

**ALIGN Homecare Inc. Independent  
Contractor Registration**

PERSONAL INFORMATION				
First Name		Middle Name		Last Name
Street Address		Apt. #	City	State      Zip Code
Home Phone Number		Cell Phone Number		Date of Birth MM/DD/YYYY
(      )		(      )		
Email Address:				
Are you authorized to work in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Driver's License State / Number			Social Security Number	
EDUCATION				
High School:			Graduated <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> GED	
College:			Graduated <input type="checkbox"/> Yes <input type="checkbox"/> No    Major:	
Professional School:			Graduated <input type="checkbox"/> Yes <input type="checkbox"/> No	

WORK HISTORY	
<b>Please list your three most recent contracts or work assignments, starting with your current or last.</b>	
1	Name: _____ Position: _____
Start Date: _____ *End Date: _____ Last Date Worked: _____ <input type="checkbox"/> Still working	
*Reason for leaving:	
Person to contact for reference:	Contact Phone: (      )

2	Name: _____	Position: _____
Start Date: _____ *End Date: _____ Last Date Worked: _____ <input type="checkbox"/> Still working		
*Reason for leaving: _____		
Person to contact for reference: _____		Contact Phone: (     )
3	Name: _____	Position: _____
Start Date: _____ *End Date: _____ Last Date Worked: _____ <input type="checkbox"/> Still working		
*Reason for leaving: _____		
Person to contact for reference: _____		Contact Phone: (     )

Professional Credentials			
_____	_____	_____	_____
License/ Certification Type	License/ Certification No.	State	Expiration Date
_____	_____	_____	_____
License/ Certification Type	License/ Certification No.	State	Expiration Date
Information concerning renewal of the applicable license, registration, or certification (specify): _____			
_____			

I currently am registered or employed as a caregiver with the following companies:	
1	Name: _____ Contact Phone: (     )
2	Name: _____ Contact Phone: (     )
3	Name: _____ Contact Phone: (     )
4	Name: _____ Contact Phone: (     )

Authorization and Release	
My signature below attests to the truthfulness of the information I have provided.	
I am registering as an Independent Contractor with ALIGN Homecare Inc. and hereby authorize ALIGN Homecare Inc. to contact the work references listed above. Further, I hereby authorize and give permission to the work references listed above to release to ALIGN Homecare Inc. any required information. In addition, I hereby release the work references listed above from all liability which may result from the release of such information.	
_____	_____
Contractor Name (Please Print)	Witness
_____	_____
Contractor Signature	Date

**CAREGIVER RATE SHEET**

Contractor Name \_\_\_\_\_ Date \_\_\_\_\_

RN \_\_\_\_\_ LPN \_\_\_\_\_ CNA \_\_\_\_\_ HHA \_\_\_\_\_

As a caregiver registering as an Independent Contractor on the referral list for ALIGN Homecare Inc. , I understand that I am self-employed and determine whether to accept a potential client opportunity. I also understand that, in addition to the rate I am paid by the client, ALIGN Homecare Inc. will charge the client a referral fee. I realize that, if I set my rates too high, other caregivers may be more affordable to clients and thereby have more opportunities for referrals.

I am interested in the following referrals: Regular Hourly \_\_\_\_\_ Live-In/ 24-Hour Shift Hourly \_\_\_\_\_

ALIGN Homecare Inc. in its marketing and administrative functions, attempts to identify client opportunities within a caregiver’s preferred range of rates:

Caregiver's Rates:

**Preferred Regular Hourly Rate**

**Low-End Regular Hourly Rate I am willing to accept**

\$ \_\_\_\_\_ / Hour

\$ \_\_\_\_\_ / Hour

**Preferred Live-In/ 24-Hour Shift Hourly Rate**

**Low-End Live-In/ 24-Hour Shift Hourly Rate I am willing to accept**

\$ \_\_\_\_\_ / Hour

\$ \_\_\_\_\_ / Hour

\_\_\_\_\_  
Independent Contractor Signature

**ALIGN Homecare Inc.**

**Independent Contractor Availability and Preferences**

Contractor Name: \_\_\_\_\_

*ALIGN Homecare Inc. requests the below information to determine whether your availability, experience, and preferences fit a given client's request for an independent contractor caregiver. However, if a client hires you, you and the client will independently determine your work schedule and the services you will provide.*

Please indicate your availability by checking the boxes below:

**HOURLY**

MORNINGS       MON  TUES  WED  THURS  FRI  SAT  SUN

AFTERNOONS     MON  TUES  WED  THURS  FRI  SAT  SUN

NIGHTS             MON  TUES  WED  THURS  FRI  SAT  SUN

**LIVE-IN/24-HOUR**  MON  TUES  WED  THURS  FRI  SAT  SUN

**CARE SERVICES LIMITATIONS AND PREFERENCES**

Please provide information ALIGN Homecare Inc. about any limitations or preferences you may have with respect to the care services you are willing to provide:

Will you use your car to transport clients?  Yes  No

Do you smoke?  Yes  No

Will you drive the client's car?  Yes  No

Will you accept referrals for clients who smoke?

Will you accept referrals for clients with pets?  Yes  No

Yes  No

Specify any pet restrictions: \_\_\_\_\_

Languages Spoken: \_\_\_\_\_

Limitations on service areas: \_\_\_\_\_

Other limitations on services: \_\_\_\_\_

Special experience or qualifications: \_\_\_\_\_

Do you have experience with the use of Hoyer lift? Yes  No

Preferences for services provided: \_\_\_\_\_



## **CAREGIVER AGREEMENT FOR REFERRAL, MARKETING AND ADMINISTRATIVE SERVICES**

***ALIGN Homecare Inc.***

This Caregiver Agreement for Referral, Marketing and Administrative Services ("Agreement") is between ALIGN Homecare Inc. ("Registry") and \_\_\_\_\_ ("Contractor"). The "Parties" means the Registry and Contractor and, in the singular, refers to either as the context makes apparent. The Parties agree as follows:

1. **Nurse Registry.** The Registry is a nurse registry licensed under Section 400.506, F.S that seeks to procure home care related contracts for self-employed home care providers operating as independent contractors. The Registry does not provide the same services as Contractor and does not hold itself out to be a provider of care services, as such services are exclusively rendered by Contractor and other independent contractor caregivers.
2. **Registry Services.** The Registry will perform the following services ("Registry Services"):
  - (a) **Confirmation of Credentials and Background.** The Registry shall confirm Contractor's professional credentials and conduct a background screening in compliance with Florida law.
  - (b) **Referral Services.** If the Contractor's credentials and background are satisfactory, the Registry shall match and refer Contractor to one or more of the Registry's clients ("Client") for potential opportunities to provide care services. The Registry will use objective criteria to determine whether Contractor is qualified to be referred for a potential Client opportunity. Contractor always retains the right to pursue or decline any Client opportunity. Clients also retain the right to accept or reject, at their discretion, any Contractor referred by the Registry.
  - (c) **Marketing and Administrative Support Services.** The Registry will provide, or coordinate the provision of, certain administrative services in support of Contractor's business, including billing and payment processing services. The Registry also shall provide marketing services to generate additional potential Client opportunities for Contractor. The Registry is not the exclusive means by which Contractor may market his or her services. Contractor is not limited in his or her ability to independently market his or her services or to use other entities to market his or her services.
3. **Contractor Representations.** Contractor agrees that he or she (i) is self-employed; (ii) maintains and operates a business that is separate and independent from the Registry; (iii) holds himself or herself out to the public as possessing the credentials, training, experience, skill and ability to provide the applicable care services in compliance with applicable Florida law; (iv) has obtained and/or expects to obtain clients through means other than the Registry.
4. **Contractor Is Not the Registry's Employee.** Contractor acknowledges that he or she is an independent contractor and not an employee of the Registry. As an independent contractor, Contractor is not subject to the provisions of the Fair Labor Standards Act or state wage and hour laws. Contractor shall not be entitled to participate in any plans, arrangements, or distributions the Registry may make in connection with any pension, stock, bonus, profit sharing or similar benefits for the Registry's employees. Contractor understands that neither Contractor nor any of his or her subcontractors or employees will be eligible for unemployment compensation or workers' compensation benefits in connection with Contractor's relationship with the Registry. Contractor acknowledges his or her sole responsibility to maintain (i) workers' compensation coverage for himself or herself and his or her employees and subcontractors to the extent required by applicable law and (ii) all other insurance required to operate his or her business in conformance with applicable law and industry standards. Contractor agrees to indemnify, defend, and hold harmless the Registry, its officers, directors, members, employees, successors, and assigns from and against any liability, cost, or expense (including reasonable attorneys' fees) for any obligations threatened or imposed upon the Registry by governmental entities in connection with such matters. This paragraph shall survive termination of this Agreement.

It also shall be the sole responsibility of the Contractor to make application for and pay fees for any business licenses or permits, where required by any state or local law, ordinance or regulations. The Registry shall not be liable and Contractor agrees to indemnify, defend, and hold harmless the Registry, its officers, directors, members, employees, successors, and assigns from and against any claims, losses, costs, fees, liabilities damages or such injuries arising out of Contractor's failure to obtain any such license or permit. This paragraph shall survive termination of this Agreement.

5. Contractor's Relationship With Client. Contractor acknowledges that he or she will negotiate with Client, and not the Registry, to determine the engagement for services between Contractor and Client. The Registry may act as a liaison between Contractor and Client in initial communications and upon request but will not determine the terms of the relationship between Contractor and Client. Contractor and Client retain the exclusive right to control and direct the means, manner, and method by which Contractor will perform services for Client.
6. Contractor's Fees for Services Provided to Clients. Contractor will provide the Registry, during Contractor's registration or otherwise, a range of fees that Contractor would be willing to accept for his or her services. The Registry, in its marketing and administrative functions, will attempt to identify potential Client opportunities within Contractor's preferred range of rates.

Contractor shall submit a weekly Timecard for each Client, certified as an accurate and complete record of hours worked that week by Contractor for the Client. The Registry will not review invoices for accuracy. Upon the Registry's receipt of Contractor's weekly invoice, Contractor authorizes and directs the Registry to (a) invoice the Client and/or Client's payor the amount due for Contractor's services pursuant to Contractor's weekly invoice, (b) assign all of Contractor's right, title, and interest to collect and receive payment from the Client and/or Client's payor to the Registry, (c) collect the amounts due to Contractor, and (d) disburse Contractor's fees to Contractor. The contractor understands and acknowledges that the Registry will charge the Client and/or Client's payor for the Registry Services it provides, which fee is separate from and in addition to the fee paid to the Contractor.

If the Registry is unable to obtain payment from the Client and/or Client's payor for Contractor's services, the Registry shall have no obligation to pay Contractor for his or her services to that Client. Contractor bears the ultimate risk of non-payment. The Registry has no obligation to advance Contractor any payment for services not yet paid. If, for any reason, the Registry chooses to advance payment or partial payment to Contractor and Client and/or Client's payor fails to pay for those services, Contractor agrees to reimburse the Registry for the amount advanced.

7. Terms and Conditions. The Parties agree the following terms and conditions govern their relationship:
  - (a) Contractor is solely responsible for all equipment, tools, vehicles, and supplies needed or desired by Contractor to perform services for Clients, to further Contractor's business, or to extend the reach of the Contractor's market.
  - (b) Contractor warrants and represents that he or she possesses the requisite skills, credentials, training, and experience in compliance with applicable Florida law to provide the services for any Client opportunity that he or she accepts, and understands that the Registry will not provide training or instruction of any kind; and
  - (c) Contractor agrees that any employee or subcontractor hired by Contractor and who provides services to a Client on Contractor's behalf will be a caregiver currently registered with the Registry and represents and warrants that said caregiver possesses the skills, credentials, training, and experience to provide such services in compliance with applicable Florida law.
8. Notice to Contractor of State Law Obligations. Contractor acknowledges that he or she has been provided printed and/or digital copies and information on where to electronically access the following rules and statutes, and agrees to comply with such rules and statutes while providing services to Clients:
  - (a) Registered nurses and licensed practical nurses: Rule 59A-18.005, F.A.C., Registration Policies; Rule 59A-18.007, F.A.C., Registered Nurses and Licensed Practical Nurses; Rule 59A-18.011, F.A.C., Medical Plan of Treatment; Rule 59A-18.012, F.A.C., Clinical Records; Rule 59A-18.013, F.A.C., Administration of Biologicals; Sections 400.506, 408.809, 400.484, 400.462, 400.488 and 408.810(5), F.S. with the referenced telephone numbers re; Rule 59A-18.018 Emergency Management Plans.

- (b) Certified nursing assistants and home health aides: Rule 59A-18.005, F.A.C., Registration Policies; Rule 59A-18.0081, F.A.C., Certified Nursing Assistant and Home Health Aide; Sections 400.506, 408.809, 400.484, 400.462, 400.488 and 408.810(5), F.S. with the referenced telephone numbers; Rule 59A-18.018, F.A.C., Emergency Management Plans.
- (c) Contractor can electronically access the above State of Florida rules and statutes at:
- <https://www.flrules.org/gateway/ChapterHome.asp?Chapter=59A-18>
  - [http://www.leg.state.fl.us/Statutes/index.cfm?App\\_mode=Display\\_Statute&URL=0400-0499/0400/0400.html](http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&URL=0400-0499/0400/0400.html)
  - [http://www.leg.state.fl.us/Statutes/index.cfm?App\\_mode=Display\\_Statute&Search\\_String=&URL=0400-0499/0408/0408PARTIIContentsIndex.html](http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0400-0499/0408/0408PARTIIContentsIndex.html)

Contractor acknowledges that Florida law requires Contractor to include in the patient record of each Client to whom Contractor provides services a description of how care will be continued during a disaster or emergency that interrupts the provision of care in Client's home. Section 400.506 (12)(a), F.S. Contractor acknowledges that he or she has the responsibility to ensure continuous care is provided to Client, excepting situations beyond Contractor's control that make it impossible to provide services. Section 400.506 (12)(a),(d), F.S. Contractor further acknowledges that Florida law requires Contractor to provide a list of medication and equipment needs to the Registry for each Client to whom Contractor provides services. Section 400.506 (12)(c), F.S.

9. Term and Termination. The term of this Agreement is for one year from the effective date written below. Either Party may terminate this Agreement by giving the other Party ten (10) days written notice of intent to terminate. The Registry may terminate this Agreement immediately with written notice to Contractor if Contractor breaches any material term ("Material Breach"). The Agreement shall not automatically renew. Termination of this Agreement will not terminate Contractor's engagement with Client, as the Registry has no right to terminate or otherwise interfere with such engagement, other than to inform Client about matters pertaining to Contractor's background checks and professional credentials as required by state law.
10. Material Breach. Material Breach includes but is not limited to: violation by Contractor of applicable state law or possession of deficient credentials under Section 400.506(19), F.S.; and failure of Client or Client's payor to pay the Registry's fee for Registry Services related to the services provided by Contractor.
11. No Legal, Tax or Other Advice. The Registry is not rendering legal, tax, or other advice and shall not be responsible for Contractor's compliance with federal, state, or local statutes, regulations, or ordinances. Contractor acknowledges that he or she may seek advice from an appropriate professional to comply with any applicable law. Contractor acknowledges that he or she has sole responsibility for all federal, state, and local tax obligations relating to compensation received from Client or any other amounts paid to Contractor. The Registry will not withhold or pay, or be obligated to withhold or pay, any payroll or employment taxes (including but not limited to FICA, FUTA, federal personal income tax, state personal income tax, state disability insurance tax, state unemployment insurance tax, and state worker's compensation insurance tax). This paragraph shall survive termination of this Agreement.
12. Indemnification. Contractor agrees to indemnify, defend and hold harmless the Registry and its officers, directors, members, employees, successors, and assigns from any and all claims, causes of action, proceedings, liabilities, obligations, losses, damages, penalties, interest, costs and expenses (including reasonable attorneys' fees) that pertain in any way to the services that Contractor or Contractor's employees or contractors have provided or agreed to provide for a Client, including but not limited to: (i) personal injury to a Client or others; (ii) property damage, including personal property in Client's home; and (iii) injuries or damages from the use of any vehicle, regardless of ownership. Contractor agrees to hold harmless, defend and indemnify the Registry to the fullest extent permitted by law from and against any and all liability related to payment or non-payment of federal, state, or local taxes, or other withholdings related to Contractor. Contractor agrees to indemnify, defend and hold harmless the Registry and its officers, directors, members, employees, successors, and assigns from and against any and all causes of action, obligations, disbursements, losses, liabilities, deficiencies, penalties, interest, claims, damages, actions, proceedings, payroll taxes, settlements, judgments, costs and expenses (including reasonable attorneys' fees) related to contracting with Contractor under any and all circumstances. Contractor hereby waives any and all rights of subrogation. This paragraph shall survive termination of this Agreement.
13. Entire Agreement. This Agreement and the Mutual Arbitration Agreement supersede all prior and contemporaneous agreements, contracts, understandings, representations, warranties, guarantees, or conditions, express or implied, oral or written, among the Parties with respect to the subject matter herein. By entering into this Agreement, the Parties forego and extinguish any rights in any prior agreement with the exception of the Mutual Arbitration Agreement. However, to the extent any dispute between Contractor and the Registry is already subject to a pending arbitration under any prior agreement to arbitrate claims, such claims shall continue to be bound by such prior agreement to arbitrate claims. No

changes to this Agreement shall be valid unless in writing and executed by both Parties, provided, however, that the Registry may assign all or any of its rights or obligations under this Agreement without the prior written consent of the Contractor. This Agreement shall be binding upon the Parties, their successors and assigns.

- 14. Severability. Should any part of this Agreement be declared to be invalid or unenforceable, the remaining provisions shall remain in full force and effect as if this Agreement has been executed without the invalid or unenforceable provision(s).
- 15. Choice of Law and Enforcement. Excepting Contractor's Mutual Arbitration Agreement, which is governed by the Federal Arbitration Act, 9 U.S.C. § 1 et seq., this Agreement and all questions relating to its validity, interpretation, performance, and enforcement shall be governed by and construed in accordance with the laws of the State of Florida, regardless of any conflicts of laws doctrines, and without any canon, custom, or rule of law requiring construction against the draftsman.

**Contractor has read and fully understands the contents of this Agreement and agrees to its terms.**

Effective this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

**ALIGN HOMECARE INC.**

**INDEPENDENT CONTRACTOR**

SIGNATURE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

NAME: \_\_\_\_\_

NAME: \_\_\_\_\_

TITLE: \_\_\_\_\_

DATE: \_\_\_\_\_

DATE: \_\_\_\_\_

ACKNOWLEDGEMENT OF  
INDEPENDENT CONTRACTOR STATUS

I, \_\_\_\_\_ acknowledge that I have requested client referrals from **ALIGN Homecare, Inc.**

I understand and agree that each client to whom I am referred by **ALIGN Homecare Inc.** is considered my employer and that **ALIGN Homecare Inc.** is not my employer. I understand and agree that I have a contract with each client-employer referred to by **ALIGN Homecare Inc.** and we have agreed on the hours, days and services performed and on the hourly Caregiver fee to which I am entitled.

**ALIGN Homecare Inc.** does not manage or supervise me or direct how or when I should perform services as that is solely between me and my clients. I agree that **ALIGN Homecare Inc.** is entitled to a registry fee as agreed in my Independent Contractor Referral Agreement.

I have had the opportunity to ask any questions regarding the above and I have had the opportunity to seek the advice of counsel before signing this Acknowledgement and accepting referrals.

Print Name:

\_\_\_\_\_

Date: \_\_\_\_\_

Signature:

\_\_\_\_\_

Witness Name:

\_\_\_\_\_

Witness Signature:

\_\_\_\_\_

## MUTUAL ARBITRATION AGREEMENT

**This Mutual Arbitration Agreement is a contract and covers important issues relating to your rights. It is your sole responsibility to read it and understand it. You are free to seek assistance from independent advisors of your choice outside of the Company or to refrain from doing so if that is your choice.**

**El Acuerdo Mutuo de Arbitraje es un contrato y cubre aspectos importantes de sus derechos. Es su absoluta responsabilidad leerlo y entenderlo. Usted tiene la libertad de procurar asistencia de asesores independientes de su elección o de abstenerse de buscar asistencia si esa es su elección.**

A. This Mutual Arbitration Agreement (“Arbitration Agreement”) is entered into on this \_\_\_day of \_\_\_\_\_, 20\_\_ by and between \_\_\_\_\_ (“Independent Contractor”) and ALIGN Homecare Inc. (the “Company”). This Arbitration Agreement applies to a covered dispute that the Company may have against Independent Contractor or that Independent Contractor may have against the Company, and/or any of its parent companies, subsidiaries, predecessor companies, successors, related companies and affiliates, franchisors, or their officers, directors, principals, shareholders, members, owners, employees, and managers or agents, each and all of which may enforce this Arbitration Agreement as direct or third-party beneficiaries.

B. The Company and Independent Contractor mutually agree to resolve all disputes between them exclusively through final and binding arbitration and not by way of court or jury trial. This Arbitration Agreement will remain in force and survive after the parties’ relationship ends. This Arbitration Agreement is governed by the Federal Arbitration Act (9 U.S.C. §§ 1 *et seq.*) and shall apply to any and all claims or disputes arising out of or relating to this Arbitration Agreement, Independent Contractor’s classification as an independent contractor, Independent Contractor’s provision of services to the Company or its care receivers, patients or residents, the payments received by Independent Contractor for providing services to the Company or its care receivers, patients or residents, the termination of this Arbitration Agreement and/or the termination of Independent Contractor’s work with the Company (including without limitation post-employment defamation or retaliation), and all other aspects of Independent Contractor’s relationship with the Company, past, present or future, whether arising under federal, state or local statutory, regulatory and/or common law (including without limitation claims or disputes regarding negligence, torts, breach of a contract or covenant, fraud, emotional distress, breach of fiduciary duty, any wage-hour law, trade secrets, unfair competition, compensation, expense reimbursement, seating, minimum wage, breaks, rest periods, discrimination, retaliation or harassment and claims arising under the Fair Credit Reporting Act, Defend Trade Secrets Act, the Civil Rights Act of 1964, 42 U.S.C. § 1981, the Americans With Disabilities Act, the Age Discrimination in Employment Act, the Family Medical Leave Act, the Fair Labor Standards Act, Rehabilitation Act, Civil Rights Acts of 1866 and 1871, the Civil Rights Act of 1991, 8 U.S.C. § 1324b (unfair immigration related practices), the Pregnancy Discrimination Act, the Equal Pay Act, the Genetic Information Non-Discrimination Act, Employee Retirement Income Security Act of 1974 (except for claims for employee benefits under any benefit plan sponsored by the Company and (a) covered by the Employee Retirement Income Security Act of 1974 or (b) funded by insurance), Affordable Care Act, Uniformed Services Employment and Reemployment Rights Act, Worker Adjustment and Retraining Notification Act, Older Workers Benefits Protection Act of 1990, False Claims Act, Occupational Safety and Health Act, Consolidated Omnibus Budget Reconciliation Act of 1985, and state statutes or regulations, if any, addressing the same or similar subject matters, and all other federal and state statutory and common law claims). Additionally, the arbitrator shall have exclusive authority to resolve any dispute relating to the scope, validity, conscionability, interpretation, applicability, or enforceability of this Arbitration Agreement. However, the preceding sentence shall not apply to the “Class Action Waiver” described in Paragraph (B)(ii)

below. Regardless of anything else in this Agreement or the American Arbitration Association (“AAA”) Rules (described below), any dispute relating to the scope, validity, conscionability, interpretation, applicability, or enforceability of the Class Action Waiver, or any dispute relating to whether this Arbitration Agreement precludes a class or collective action proceeding, may only be determined by a court and not an arbitrator.

(i) If either party wishes to initiate arbitration, the initiating party must notify the other party in writing via certified mail, return receipt requested, or hand delivery within the applicable statute of limitations period (deadline for filing). This demand for arbitration must include (1) the name and address of the party seeking arbitration, (2) a statement of the legal and factual basis of the claim, and (3) a description of the remedy sought. Any demand for arbitration by Independent Contractor must be delivered to **ALIGN Homecare Inc.** 7855 NW 12th St. Suite # 205 Doral, FL 33126 . If the Company initiates arbitration against Independent Contractor, it will provide notification to Independent Contractor at the last address Independent Contractor provided in writing to the Company.

(ii) **Class and Collective Action Waiver.** Both the Company and Independent Contractor mutually agree that by entering into this Arbitration Agreement, both waive their right to have any dispute or claim brought, heard or arbitrated as a class action and/or collective action, and an arbitrator shall not have any authority to hear or arbitrate any class and/or collective action (“Class Action Waiver”). In any case in which (1) the dispute is filed as a class or collective action and (2) there is a final judicial determination that all or part of the Class Action Waiver is unenforceable, the class or collective action to that extent must be litigated in a civil court of competent jurisdiction, but the portion of the Class Action Waiver that is enforceable shall be enforced in arbitration. Independent Contractor will not be retaliated against, disciplined or threatened with discipline as a result of his or her filing of or participation in a class or collective action in any forum. However, the Company may lawfully seek enforcement of this Arbitration Agreement and the Class Action Waiver under the Federal Arbitration Act and seek dismissal of such class or collective actions or claims. The Class Action Waiver shall be severable in any case in which the dispute is filed as an individual action and severance is necessary to ensure that the individual action proceeds in arbitration.

(iii) Independent Contractor agrees and acknowledges that entering into this Arbitration Agreement and referencing the types of claims covered by this Arbitration Agreement does not change Independent Contractor’s classification as an independent contractor, that Independent Contractor is not an employee of the Company or its care receivers, patients or residents and that any disputes in this regard shall be subject to arbitration as provided in this Arbitration Agreement.

(iv) Any arbitration shall be governed by the American Arbitration Association Commercial Arbitration Rules (“AAA Rules”), except as follows:

(A) The arbitration shall be heard by one arbitrator selected in accordance with the AAA Rules. The arbitrator shall be an attorney with experience in the law underlying the dispute who is licensed to practice law in the state in which the arbitration takes place or a retired state or federal judge who presided in the same state where the arbitration will be held.

(B) If the parties cannot otherwise agree on a location for the arbitration, the arbitration shall take place within 40 miles of the last location that Independent Contractor provided services for a client of the Company.

(C) Each party will pay the fees for its own attorneys, subject to any remedies to which that party may later be entitled under applicable law. Costs unique to arbitration, including the cost of the Arbitrator and the meeting site (“Arbitration Costs”), will be borne by the Company and Independent

Contractor equally, unless otherwise required by applicable law, as determined by the Arbitrator, and any dispute regarding a party's obligation to pay Arbitration Costs will be determined by the Arbitrator. In the event Independent Contractor contends that, as a matter of law, it is not responsible for payment of all or some of the Arbitration Costs, Independent Contractor will have no obligation to pay any portion of the contested Arbitration Costs until, and only if, the Arbitrator determines that Independent Contractor is responsible for such costs. If necessary, for arbitration of the dispute, the Company agrees to cover the amount of the Arbitration Costs contested by the Independent Contractor until such time as the Arbitrator determines payment responsibility. In the event the law (including the common law) of the jurisdiction in which the arbitration is held requires a different allocation of fees and costs in order for this Arbitration Agreement to be enforceable, then such law shall be followed.

(D) The Arbitrator shall issue orders (including subpoenas to third parties) allowing the parties to conduct discovery sufficient to allow each party to prepare that party's claims and/or defenses, taking into consideration that arbitration is designed to be a speedy and efficient method for resolving disputes.

(E) The Arbitrator may award any remedy to which that party is entitled under applicable law, but remedies are limited to those that would be available to a party in his or her individual capacity in a court of law for the claims presented to and decided by the Arbitrator, and no remedies that otherwise would be available to an individual in a court of law will be forfeited by this Arbitration Agreement. The Arbitrator shall apply the state or federal substantive law, or both, as is applicable to the claims and defenses made in the arbitration hearing.

(F) The Arbitrator may hear and decide motions to dismiss and/or motions for summary judgment by any party.

(G) The Arbitrator's decision or award shall be in writing with findings of fact and conclusions of law. Judgment may be entered on the arbitrator's decision or award in any court having jurisdiction.

(v) This Arbitration Agreement does not apply to litigation, if any, between Independent Contractor and the Company pending in a state or federal court or arbitration as of the date of Independent Contractor's receipt of this Arbitration Agreement. Nothing in this Arbitration Agreement prevents Independent Contractor from making a report to or filing a claim or charge with a government agency, including without limitation the Equal Employment Opportunity Commission, U.S. Department of Labor, U.S. Securities and Exchange Commission, National Labor Relations Board, Occupational Health and Safety Administration, or the Office of Federal Contract Compliance Programs. Nothing in this Arbitration Agreement prevents the investigation by a government agency of any report, claim or charge otherwise covered by this Arbitration Agreement. This Arbitration Agreement also does not prevent federal administrative agencies from adjudicating claims and awarding remedies based on those claims, even if the claims would otherwise be covered by this Arbitration Agreement. Nothing in this Arbitration Agreement prevents or excuses a party from satisfying any conditions precedent and/or exhausting administrative remedies under applicable law before bringing a claim in arbitration. The Company will not retaliate against Independent Contractor for filing a claim with an administrative agency or for exercising rights (individually or in concert with others) under Section 7 of the National Labor Relations Act to the extent the National Labor Relations Act applies. This Arbitration Agreement does not apply to any claim that an applicable federal statute states cannot be arbitrated or subject to a pre-dispute arbitration agreement, and it does not apply to disputes between the parties that may not be subject to a pre-dispute arbitration agreement as provided by an Act of Congress.

(vi) A party may apply to a court of competent jurisdiction for temporary or preliminary injunctive relief in connection with an arbitrable controversy in accordance with applicable law, and any such application shall not be deemed incompatible with or waiver of this agreement to arbitrate. The court to which the application is made is authorized to consider the merits of the arbitrable controversy to the extent it deems necessary in making its ruling, but only to the extent permitted by applicable law. All determinations of final relief, however, will be decided in arbitration.

(vii) The AAA Rules may be found at [www.adr.org](http://www.adr.org) or by searching for “AAA Commercial Arbitration Rules” using a service such as [www.Google.com](http://www.Google.com) or by asking the Company to provide a copy.

C. This Arbitration Agreement replaces all prior agreements regarding the arbitration of disputes and is the full and complete agreement relating to the resolution of disputes covered by this Arbitration Agreement. If any provision of this Arbitration Agreement is adjudged to be invalid, void, voidable or otherwise unenforceable, in whole or in part, such provision shall, without affecting the validity of the remainder of the Arbitration Agreement, be severed from this Arbitration Agreement. All remaining provisions shall remain in full force and effect.

**D. Independent Contractor’s Right To opt Out of This Arbitration Agreement. Arbitration is not a mandatory condition of Independent Contractor’s relationship with the Company, and therefore Independent Contractor may opt out and not be subject to this Arbitration Agreement.** The Independent Contractor must submit a signed and dated statement notifying the Company that the Independent Contractor wishes to opt out and not be subject to this Arbitration Agreement. In order to be effective, the signed and dated opt out notice must be returned to **ALIGN Homecare Inc.** 1728 SW 22 Street Suite 100, Miami FL 33145 within 30 days of Independent Contractor’s receipt of this Arbitration Agreement. An Independent Contractor who timely opts out as provided in this paragraph will not be subject to any adverse action as consequence of that decision and may pursue available legal remedies without regard to this Arbitration Agreement. Should an Independent Contractor not opt out of this Arbitration Agreement within 30 days of the Independent Contractor’s receipt of this Arbitration Agreement, continuing the Independent Contractor’s relationship with the Company constitutes mutual acceptance of the terms of this Arbitration Agreement by the Independent Contractor and the Company. An Independent Contractor has the right to consult with counsel of the Independent Contractor’s choice concerning this Arbitration Agreement.

E. The Company and Independent Contractor agree that the mutual obligations by the Company and Independent Contractor to arbitrate disputes provide adequate consideration for this Arbitration Agreement.

**AGREED:**

\_\_\_\_\_  
Independent Contractor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Independent Contractor (Print Name)

and

ALIGN HOMECARE INC. , INC

## AHCA Authorized Duties

### 59A-18.0081 Certified Nursing Assistant and Home Health Aide.

The certified nursing assistant (C.N.A.) and the home health aide shall:

- (1) Be limited to assisting a patient in accordance with section 400.506(6)(b), F.S.;
- (2) Be responsible for documenting services provided to the patient or client and for filing said documentation with the nurse registry on a regular basis. These service logs will be stored by the nurse registry in the client's file. The service logs shall include the name of the patient or client and a listing of the services provided;
- (3) Be responsible for observing appearance and gross behavioral changes in the patient and reporting these changes to the patient's health care surrogate or other person designated by the patient and the nurse registry or to the responsible facility employee if staffing in a facility;
- (4) Be responsible to maintain a clean, safe and healthy environment, which may include light cleaning and straightening of the bathroom, straightening the sleeping and living areas, washing the patient's dishes or laundry, and such tasks to maintain cleanliness and safety for the patient;
- (5) Perform other activities as taught and documented by a registered nurse, concerning activities for a specific patient and restricted to the following:
  - (a) Assisting with the change of a colostomy bag, reinforcement of dressing;
  - (b) Assisting with the use of devices for aid to daily living such as a wheelchair or walker;
  - (c) Assisting with prescribed range of motion exercises;
  - (d) Assisting with prescribed ice cap or collar;
  - (e) Doing simple urine tests for sugar, acetone or albumin;
  - (f) Measuring and preparing special diets;
  - (g) Measuring intake and output of fluids; and,
  - (h) Measuring temperature, pulse, respiration or blood pressure.
- (6) Be prohibited from changing sterile dressings, irrigating body cavities such as giving an enema, irrigating a colostomy or wound, performing gastric irrigation or enteral feeding, catheterizing a patient, administering medications, applying heat by any method, or caring for a tracheostomy tube.
- (7) For every CNA, a nurse registry shall have on file a copy of the person's State of Florida certification.
- (8) For every home health aide registered with the nurse registry since May 4, 2015, a nurse registry shall have on file a certificate or documentation of successful completion of at least forty hours of home health aide training, pursuant to section 400.506(6)(a), F.S., from a public vocational technical school or a non-public postsecondary career school licensed by the Commission on Independent Education, Florida Department of Education.
- (9) Individuals who earn their CNA certificate in another state must contact the Florida Certified Nursing Assistant office at the Department of Health to inquire about taking the written examination prior to working as a CNA in Florida, pursuant to chapter 464, part II, F.S.
- (10) Home health aides registered with the nurse registry since the effective date of this rule who complete their training in another state must provide a certificate of completion of home health aide training from a public vocational technical school or a career education school that is licensed in that state.
- (11) CNAs and home health aides referred by nurse registries must maintain a current cardiopulmonary resuscitation (CPR) certification from an instructor or training provider that is approved to provide training by the American Heart Association, the American Red Cross, or the Health and Safety Institute, and that provides CPR training in which the student is required to demonstrate, in person, that he or she is able to perform cardiopulmonary resuscitation.
- (12) Licensed practical nurses and registered nurses that are licensed in Florida or another state may work as home health aides. Also, persons who have completed the licensed practical nurse or registered nurse training from a public school, college, or university or a licensed nonpublic career education school or college in Florida who are not yet licensed may work as home health aides.
- (13) A certified nursing assistant may work as a home health aide.
- (14) C.N.A.s and home health aides referred by nurse registries may assist with self-administration of medication as described

in section 400.488, F.S.

(a) Home health aides and C.N.A.s assisting with self-administered medication, as described in section 400.488, F.S., shall have received a minimum of 2 hours of training covering the following content:

1. Training shall cover state law and rule requirements with respect to the assistance with self-administration of medications in the home, procedures for assisting the resident with self-administration of medication, common medications, recognition of side effects and adverse reactions and procedures to follow when patients appear to be experiencing side effects and adverse reactions. Training must include verification that each C.N.A. and home health aide can read the prescription label and any instructions.

2. Individuals who cannot read shall not be permitted to assist with prescription medications.

(b) Documentation of training on assistance with self-administered medication from one of the following sources is acceptable:

1. Documentation of 2 hours of training in compliance with subsection 59A-8.0095(5), F.A.C., from a home health agency if the home health aide or C.N.A. previously worked for the home health agency;

2. A training certificate for assisted living facility staff in compliance with section 429.52(6), F.S.;

3. A training certificate for at least 2 hours of training from a career education school licensed pursuant to chapter 1005, F.S., and rule division 6E, F.A.C., by the Department of Education, Commission for Independent Education;

4. Documentation of at least 2 hours of training by a provider approved by the Florida Board of Nursing, Department of Health.

(c) Documentation of the training must be maintained in the file of each home health aide and C.N.A. who assists patients with self-administered medication.

(d) In cases where a home health aide or a C.N.A. will provide assistance with self-administered medications as described in section 400.488, F.S., and paragraph (e) below, a review of the medications for which assistance is to be provided shall be conducted by a registered nurse or licensed practical nurse to ensure the C.N.A. and home health aide are able to assist in accordance with their training and with the medication prescription and the medication is not required to be administered by a nurse. If the patient will not consent to a visit by the nurse to review the medications, a written list with the dosage, frequency and route of administration shall be provided by the patient or the patient's health care surrogate, family member, or person designated by the patient to the home health aide or CNA to have reviewed by the nurse. The patient or the patient's surrogate, guardian, or attorney in fact must give written consent for a home health aide or C.N.A. to provide assistance with self-administered medications, as required in section 400.488(2), F.S.

(e) The trained home health aide and C.N.A. may also provide the following assistance with self-administered medication, as needed by the patient and as described in section 400.488, F.S.:

1. Prepare necessary items such as juice, water, cups, or spoons to assist the patient in the self-administration of medication,

2. Open and close the medication container or tear the foil of prepackaged medications,

3. Assist the resident in the self-administration process. Examples of such assistance include the steadying of the arm, hand, or other parts of the patient's body so as to allow the self-administration of medication,

4. Assist the patient by placing unused doses of solid medication back into the medication container.

(15) The nurse registry is not obligated to monitor, manage or supervise a certified nursing assistant or home health aide pursuant to section 400.506(19), F.S. The nurse registry is not obligated to review patient or client records per section 400.506(20), F.S., but the nurse registry is not prohibited from reviewing records and may do so. In the event of violation of section 400.488, F.S., or other state laws that comes to the attention of the nurse registry, the nurse registry shall take the actions specified in section 400.506(19), F.S.

*Rulemaking Authority 400.488, 400.497, 400.506 FS. Law Implemented 400.488, 400.497, 400.506 FS. History—New 1-27-94, Amended 12-24-00, 8-10-06, 3-15-07, 5-4-15, 2-8-16.*

Employee Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

## EXPLANATION FOR W-9 FORM

You are an Independent Contractor registered with ALIGN Homecare Inc. As such, you are responsible for paying your own income taxes. We will provide you with a 1099 at year end showing your total annual earnings. Please fill out the W9 form for this reason.

Independent Contractor Signature: \_\_\_\_\_



**PRIVACY POLICY ACKNOWLEDGEMENT FORM**

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

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

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Employee/Contractor Name (Printed)

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Employee/Contractor Signature

---

DATE



Non-Medical Acknowledgement

I acknowledge ALIGN Homecare Inc. Is a non-medical home care provider. I understand caregivers registered with ALIGN Homecare Inc. are not licensed or certified to administer or dispense medications of any kind, shave clients with razor, provide wound care, grooms nails, set up, modify or alter any medical equipment that require a trained, certified or licensed professional.

I understand that there may be other duties which have not been listed in the above-mentioned list.

I agree to hold ALIGN Homecare Inc. harmless for any of my activities for which I am not licensed to perform.

Independent Contractor: \_\_\_\_\_ Date: \_\_\_\_\_

ALIGN Representative: \_\_\_\_\_ Date: \_\_\_\_\_

WAIVER AND RELEASE OF LIABILITY AND ASSUMPTION OF RISK ACKNOWLEDGEMENT

Patient address: \_\_\_\_\_

Patient name: \_\_\_\_\_

Indemnitor: \_\_\_\_\_

Independent contractor

The indemnitor hereby releases the indemnities from any liability for damages from illness, injury and /or death that arises out of, or is connected with, or in any manner relates, to the Home Health Aide or certified assistants provided at the work place location

Indemnitor represents that:

1. I am 18 years of age or older
2. I am submitting this release, waiver of liability, and assumption of risk declaration voluntarily and of my own free will.
3. I have no physical or emotional problems, nor any history thereof, which will impair my ability to frequent the indemnitee address location and in a safe manner.
4. I understand and agree that it is my responsibility to assess the hazards presented by my use of the indemnities address Location and further agree that I am the ultimate judge as to whether I can frequent the indemnities address Location with risk of harm to myself.
5. I understand and EXPRESSLY ASSUME all the dangers incident top frequenting the indemnitee address Location, and hereby RELEASE ALL CLAIMS, including but not limited to, personal injury, property damage or destruction, and death, false positives, whether caused by NEGLIGENCE, breach of contract or otherwise, and whether for bodily injury, property damage or loss otherwise, which I may ever have against the indemnities
6. My frequenting of indemnities Address Location is entirely optional and my own free choice.
7. My frequenting of indemnities Location is in no way a requirement of employment by indemnities.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**INDEPENDENT CONTRACTOR REPRESENTATIONS**

These Independent Contractor Representations have been developed to clarify the relationship between ALIGN Homecare Inc. ("Registry") and the caregivers it refers for potential client opportunities.

**I hereby represent and affirm:**

- 1. I operate my own business as a care provider that is separate and independent from the Registry. I am engaging the Registry to provide my business with certain services, including (i) confirmation of credentials and background screening, (ii) referrals for potential client opportunities, and (iii) marketing, billing, and administrative support. **Initials** \_\_\_\_\_
- 2. I do not seek employment with the Registry and understand that I am an independent contractor, not an employee, of the Registry. **Initials** \_\_\_\_\_
- 3. I am free to accept or decline referrals to provide care services to Registry clients. I understand that Registry clients are free to accept or decline to receive services from me. **Initials** \_\_\_\_\_
- 4. The Registry may act as a liaison in certain communications between me and Registry clients and may provide market information. However, I understand that the client and I ultimately will decide the terms and condition of our relationship, including the duration our relationship, my pay rate, my work schedule, and the scope of services provided. **Initials** \_\_\_\_\_
- 5. I acknowledge that the Registry will not monitor or supervise the care services that I provide. The Registry will not provide training or instructions, set policies, evaluate my performance, discipline me, or otherwise control the manner in which I operate my business as a care provider. **Initials** \_\_\_\_\_
- 6. I acknowledge that I am responsible for creating records of the hours that I work and verifying the records' accuracy. The Registry may collect my time records and use that information in the course of its administrative and pay-related services, but it will not create the records, verify their accuracy, or make corrections. **Initials** \_\_\_\_\_
- 7. I am responsible for paying all taxes and for filing all tax returns with respect to all income I derive from performing services for clients referred to me by the Registry. **Initials** \_\_\_\_\_
- 8. I am solely responsible for any work-related injuries to me and/or to my employees and for complying with any State laws related to such injuries. **Initials** \_\_\_\_\_
- 9. I understand that the Registry is not my employer for purposes of health coverage and that I will not receive an offer of health care coverage from the Registry. **Initials** \_\_\_\_\_
- 10. As the sole proprietor of my business, I acknowledge that I am not eligible for unemployment compensation benefits through my relationship with the Registry. **Initials** \_\_\_\_\_
- 11. The Registry has provided me a document, "State Law Notices to Contractors," containing the rules and regulations to be provided to contractors under Rule 59A-18.005, F.A.C. **Initials** \_\_\_\_\_

By signing below, I represent and warrant that I have carefully read, and I fully understand each and every one of the foregoing representations and that I initialed only those statements that are true and correct. I understand that the Registry relies upon these representations as a condition of entering into the Agreement for Referral, Marketing and Administrative Services with me.

\_\_\_\_\_  
Independent Contractor Name (Print)

Signature \_\_\_\_\_ Date \_\_\_\_\_



INDEPENDENT CONTRACTOR FINDER'S AGREEMENT

This Independent Contractor Finder 's Fee Agreement ("Finder 's fee Agreement") Is entered into on this \_\_\_ day of \_\_\_\_\_, 202\_\_\_ by and between \_\_\_\_\_ ("Independent Contractor ") and ALIGN Homecare Inc.

I, \_\_\_\_\_, Agree to compensate ALIGN Homecare Inc. A finder's fee/referral fee in the form of a lump sum in the amount of \$1500.00, in the event I solicit or attempt to solicit or accept business-whether directly or indirectly on my own behalf or behalf of another party or in conjunction with another party – from ALIGN Homecare Inc. clients, or prospective clients with whom I have transacted with on behalf of ALIGN for a period of 12 Months after termination of my contract.

Caregiver Signature: \_\_\_\_\_ Date: \_\_\_\_\_

ALIGN Representative: \_\_\_\_\_ Date: \_\_\_\_\_

El acuerdo de tarifas de referidos de contratistas independientes ("Acuerdo de tarifas de referido") el \_\_\_ dia de \_\_\_\_\_, 202\_\_\_ entre ALIGN Homecare Inc. Yo, \_\_\_\_\_, aceptó compensar a ALIGN Homecare Inc. una comisión de intermediario en forma de una suma global de \$1,500.00, en el caso de que solicite o intente solicitar o aceptar negocios, ya sea directa o indirectamente en mi propio nombre o en nombre de otra parte o en conjunto con otra parte, de los clientes de ALIGN Homecare Inc. o posibles clientes con los que he realizado transacciones en nombre de ALIGN durante un periodo de 12 meses después de la terminación de mi contrato.

Contratista Independiente: \_\_\_\_\_ Fecha: \_\_\_\_\_

Representante de ALIGN Homecare Inc. : \_\_\_\_\_ Fecha: \_\_\_\_\_



Hepatitis B Vaccine Waiver

I \_\_\_\_\_ Understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) Infection

I have been given information on where to be vaccinated with hepatitis B vaccine.

I decline Hepatitis B vaccine at this time.

I want to accept the hepatitis B vaccination at this time

I am vaccinated against hepatitis B and I can provide proof

I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease.

Independent contractor: \_\_\_\_\_ Date: \_\_\_\_\_



### **Refusal of Influenza Vaccination**

My affiliated Nurse Registry, ALIGN Homecare Inc. Inc., has provided me with information about the Influenza vaccine,

I acknowledge that I am aware of the following facts:

- Influenza vaccination is recommended to all healthcare workers to protect patients from Influenza its complications and death.
- Influenza is a serious respiratory disease that kills thousands of people in the United States each year.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding of the virus can spread influenza to patients.
- If I become infected with influenza, even if my symptoms are mild or non-existent, I can spread it to others, and they can become seriously ill.
- I understand that the strain of the virus that causes influenza infections change almost every year and, even if they do not change, my immunity declines over time. This is why vaccination against influenza is recommended every year.
- I understand I cannot get influenza from the influenza vaccine.
- The consequences of my refusal to be vaccinated could have life-threatening consequences to my health and the health of those to whom I have contact with, including
  - o All patients ALIGN Homecare Inc. refers
  - o My Family
  - o My community
  - o My co-workers

Despite these facts, I am choosing to decline influenza vaccination at this present time for the following reasons:

I understand that I can change my mind and accept influenza vaccination if the vaccine is still available.

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

Independent Contractor: \_\_\_\_\_ Date: \_\_\_\_\_

Independent Contractor Signature: \_\_\_\_\_



# ATTESTATION OF COMPLIANCE with Background Screening Requirements

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

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

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

**Employee/Contractor Name:**

**Health Care Provider/ Employer Name:** ALIGN Homecare Inc.

**Address of Health Care Provider:** 7855 NW 12th ST. #205 Doral, FL. 33126

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

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

(a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.

(b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.

(c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.

(d) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(e) Section 782.04, relating to murder.

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

(g) Section 782.071, relating to vehicular homicide

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

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

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

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

(l) Section 787.01, relating to kidnapping.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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**Attestation**

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

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

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date



# Employment Eligibility Verification

## Department of Homeland Security

### U.S. Citizenship and Immigration Services

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

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

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

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

Last Name (Family Name)		First Name (Given Name)		Middle Initial (if any)	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number (if any)	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		Employee's Email Address		Employee's Telephone Number	
<p><b>I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.</b></p>		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):				
		<input type="checkbox"/> 1. A citizen of the United States				
		<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)				
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)				
<input type="checkbox"/> 4. A noncitizen (other than <b>Item Numbers 2.</b> and <b>3.</b> above) authorized to work until (exp. date, if any) _____						
If you check <b>Item Number 4.</b> , enter one of these:						
USCIS A-Number		OR	Form I-94 Admission Number		OR	Foreign Passport Number and Country of Issuance
Signature of Employee				Today's Date (mm/dd/yyyy)		

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

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

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)	<p><b>Additional Information</b></p>    <input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

<p><b>Certification:</b> I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.</p>		First Day of Employment (mm/dd/yyyy):
Last Name, First Name and Title of Employer or Authorized Representative		Signature of Employer or Authorized Representative
		Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name		Employer's Business or Organization Address, City or Town, State, ZIP Code

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

## LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

Document Title	Document Number (if any)	Expiration Date (if any) ( <i>mm/dd/yyyy</i> )
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**I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.**

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

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

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

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

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

**I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.**

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

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

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

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

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

**I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.**

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

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

# Request for Taxpayer Identification Number and Certification

Go to [www.irs.gov/FormW9](http://www.irs.gov/FormW9) for instructions and the latest information.

**Give form to the  
 requester. Do not  
 send to the IRS.**

**Before you begin.** For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

<b>Print or type.</b> See <i>Specific Instructions</i> on page 3.	<b>1</b>	Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)		
	<b>2</b>	Business name/disregarded entity name, if different from above.		
	<b>3a</b>	Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only <b>one</b> of the following seven boxes.  <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C corporation <input type="checkbox"/> S corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate  <input type="checkbox"/> LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) _____ <b>Note:</b> Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner.  <input type="checkbox"/> Other (see instructions) _____	<b>4</b> Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):  Exempt payee code (if any) _____  Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any) _____  <i>(Applies to accounts maintained outside the United States.)</i>	
	<b>3b</b>	If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions _____ <input type="checkbox"/>		
	<b>5</b>	Address (number, street, and apt. or suite no.). See instructions.	Requester's name and address (optional)	
	<b>6</b>	City, state, and ZIP code		
	<b>7</b>	List account number(s) here (optional)		

## Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

<b>Social security number</b>									
-				-					
<b>or</b>									
<b>Employer identification number</b>									
-									

**Note:** If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

## Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

<b>Sign Here</b>	Signature of U.S. person	Date
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## General Instructions

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

**Future developments.** For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to [www.irs.gov/FormW9](http://www.irs.gov/FormW9).

### What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

### Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they



SOCIAL SECURITY#: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

**DIRECT DEPOSIT INFORMATION**

Please fill in the information below

Account Name: \_\_\_\_\_

Bank Name: \_\_\_\_\_

\_\_\_\_\_

Type of Account \_\_\_\_\_ Checking \_\_\_\_\_ Savings

\_\_\_\_\_

Bank Routing # (ABA)

\_\_\_\_\_

Account #

This authorizes ALIGN HOMECARE INC. (the "Company") to send credit entries (and appropriate debit and adjustment entries), electronically or by other commercial accepted method to my account (s) indicated below and to other accounts I identify in the future (the "Account"). This authorizes the financial institution holding the Account to post all such entries. This authorization will be in effect until the Company receives written termination notice from myself or has a reasonable opportunity to act on it.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**ALIGN Homecare Inc.**

7855 NW 12th ST. #205 Doral, FL. 33126

To: \_\_\_\_\_ From: \_\_\_\_\_

Fax: \_\_\_\_\_ Return to fax: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_

Re: \_\_\_\_\_ CC: \_\_\_\_\_

Urgent  For review  Please comment  X please reply ASAP

**Employment/Registration verification**

Please complete to the best of your knowledge

Independent Contractor's Name: \_\_\_\_\_

Dates of registration: \_\_\_\_\_

Is the individual eligible for rehire? Y/N

If not, why? \_\_\_\_\_

Comments: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## EMERGENCY NOTIFICATION

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**AS PER AGENCY POLICY, EVERY EMPLOYEE MUST COMPLETE AT LEAST TWO EMERGENCY NOTIFICATIONS AS WELL AS UPDATE THE FORM AS NECESSARY.**

Contractor Name: \_\_\_\_\_ Date: \_\_\_\_\_

**IN CASE OF EMERGENCY NOTIFY NEXT OF KIN**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

**SECONDARY EMERGENCY CONTACT (FRIEND OR RELATIVE NOT LIVING WITH YOU)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_