

Application for Employment PRE-EMPLOYMENT QUESTIONNAIRE EQUAL OPPORTUNITY EMPLOYER

Personal Information

DATE _____

NAME (LAST NAME FIRST)		SOCIAL SECURITY NO.	
PRESENT ADDRESS	CITY	STATE	ZIP CODE
PERMANENT ADDRESS	CITY	STATE	ZIP CODE
PHONE NO.	SECONDARY PHONE NO.	REFERRED BY	

Employment Desired

POSITION	DATE YOU CAN START	SALARY DESIRED
ARE YOU EMPLOYED NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF SO, MAY WE INQUIRE OF YOUR PRESENT EMPLOYER? <input type="checkbox"/> YES <input type="checkbox"/> NO	
EVER APPLIED TO THIS COMPANY BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO	WHERE	WHEN

Education History

	NAME & LOCATION OF SCHOOL	YEARS ATTENDED	DID YOU GRADUATE	SUBJECTS STUDIED
HIGH SCHOOL				
COLLEGE				
TRADE, BUSINESS, OR CORRESPONDENCE SCHOOL				

General Information

SUBJECT OF SPECIAL STUDY/RESEARCH WORK	
SPECIAL TRAINING	
SPECIAL SKILLS	
U.S. MILITARY OR NAVAL SERVICE	RANK

Former Employers (LIST BELOW LAST FOUR EMPLOYERS, STARTING WITH LAST ONE FIRST)

DATE MONTH AND YEAR	NAME & ADDRESS OF EMPLOYER	SALARY	POSITION	REASON FOR LEAVING
FROM				
TO				
FROM				
TO				
FROM				
TO				
FROM				
TO				

References (GIVE BELOW THE NAMES OF THREE PERSONS NOT RELATED TO YOU, WHOM YOU HAVE KNOWN AT LEAST ONE YEAR.)

NAME	ADDRESS	BUSINESS	YEARS KNOWN

Authorization

"I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed, falsified statements on this application shall be grounds for dismissal.

I authorize investigation of all statements contained herein and the references and employers listed above to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release the company from all liability for any damage that may result from utilization of such information.

I also understand and agree that no representative of the company has any authority to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to the foregoing, unless it is in writing and signed by an authorized company representative.

This waiver does not permit the release or use of disability-related or medical information in a manner prohibited by the Americans with Disabilities Act (ADA) and other relevant federal and state laws.

I understand that a consumer credit report or criminal records check may be necessary prior to my employment. If such reports are required, I understand that, in compliance with federal law, the company will provide me with a written notice regarding the use of these reports and will also obtain a separate written authorization from me to consent to these reports. I also understand that a poor credit history or conviction will not automatically result in disqualification from employment."

In compliance with federal law, all persons hired will be required to verify identity and eligibility to work in the United States and to complete the required employment eligibility verification document form upon hire.

DATE _____ SIGNATURE _____

Do Not Write Below This Line

DATE _____ INTERVIEWED BY _____

Remarks

NEATNESS			CHARACTER	
PERSONALITY			ABILITY	
HIRED	FOR DEPT.	POSITION	WILL REPORT	SALARY WAGES

APPROVED:

EMPLOYMENT MANAGER _____ DEPARTMENT HEAD _____ GENERAL MANAGER _____

This application for employment is sold only for general use throughout the United States. TOPS assumes no responsibility and hereby disclaims any liability for the inclusion in this form of any questions or requests for information upon which a violation of local, state, and/or federal law may be based. It is the user's responsibility to ensure that this form's use complies with applicable laws, which change from time to time.



SOUTHSIDE WELLNESS CENTER

3017 PARK AVENUE ST. LOUIS, MO 63104 314-664-5024 314-664-5206 Fax

REFERENCE CHECK

DATE: _____

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

APPLICANT'S NAME: _____

DEAR: _____:

The above person has applied to Southside Wellness Center for employment in the field of In-Home Service or Driver. Please complete the form below and return it in the enclosed envelope or fax it so that we can give the application proper consideration. Since it is our policy not to assign anyone without a completed reference check, we would appreciate your prompt attention.

I hereby release from all liability the company or person named above and authorize them to release all information regarding this reference.

Applicant's Signature: _____ **Date:** _____

PLEASE FILL IN THE INFORMATION BELOW

How long have you known the applicant? _____

Dependability: _____

Does he/she get along well with others? _____

Additional Comments: _____

Signature: _____ Date: _____

Please return in the enclosed self-address envelope or FAX to 314-664-5206 or scan and email to southsidewellness314@gmail.com.

Thank you for providing this helpful information. Please note that all information provided is kept in strictest confidence.

SOUTHSIDE WELLNESS CENTER

3017 PARK AVENUE ST. LOUIS, MO 63104 314-664-5024 314-664-5206 Fax

REFERENCE CHECK

DATE: _____

NAME: _____

COMPANY: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

APPLICANT'S NAME: _____

DEAR: _____:

The above person has applied to Southside Wellness Center for employment in the field of In-Home Service or Driver. Please complete the form below and return it in the enclosed envelope or fax it so that we can give the application proper consideration. Since it is our policy not to assign anyone without a completed reference check, we would appreciate your prompt attention.

I hereby release from all liability the company or person named above and authorize them to release all information regarding this reference.

Applicant's Signature: _____ **Date:** _____

PLEASE FILL IN THE INFORMATION BELOW

EMPLOYMENT DATES	FROM:	TO:	
POSITION(S) HELD			
	Above Average	Average	Below Average
Quality of Work	()	()	()
Cooperation	()	()	()
Dependability/Attendance	()	()	()
Personal Traits/Habits	()	()	()
REASON FOR SEPARATION			
IS APPLICANT ELIGIBLE FOR REHIRE? IF NOT, WHY NOT?			

ADDITIONAL COMMENTS: _____

SIGNATURE: _____ TITLE: _____ DATE: _____

Please return in the enclosed self-address envelope or FAX to 314-664-5206 or scan and email to southsidewellness314@gmail.com.

Thank you for providing this helpful information. Please note that all information provided is kept in strictest confidence.



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
 FAMILY CARE SAFETY REGISTRY
WORKER REGISTRATION

FCSR USE ONLY

Register online at www.health.mo.gov/safety/fcsr OR mail this form, copy of Social Security card, and payment to Missouri Dept. of Health and Senior Services, Fee Receipts, PO Box 570, Jefferson City, MO 65102.

REGISTRATION TYPE (Check all that apply. Complete column on right only if Long Term Care/Personal Care selected from left.)

- Adoptive Parent
Agency Name: _____
- Child Care
- Foster Parent/Family Member of Foster Parent
County Office: _____
- Hospital
- Long Term Care/Personal Care (Please choose subcategory at right ▶.)
- Mental Health/Psychiatric Hospital
- Voluntary (Select voluntary if no other registration type applies.)

Long Term Care / Personal Care Subcategories (Complete if LTC/PC selected at left.)

- Adult Day Care
- Assisted Living Facility
- Hospice
- Hospital LTAC/Swing Bed
- Mental Health – Residential Facility/ICF
- Nursing Facility/Skilled Nursing
- Personal Care – Home Health
- Personal Care – In-Home Services
- Personal Care – Consumer Directed Services/Center for Independent Living
- Personal Care – HCY/PDW/DDD/Other

A one-time registration fee of \$14.00 applies to all categories except Foster Parents. Foster Parents must list the Children's Division county office.

Register only once. If you believe you have already registered, check our website at www.health.mo.gov/safety/fcsr or call, toll free, 866-422-6872.

SOCIAL SECURITY NUMBER (Mail copy of card with form.)

PERSONAL INFORMATION (Provide all names you have used, starting with most recent. Include legal names and nicknames.)

LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX (JR., SR., II, III)
BIRTH NAME (LIST FULL NAME)		PRIOR NAMES USED (IF APPLICABLE, LIST FIRST AND LAST NAMES.)	DATE OF BIRTH (MM-DD-YYYY)
			GENDER <input type="checkbox"/> M <input type="checkbox"/> F

CONTACT INFORMATION

MAILING ADDRESS (ENTER YOUR STREET ADDRESS OR POST OFFICE BOX. THIS ADDRESS MUST BE DIFFERENT FROM EMPLOYER ADDRESS.)

CITY	STATE	ZIP CODE	COUNTY
TELEPHONE	EMAIL ADDRESS (REQUIRED)	COUNTRY (COMPLETE ONLY IF OUTSIDE U.S.)	

EMPLOYER ASSOCIATED WITH THIS REGISTRATION (Complete either left or right column, not both.)

<input type="checkbox"/> My current/potential child care, long term care or mental health care employer is:			<input type="checkbox"/> No Employer, because I am a(n):		
EMPLOYER NAME			<input type="checkbox"/> Adoptive Parent <input type="checkbox"/> Foster Parent/Family Member <input type="checkbox"/> Home Child Care Provider <input type="checkbox"/> Private Pay/Private Duty <input type="checkbox"/> Student <input type="checkbox"/> Volunteer <input type="checkbox"/> Other (Explain: _____)		
EMPLOYER ADDRESS					
EMPLOYER CITY	STATE	ZIP			
EMPLOYER TELEPHONE	EMPLOYER CONTACT NAME	EMPLOYER CONTACT TITLE			

REGISTRATION AGREEMENT

The information provided is complete and accurate to the best of my knowledge. I understand it is unlawful to withhold or falsify information required on this form. I grant my permission for the Missouri Department of Health and Senior Services (DHSS) to obtain any and all background information authorized by law to process this request. Furthermore, I authorize the DHSS to release the fact that I am a registrant in the Family Care Safety Registry (FCSR) and any related background information to the requester of the FCSR for employment purposes only, as provided in §210.921, subsection 1, subdivisions (1) and (2), RSMo. For purposes of the FCSR, "employment purposes" includes direct employer/employee relationships, prospective employer/employee relationships, and screening and interviewing of persons or facilities by those persons contemplating the placement of an individual in a child care, elder care or personal care setting. I understand that if I dispute the information contained in the FCSR I have the right to appeal the accuracy of the transfer of information to the FCSR within thirty (30) days of receiving the results of the background screening.

NOTICE: The FCSR may choose to deposit the check enclosed electronically as an ACH debit entry to my designated bank account. I understand that my signature below authorizes my financial institution to deduct this payment from my account. In the event that DHSS or its subcontractor is unable to secure funds from my account or I provide insufficient or inaccurate information regarding my account, my obligation to the DHSS will remain unpaid and further collection action may be taken by the DHSS or its subcontractor, including, but not limited to, returned check fees.

SIGNATURE OF APPLICANT	DATE OF SIGNATURE (MUST BE WITHIN SIX MONTHS OF SUBMISSION.)
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WHAT IS THE FAMILY CARE SAFETY REGISTRY?

The Family Care Safety Registry (FCSR), administered by the Missouri Department of Health and Senior Services (DHSS), provides families and employers with a method to obtain background screening information. The Registry, through various state agencies, offers several resources to screen child care, long term care and mental health workers:

- State criminal history and sex offender registry records maintained by the Missouri State Highway Patrol
- Child abuse/neglect records maintained by the Missouri Department of Social Services
- The Employee Disqualification List maintained by the Missouri Department of Health and Senior Services
- The Employee Disqualification Registry maintained by the Missouri Department of Mental Health
- Child care facility licensing records maintained by the Missouri Department of Health and Senior Services
- Foster parent records maintained by the Missouri Department of Social Services

WHO HAS TO REGISTER?

Any person hired on or after January 1, 2001, as a child care worker or elder care worker, hired on or after January 1, 2002, as a personal care worker, or hired on or after January 1, 2009, as a mental health worker, as provided in §210.906, RSMo, is required to make application for registration in the Family Care Safety Registry within fifteen (15) days of the beginning of employment. **Such person who fails to submit a completed registration form to the DHSS without good cause, as determined by the department, is guilty of a class B misdemeanor.** Employees and volunteers from non-state and/or federally regulated entities are NOT REQUIRED to register with the FCSR.

HOW DO I COMPLETE THE REGISTRATION FORM?

Registration Type – Check at least one box from the left column for type of registration that best describes your worker category. If no other type applies, select "Voluntary." (A "voluntary registrant" is a person who is not mandated to register with the Family Care Safety Registry pursuant to §210.900 et seq., RSMo.) If you checked Long Term Care / Personal Care, please also make one or more selections from the column on the right for subcategory.

Social Security Number – You must provide your Social Security number pursuant to 19CSR 30-80.030(1). This identifying information, including Social Security number, will be used for internal identification purposes and to conduct background screenings for the resource information listed in paragraph one above.

Personal Information – List your current Last Name, First Name, Middle Name, and any suffix associated with your last name. List any other names by which you may have been known, including maiden names, past married names, and nicknames (attach additional sheets if needed). For identification purposes, list your gender and date of birth.

Contact Information – List your address, city, state, ZIP code, and county. Include your telephone number and email address. We will use this information to notify you of registration results and any background screenings conducted. Email notifications will be encrypted for improved security. To reduce postage costs, the Registry may contact you to request a personal email address if one is not provided.

Employer Associated with this Registration - If you are currently employed by or are seeking employment with a child care or long term care provider, please list the facility name, address, telephone number, and contact person. If registration is not for employment purposes, make a selection from column on right. The employer entered in this section will not receive a copy of the registration notification. Employers eligible to use the Registry for caregiver screenings must make a separate request for your background information.

Registration Agreement – Sign and date the registration form. Your signature will authorize the Family Care Safety Registry to conduct the background screening outlined in §210.903.2, RSMo and to provide the information to requesters for employment purposes, as provided in §210.921.1, RSMo.

WHERE DO I SEND MY REGISTRATION FORM?

Send your completed registration form and photocopy of Social Security card and required fee to the **Missouri Department of Health and Senior Services, ATTN: Fee Receipts, P.O. Box 570, Jefferson City, MO 65102.** If you have questions, please call the Registry using the toll-free telephone number, 866-422-6872.

WHEN WILL I KNOW THE RESULTS OF MY BACKGROUND SCREENING?

After the background screening has been completed, you will be notified in writing of the results that will be recorded in the Family Care Safety Registry. You will also be notified in writing each time background screening information is provided. The notification will contain the name and address of the person who made the request and the background information disclosed. The person making the request will be informed that information will be released for employment purposes only, pursuant to §210.921.1, RSMo. Any person using Registry information for any other purpose is guilty of a class B misdemeanor. In addition, state agencies can request information for licensure or regulatory purposes. Prior to disclosing information, the Registry obtains the name and address of the requester, and determines that the request is for employment or regulatory purposes. To ensure you receive these notifications, it will be important for you to notify the Family Care Safety Registry when you have a change in your contact information. Notify the Family Care Safety Registry of changes in personal or contact information using the toll-free telephone number, 866-422-6872, by email to fcsr@health.mo.gov, or by mail to FCSR, PO Box 570, Jefferson City, MO 65102.

WHAT IF I DON'T AGREE WITH THE RESULTS OF MY BACKGROUND SCREENING?

As provided in §210.912, RSMo, you have the right to appeal the information transferred to the Family Care Safety Registry. Your right to appeal is limited to the accuracy of the transfer of information from the state agency that maintains the background information and does not include a right to appeal the accuracy of the substance of the information transferred. An appeal must be filed in writing to the Office of the Director, Missouri Department of Health and Senior Services, P.O. Box 570, Jefferson City, MO, 65102, within 30 days of receiving the results of the background screening determination. An administrative appeal shall be set within 30 days of the filing of the appeal and a decision shall be made within 60 days. This right to appeal is in addition to any other appeal rights granted by state law.

WHAT INFORMATION WILL BE DISCLOSED BY THE FAMILY CARE SAFETY REGISTRY?

Disclosure of background information on a person registered in the Family Care Safety Registry will be limited. If the person is registered, the Registry worker will disclose whether the person's name is listed in any of the background checks pursuant to §210.903, subsection 2, RSMo, and if so, which one(s). Specific information will be disclosed by the Registry pursuant to §210.921, subsection 1, subdivision (2).



Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

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

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

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
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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		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				

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)
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I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented 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
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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.

<p align="center">LIST A</p> <p align="center">Documents that Establish Both Identity and Employment Authorization</p>	<p align="center">OR</p> <p align="center">LIST B</p> <p align="center">Documents that Establish Identity</p>	<p align="center">AND</p> <p align="center">LIST C</p> <p align="center">Documents that Establish Employment Authorization</p>
<p>1. U.S. Passport or U.S. Passport Card</p>	<p>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</p>	<p>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</p>
<p>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</p>	<p>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</p>	<p>2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)</p>
<p>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</p>	<p>3. School ID card with a photograph</p>	<p>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</p>
<p>4. Employment Authorization Document that contains a photograph (Form I-766)</p> <p>5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:</p> <p>a. Foreign passport; and</p> <p>b. Form I-94 or Form I-94A that has the following:</p> <p>(1) The same name as the passport; and</p> <p>(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.</p>	<p>4. Voter's registration card</p>	<p>4. Native American tribal document</p>
<p>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</p>	<p>5. U.S. Military card or draft record</p>	<p>5. U.S. Citizen ID Card (Form I-197)</p>
	<p>6. Military dependent's ID card</p>	<p>6. Identification Card for Use of Resident Citizen in the United States (Form I-179)</p>
	<p>7. U.S. Coast Guard Merchant Mariner Card</p>	<p>7. Employment authorization document issued by the Department of Homeland Security</p>
	<p>8. Native American tribal document</p>	
	<p>9. Driver's license issued by a Canadian government authority</p> <p>For persons under age 18 who are unable to present a document listed above:</p>	
	<p>10. School record or report card</p>	
	<p>11. Clinic, doctor, or hospital record</p>	
	<p>12. Day-care or nursery school record</p>	

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

Refer to the instructions for more information about acceptable receipts.

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, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2021 if you meet both of the following conditions: you had no federal income tax liability in 2020 and you expect to have no federal income tax liability in 2021. You had no federal income tax liability in 2020 if (1) your total tax on line 24 on your 2020 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2021 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 15, 2022.

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 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.



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

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You 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 2021 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.

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.**

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 _____	
	(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying widow(er) <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)	

▶ 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.

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

TIP: To be accurate, submit a 2021 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Step 3: Claim Dependents	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly): Multiply the number of qualifying children under age 17 by \$2,000 ▶ \$ _____ Multiply the number of other dependents by \$500 ▶ \$ _____ Add the amounts above and enter the total here	3	\$
Step 4 (optional): Other Adjustments	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income	4(a)	\$
	(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here	4(b)	\$
	(c) Extra withholding. Enter any additional tax you want withheld each pay period	4(c)	\$

Step 5: Sign Here	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.		
	▶ _____ Employee's signature (This form is not valid unless you sign it.)	▶ _____	Date

Employers Only	Employer's name and address _____	First date of employment _____	Employer identification number (EIN) _____
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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 2021 itemized deductions (from Schedule A (Form 1040)). 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: $\left\{ \begin{array}{l} \bullet \$25,100 \text{ if you're married filing jointly or qualifying widow(er)} \\ \bullet \$18,800 \text{ if you're head of household} \\ \bullet \$12,550 \text{ if you're single or married filing separately} \end{array} \right\}$ 2 \$ _____

- 3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. 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)). 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.

SOUTHSIDE WELLNESS CENTER

3017 PARK AVENUE ST. LOUIS, MO 63104 314-664-5024 314-664-5206 Fax

APPLICATION/EMPLOYMENT REQUIREMENTS

If you are applying for any employment, you must provide photo identification and Social Security card copies with you completed application. The application must also include work and personal reference addresses and contact information.

If you are employed in the KITCHEN, you must provide the following:

1. Current Police Record Check
2. Current Medical Exam
3. Current Shot Record
4. Current TB Test
5. FCSR*
6. DSL List*

If you are employed as a DRIVER/AIDE, you must provide the following:

1. Annual Medical Exam
2. Annual Drug Test Current
3. Missouri Driving Record
4. Annual Finger Print Check
5. Annual CPR & First Aid
6. Current Police Record Check
7. Annual FCSR*
8. DSL List*

If you are employed as a HOME HEALTH AIDE, you must provide the following:

1. Current Medical Exam
2. Current TB Test
3. Attend Mandatory Training
4. FCSR*
5. DSL List*

If you volunteer or work in any other capacity, you must provide the following:

1. Police Record Check
2. Training*
3. FCSR*
4. DSL List*

Ollie M. Stewart

Ollie M. Stewart
Executive Director

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DRIVER APPLICANT'S QUALIFICATIONS FOR HIRE

Please read this information before filling out an application for employment.

Driver Requirements:

You are at least 21 years of age.

Applicant must be able to read, write and follow instructions.

Experience driving a van and/or shuttle bus.

Applicants must not have had any of the following:

1. Have no felony convictions in the past five (5) years.
2. Have not had driver's license suspended or revoked in the past three (3) years.

Thank you.

Ollie M. Stewart

Ollie M. Stewart
Executive Director