY THE 23ND OF THE MONTH.** ANY PAPERWORK NOT RECEIVED BY THAT TIME WILL NOT BE PAID UNTIL THE NEXT PAYDAY (WHICH IS THE 8TH).

The last day of the month is for hours worked on/between the 16th and the 30th/31st. You must **fax or scan & email** your time sheets to the office **NO LATER THAN 9AM ON THE FIRST DAY OF THE MONTH TO RECEIVE YOUR PAY BY THE 8TH OF THE MONTH.** ANY PAPERWORK NOT RECEIVED BY THAT TIME WILL NOT BE PAID UNTIL THE NEXT PAYDAY (WHICH IS THE 23RD.)

The fax number is **602 633 1076 and email is Colette@wheelspediatrictherapy.com.** You must **send us both your habilitation reports (if applicable) AND the SIGNED timesheets** with client's name at the top for each day you have hours for that client in order to be paid.

Employee Signature _____ Date_____

Witness _____ Date _____

ADA-Compliant Pre-Pandemic Employee Survey

Directions: Answer "yes" to the whole questions **without** specifying the reason or reasons that apply to you. Simply check "yes" or "no" **at the bottom.**

In the event of a pandemic, would you be unable to come to work because of any of the following reasons:

- If schools or day-care centers were closed, you would need to care for a child;
- If other services were unavailable, you would need to care for other dependents;
- If public transport were sporadic or unavailable, you would be unable to travel to work, and/or;
- If you or a member of your household fall into one of the categories identified by CDC as being at high risk for seious complications from the pandemic influenza virus, you would be advised by public health authorities not to come to work (e.g., pregnant women; persons with compromised immune systems due to cancer, HIV, history of organ transplant or other medical conditions; persons less than 65 years of age with underlying chronic conditions; or persons over 65)

Answer: YES _____ **NO** _____

HIPAA Rules & Regulations and policies held by Wheels on the Bus, Inc.

We understand that as in-home providers we become very close to our families. We may be invited birthday parties, participate in family functions, etc.... It is easy to forget that though we feel like part of the family, our presence is as medical professionals.

HIPAA was put into law to protect all *"individually identifiable health information."* *"Individually identifiable health information"* is information, including demographic data, that relates to:

- the individual's past, present or future physical or mental health or condition,
- the provision of health care to the individual, or
- the past, present, or future payment for the provision of health care to the individual

Please remember, we do not discuss details of a child's treatment or condition with anyone other than the parent or responsible party. For example, we do not say: "This is (child's name), I am his/her provider." Or: "(child) has special needs." Any information that would lead to the conclusion that the child has a diagnosis (even if it's obvious) or that they are receiving services is a violation of the HIPPA law. When discussing your job with others, you may not divulge any identifying information of the child, such as his/her cross roads, school, child's last names, or parent's names. Examples of what you may say are: "I work with a child with cognitive delay. He's 7 yrs old. My job is so rewarding." Or: "I took my client to the park today. I really feel he/she is socializing so much better. He/she is doing so well!" We absolutely **do not post pictures on Facebook of the child or post status updates regarding the child. In fact, use of your cell phone while working with a client should be limited to emergencies only.

Reports, time sheets, and any other email correspondence containing protected information must be sent **by secure email or fax only.** Example: You may send an email that says "John's mother kept me 1 hr late today" but a secured email is required if stating "I worked with John Doe 1 extra hour today."

HIPAA is a very serious matter. If you have any questions regarding this or any other policies & regulations, please do not hesitate to contact your supervisor.

Vehicle Inspection Sheet

Driver _____ **Date** _____

Make _____ **Model** _____ **License #**_____ **Mileage** _____

The items on this inspection sheet should be checked bi-annually. A separate sheet should be filled out for each vehicle driven. Any discrepancies should be detailed on the bottom of this sheet.

___ Check Seat Belts
___ Visual Inspection for Exterior Damage/Leaks under vehicle
___ Check inside Engine compartment for leaks/loose items
___ Washer Fluid Level
___ Power Steering Fluid Level
___ Start Engine and check Transmission Fluid Leve (Fluid should be hot)
___ Check for Air Gauge
___ Check Tires for wear and pressure
___ Check Horn
___ Check A/C is working properly
___ Check windshield wiper/washer
___ Check highlight/signal lights/4 way flashers/tail lights/backup lights
___ Check interior lights
___ Check mirrors for damage and adjustments
___ Check fuel level
___ Check first aid kit on board and full
___ As you drive, continually check for any strange smells, sounds, vibrations, or anything that does not feel right.
___ Check heater/defroster
___ Check that brakes are in operating condition
___ Auto insurance verified

The following discrepancies were note: _____
_____
_____
_____

Corrective action taken: _____
_____
_____

As a Wheels on the Bus, Inc. employee or contractor, you are responsible for regular maintenance and any other vehicle safety repairs to maintain your vehicle in proper and safe order after initial inspection. Wheels on the Bus, Inc. in *NOT* responsible for regular verification but may, at any time, request you to comply with a new inspection.

Driver's Signature: _____

Wheels on the Bus Pediatric Therapy

Please follow the instructions below, print and bring to your interview.

To obtain a Motor Vehicle Record online, please follow these directions:

1. Go to www.azdot.gov/mvd
2. Click Online Services
3. Click More
4. Click Motor Vehicle Record
5. Check Driver License Motor Vehicle Record – 39 Month Uncertified
6. The rest of the process is self-explanatory

The fee for this is $3.00

Dress Code

It is management's intent that work attire should be consistent with the mission of Wheels on the Bus, Inc to provide safe and professional care to children with special needs. Wheels on the Bus, Inc observes a "business casual" style of dress. Below are guidelines which must be adhered to. Any questions may be directed to Colette Marotto, Toni Therrien, or Shaylie Schaefer.

1. **Pants**
    a. Jeans may be worn as long as they fit appropriately and have no holes or major embellishments.
    b. Shorts and skirts may be worn if no more than 2 inches above the knee.
    c. Yoga/workout pants *may not* be worn. (There may be some exceptions to this as some have a sheen and cut resembling that of a dress pant.)
2. **Tops**
    a. Cotton tops and t-shirts may be worn as long as:
        i. There are no holes
        ii. Any writing or pictures are child appropriate.
        iii. The fit appropriately covers both the midriff and décolletage (cleavage).
        iv. Tank tops and spaghetti straps *may not* be worn.
        v. Sleeveless tops *may* be worn. (Sleeveless is defined as having material that extends from the bottom of the neck across to the shoulder.)
3. **Shoes**
    a. Closed toed shoes are required. Tennis shoes are acceptable as long as they are clean and presentable.

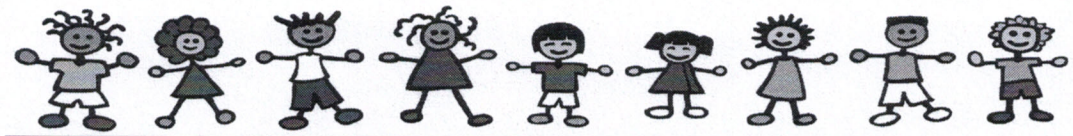
4. **Other decorations**
    a. Tattoos
        i. Tattoos should be covered or minimally exposed. If a tattoo is not appropriate for children it ***must*** be covered at all times.
    b. Piercings
        i. It is best to keep all jewelry to a minimum for safety reasons. Some of our consumers have aggressive behaviors and may cause damage if a situation arises. Please use caution.
        ii. We will allow a small stud in the nose or eyebrow, but again, please use good judgment in regards to safety.
        iii. Hoop or dangling earrings are ***expressly forbidden,*** as they will inevitably be yanked out of a provider/therapist's ear at some point. This is painful, bloody and sure to lead to infection. Wheels will *not* be responsible for any costs related to directly breaking this rule, nor for not using caution when it comes to other piercings (see b-i. & ii above). If a child is aggressive, impulsive, mentally impaired or otherwise physically able to reach and grab, 'using caution' is easily interpreted as taking said piercing out for the day, and *not doing so is at your own risk.*
    c. Hair
        i. Only natural tones are acceptable. Any shade of black, brown, red or blonde but not blue, pink, etc...

    d. Hygiene
        i. Practice appropriate hygiene. Many of our clients are immune deficient, have breathing trouble, etc... Please refrain from wearing strong perfumes and smelling of cigarette smoke (we ask our employees to please refrain from smoking before entering family homes).
        ii. Please take special precautions during summer months. We recommend keeping water, Febreeze and deodorant in your vehicle.

**** Please remember that we are entering someone's home. We must be respectful of the vast array of families we service. Use good judgment and when in doubt, ask. ****

_____ _____

Employee Signature **Witness Signature**



Wheels on the Bus, Inc
Pre-Service Orientation Form

PROVIDER INFORMATION

Provider's Name: _____ Provider's Phone: _____

Employer Tax No.: _____AHCCS ID NO.: _____

CRITICAL INFORMATION

Child's Name: _____ Assists #: _____DOB: _____

Child's Address:_____ Phone #: _____

Responsible Party's name: _____ Relationship: _____

Support Coordinator name/location: _____ Phone #: _____

Day Program (*If applicable)*

Name of Day Program: _____ Program Type: _____

Days and Hours of Attendance: _____ Transportation Method: _____

Day Program Address: _____ Phone #: _____

HEALTH - MEDICAL

----------**CURRENT MEDICATIONS AND MEDICAL ISSUES**----------

Special Trianing Required?: _____ **Med Training Needed??** _____

Seizure Management Training??: _____ **Current Medications**: _____

Med Log Required: □ Yes □ No **Special Medication Instructions**: _____

Allergies: □ Food _____ □ Medications_____

□ Other _____ □ Bee Stings _____

Recommended response to allergic reaction: _____

Seizures: □ Yes □ No

Describe: _____ Frequency: _____ Approximate Duration: _____

Recommended response to seizure activity: _____

Assistive devices: □ Vision _____ □ Hearing _____ □ Dental _____

Protective Devices: □ Yes □ No

Instructions for Use: _____ Purpose: _____

Other Individualized Health Care Routines: _____

Emergency Contact: Name _____ Relationship _____

Phone (_____) _____-_____ Alt Phone (_____) _____-_____

Name of ALTCS/DDD Health Plan: _____ **AHCCCS ID #:** _____ **Phone #:** _____

Other Health Insurance Information: _____

Primary Care Physician's Name: _____ **Phone #:** _____

Address: _____

Preferred Hospital or Urgent Care: _____ **Phone:** _____

Child's Name: _____ Assists #: _____DOB: _____

DIET

Food: Independent with utensils □ Yes □ No Requires limited assistance □ Yes □ No

Requires significant assistance □ Yes □ No Tube Feeding □ Yes □ No Eating disorder □ Yes □ No

Does food present a choking hazard? □ Yes □ No

Required consistency of food: □ Normal □ Chopped □ Pureed

Beverages: Independent with any cup/glass □ Yes □ No Independent with adaptive □ Yes □ No

Requires limited assistance □ Yes □ No Requires significant assistance □ Yes □ No

Independent in obtaining/requesting beverages □ Yes □ No

Describe adaptive eating/drinking equipment: _____

COMMUNICATION

□ Uses complete sentences □ Uses simple sentences □ Signs □ Nods yes/no □ Gestures

Describe Augmentative Communication Devices (*if applicable*): _____

MOBILITY

Balance while standing: □ Excellent □ Moderate □ Poor □ Utilizes Adaptive Aids

Method: □ Crawling □ Kneeling □ Standing □ Walking □ Running □ Climbing

Mobility Aids: □ N/A □ Walker □ Cane □ Crutches □ AFOs □ Leg braces □ Wheelchair

Positioning instructions: _____

Lifting/Carrying instructions: _____

Personal Care Skills

Dressing: □ Independent □ Requires prompting □ Requires limited assistance
□Requires significant assistance

Toileting: □ Independent □ Requires prompting □ Requires limited assistance
□Requires significant assistance

Bathing: □ Independent □ Requires prompting □ Requires limited assistance
□Requires significant assistance

Dental Care: □ Independent □ Requires prompting □ Requires limited assistance
□Requires significant assistance

Menses: □ Independent □ Requires prompting □ Requires limited assistance
□Requires significant assistance

Med. Admin.: □ Independent □ Requires prompting □ Requires limited assistance
□Requires significant assistance

Special Instructions:

_____

_____

Behavioral Concerns (*if applicable*) CIT Training □ Yes □ No

Description	Frequency	Recommended Intervention
Aggression:		
Self-Injurious behavior:		
Property Destruction:		
AWOL:		
Self Stimulation:		
Sexual Acting Out:		
Other:		

Is a behavioral Treatment Plan available: □ Yes □ No **Reason for RBT:** _____

Method used to obtain information: _____

Signatures

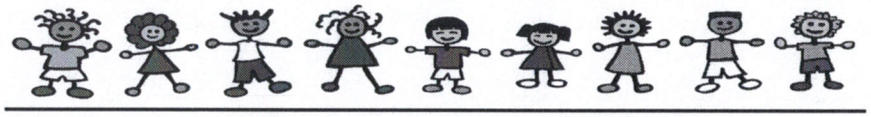
Signature of Responsible Party_____

Relationship _____Date _____

Print Provider's Name _____

Signature_____ Date _____

Equal Opportunity Employer/Program – Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Tittle II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities ADA Coordinator at 60-542-0419;TTY/TDD Services: 7-1-1. –Free language assistance for DES services is availablew upon request. Disponible en español en linea o en la ofinina local.



Where to Send Reports

Emails that contain Protected Health Information (PHI) or any other confidential information must be sent secure/ encrypted. For providers who do not have an encrypted method to send information, please fax. **Therapists only:** Please contact us for a secure email option.

Document	Due Date	Where to send
Time Sheets/ Hab Reports	Time sheets: 16th of the month by 9am 1st of the month 9am **Some providers have been instructed to turn in reports **twice** a month, all others should turn in hab reports on the 1st.	Colette@wheelspediatrictherapy.com Please cc: Anay@wheelspediatrictherapy.com Fax: 602-633-1076
Daily Notes	1st of the month 16th of the following month for therapy assistants	Anay@wheelspediatrictherapy.com Please cc: Colette@wheelspediatrictherapy.com Fax: 602-633-1076
Therapy Quarterly reports	Jan 31st, April 30th, July 31st and Oct 31st of each year and can be accepted up to 21 days early.	Colette@wheelspediatrictherapy.com Please cc: Anay@wheelspediatrictherapy.com Fax: 602-633-1076
Personnel file documents	Due dates will vary based on the type of certification or document. Please return requested items ASAP and *before* the expiration date.	AmberB@wheelspediatrictherapy.com Please cc: Colette@wheelspediatrictherapy.com Fax: 602-633-1076
Incident Reports	A phone call to Colette should be made **immediately** if an incident occurs. The incident report should be submitted ASAP.	Colette: 480.242.5903 Colette@wheelspediatrictherapy.com Please cc: Toni@wheelspediatrictherapy.com
Vacation Requests/ Calling out sick	Vacation requests are due 14 days prior to the start date and must be *approved*. If you are calling out sick, please notify us ASAP via email or text.	Colette@wheelspediatrictherapy.com 480.242.5903 Toni@wheelspediatrictherapy.com 602.708.7908
Evals	Evals are due 14 days from the eval date. Please remember that no billing will be processed without submitting an insurance form.	Toni@wheelspediatrictherapy.com Please cc: Colette@wheelspediatrictherapy.com
Insurance Forms	Please remember that no billing will be processed without submitting an insurance form.	Colette@wheelspediatrictherapy.com
Contact Numbers	Colette: 480.242.5903 Toni: 480.204.7475	Anay: 623-225-2932 (Spanish speaking) Amber: 602.708.2291

08/2013 NF

Month/year _____ Client Name_____ Provider Name _____

WHEELS ON THE BUS, INC TIMESHEET

Responsible Person Name _____

Responsible Person Signature_____ Provider Signature _____

***My signature attests that the services, dates, times, ratios, and Place of Service codes are accurate**

Respite **Habilitation**

Date	Time In	am/ pm	Time Out	am/ pm	Total	POS (H/C)	*Ratio (1:1, 1:2 or 1:3)	Date	Time In	am/ pm	Time Out	am/ pm	Total	POS (H/C)	*Ratio (1:1, 1:2 or 1:3)

Respite Total Hours **Hab Total Hours**

***In no event will more than three consumers receive the same service with a single direct service staff person at the same time. Ratios are to be written as 1:1 (1 staff to 1 consumer), 1:2 (1 staff to 2 consumers) or 1:3 (1 staff to 3 consumers)**

Please fax or email by 9AM on the 1st and 16th of each month to 602 633 1076 or colettemarotto@yahoo.com.

POS = Place of Service. Indicate 'H' for home and 'C' for community. These services can *only* take place in the client home or in the community. Any other place, such as a private school, provider home, or private site (non-public), must be DDD inspected and approved, and written approval to do these services must be received by WOTB prior to service starting. Toni Therrien and Colette Marotto are the only authorized WOTB reps to give such approval, directly to each provider. Payments will not be issued for services provided in unapproved sites, and disciplinary actions will be taken.

Month/year _____ Client Name_____ Provider Name _____

WHEELS ON THE BUS, INC TIMESHEET

Responsible Person Name _____

Responsible Person Signature_____ Provider Signature _____

***My signature attests that the services, dates, times, ratios, and Place of Service codes are accurate**

Respite **Habilitation**

Date	Time In	am/ pm	Time Out	am/ pm	Total	POS (H/C)	*Ratio (1:1, 1:2 or 1:3)	Date	Time In	am/ pm	Time Out	am/ pm	Total	POS (H/C)	*Ratio (1:1, 1:2 or 1:3)

	Respite Total Hours	Hab Total Hours

***In no event will more than three consumers receive the same service with a single direct service staff person at the same time. Ratios are to be written as 1:1 (1 staff to 1 consumer), 1:2 (1 staff to 2 consumers) or 1:3 (1 staff to 3 consumers)**

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Month/year _____ Client Name_____ Provider Name _____

WHEELS ON THE BUS, INC TIMESHEET

Responsible Person Name _____

Responsible Person Signature_____ Provider Signature _____

***My signature attests that the services, dates, times, ratios, and Place of Service codes are accurate**

Respite **Habilitation**

Date	Time In	am/ pm	Time Out	am/ pm	Total	POS (H/C)	*Ratio (1:1, 1:2 or 1:3)	Date	Time In	am/ pm	Time Out	am/ pm	Total	POS (H/C)	*Ratio (1:1, 1:2 or 1:3)

Respite Total Hours **Hab Total Hours**

***In no event will more than three consumers receive the same service with a single direct service staff person at the same time. Ratios are to be written as 1:1 (1 staff to 1 consumer), 1:2 (1 staff to 2 consumers) or 1:3 (1 staff to 3 consumers)**

Please fax or email by 9AM on the 1st and 16th of each month to 602 633 1076 or colettemarotto@yahoo.com.

POS = Place of Service. Indicate 'H' for home and 'C' for community. These services can *only* take place in the client home or in the community. Any other place, such as a private school, provider home, or private site (non-public), must be DDD inspected and approved, and written approval to do these services must be received by WOTB prior to service starting. Toni Therrien and Colette Marotto are the only authorized WOTB reps to give such approval, directly to each provider. Payments will not be issued for services provided in unapproved sites, and disciplinary actions will be taken.

Monthly Habilitation Progress Report

Child Name: **Employee Name:** **Month/Year:**

Instructions: Report on each functional outcome by completing **all** boxes. **Use as many pages as needed** to document all current outcomes. In the data boxes, use the codes below to indicate the child's average performance on each date that you worked.

+ = Independent response (no assistance needed) ***M*** *= Modeling prompt* ***HOH*** *= Hand Over Hand Assistance*
V *= Visual prompt* ***VP*** *= Verbal prompt* ***P*** *= Physical prompt* ***-*** *= No Response (unable to prompt)*

Functional Outcome:	
Dates: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	
Describe all teaching strategies being used:	Describe what progress has been made:
Describe any challenges or barriers to achieving this outcome:	Other comments about this outcome:

Functional Outcome:	
Dates: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	
VP	
Describe all teaching strategies being used:	Describe what progress has been made:
Describe any challenges or barriers to achieving this outcome:	Other comments about this outcome:

Functional Outcome:	
Dates: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	
Describe all teaching strategies being used:	Describe what progress has been made:
Describe any challenges or barriers to achieving this outcome:	Other comments about this outcome:

Reminder for Parents: Reports are submitted to DDD as received. Please ensure your habilitator has sufficiently completed this report before signing.

_____ ___/___/_____ _____ ___/___/_____ _____

Employee Signature *Date* *Parent/Guardian Signature* *Date* *Name of DDD Support Coordinator*

Monthly Habilitation Progress Report

Child Name: **Employee Name:** **Month/Year:**

Instructions: Report on each functional outcome by completing **all** boxes. **Use as many pages as needed** to document all current outcomes. In the data boxes, use the codes below to indicate the child's average performance on each date that you worked.

+ = Independent response (no assistance needed) ***M*** *= Modeling prompt* ***HOH*** *= Hand Over Hand Assistance*
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Functional Outcome:

Dates:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Describe all teaching strategies being used:	Describe what progress has been made:
Describe any challenges or barriers to achieving this outcome:	Other comments about this outcome:

Functional Outcome:

Dates:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
							VP																								

Describe all teaching strategies being used:	Describe what progress has been made:
Describe any challenges or barriers to achieving this outcome:	Other comments about this outcome:

Functional Outcome:

Dates:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Describe all teaching strategies being used:	Describe what progress has been made:
Describe any challenges or barriers to achieving this outcome:	Other comments about this outcome:

Reminder for Parents: Reports are submitted to DDD as received. Please ensure your habilitator has sufficiently completed this report before signing.

_____	___/___/_____	_____	___/___/_____	_____
Employee Signature	*Date*	*Parent/Guardian Signature*	*Date*	*Name of DDD Support Coordinator*