Bella Mente
1418 E US Highway 169
Grand Rapids MN 55744
888-735-3555
thejourney@bellamentegroup.com

2017
PCA Choice
Employment Packet Checklist

	Document Name	Form Needs to be Completed By:	
		Employee	Managing Party
☐	Employee/ Client Relationship From	✓	✓
☐	Job Description	✓	✓
☐	Background	✓	
☐	W4	✓	
☐	I9 (see example)	✓	✓
☐	Employment Agreement	✓	
☐	Application for Employment	✓	
☐	MHCP Enrollment	✓	
☐	MHCP Provider Agreement	✓	
☐	Training Certificate Instructions	✓	
☐	Wage Payment Election and Consent	✓	

If you have any questions before submitting your application, please call 218-327-8294 and ask to speak to Human Resources

Do not begin working until the Managing Party has been notified by BELLA MENTE.

Office Use	
Employee Number	Entered by
Hire Date	Verified by

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EMPLOYEE/CLIENT RELATIONSHIP FORM

To be completed by the Employee

First Name	Middle Name	Last Name

Date of Birth (MM/DD/YYYY)	Phone Number	Social Security Number

Address

City	State	Zip

Email Address (Required)	Preferred contact method for new hire status ☐ Email ☐Phone ☐Mail

To be completed by the Employee

Relationship of **Employee** to the **Client** – check the appropriate box:

☐ Parent	☐ Grandparent
☐ Step Parent	☐ Grandchild
☐ Spouse	☐ Other:_____
☐ Sibling	☐ Not related to Client
☐ Child	

To be completed by the Client or Client Representative

Client Name	Preferred contact method for new hire status ☐ Email ☐Phone ☐Mail

Client Representative's Name	Email of Client Representative

Phone of Client Representative	Anticipated Number of hours the employee will work per week (check one) ☐1-29 hours ☐30-40 hours Wage: $

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JOB DESCRIPTION

Job details specific to the client-please be as descriptive as possible.
If an item does not apply, show 'NA'

1. Staff provides personal care assistance to client as directed (client/client's representative fills in details):
   - Bathing-
   - Grooming-
   - Dressing-
   - Positioning-
   - Toileting-
   - Oral care-
   - Other cares (describe)-

2. Staff assists the client with meals as directed:
   Details:

3. Is able to properly and safely lift, transfer and transport client in devise(s) indicated below: Details:

4. Is able to lift up to _____ pounds

5. Other responsibilities, for example, community access, life skills, therapies, behavior management, educational activities, etc. Please list and explain expectations in detail.

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AS AN EMPLOYEE OF THE ROCK, IT IS THE EXPECTATION OF BOTH THE ROCK AND THE **CLIENT**

THAT **YOU**:

6. Are able to work independently
7. Follow through with job responsibilities in a timely manner
8. Utilize proper lifting and body mechanics to prevent personal injury
9. Demonstrate knowledge of and adhere to all infection control procedures including proper hand washing techniques and contact with blood spills and other bodily fluids
10. Manage time effectively
11. Demonstrate knowledge and skills necessary to provide care appropriate to the age of the client
12. Provide care as directed by the client or the client's representative
13. Recognize and report changes in client's conditions to the appropriate person.
14. Document as required by the client or client representative and by BELLA MENTE
15. Display appropriate, courteous attitude and behavior (respect, support, loyalty) toward the client, the client's representative and family, and toward other staff
16. Exercise discretion and maintain confidentiality in all matters relating to the client, the client's representative and family and other staff
17. Maintain calm and professional demeanor in stressful situations
18. Limit personal phone usage
19. Wear appropriate clothing and accessories; give proper attention to personal hygiene
20. Adhere to the client's or the client's representative policy for attendance and tardiness, including providing proper notification for absences or tardiness
21. Follow the client's or client representative's directions regarding smoking while at work

Employee complete this section:

_____ _____
Employee Signature Date

_____ _____
Client/Responsible Party Signature Date

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MN Department of Human Services Background Study Information Form

Agency: Bella Mente
1418 E US Highway 169
Grand Rapids MN 55744

Please print legibly. Information provided on this form must match identically to the information on your form of ID (Driver's License, Government Issued ID, Passport or other acceptable document). Please contact BELLA MENTE for questions on this requirement.

****ENCLOSE A PHOTOCOPY OF YOUR FORM OF ID WITH THIS FROM. SEE ATTACHED "ACCEPTABLE FORMS OF ID FOR DHS BACKGROUND"**

Minnesota Department of Human Services, Minnesota Bureau of Criminal Apprehension, and the Federal Bureau of Investigation require BELLA MENTE to collect this information in order for DHS to conduct a fingerprint based criminal record search.

Personal Data

First Name	Middle Name	Check here if you do not have a middle name ☐	Last Name
Date of Birth (MM/DD/YYYY)	Gender: Male☐ Female☐		Social Security Number*
Phone Number	Email Address		
Race (optional)	Eye color		Hair color
Height	Weight		Place of Birth (State)
Preferred contact method for further steps of the background study ☐ Email ☐Phone ☐Mail			

*Social Security number is not required to initiate a background study, but is necessary for the background study to be transferrable. Should you wish to work in multiple programs and have your background transferrable, this information is required.)

Other names known by (Maiden names, married names, nicknames, etc.)

First Name	Middle Name	Last Name
First Name	Middle Name	Last Name

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First Name	Middle Name	Last Name

Form of Identification Information

Document Type (Driver's License, Government Issued ID, Passport etc.)	Issuing State/Authority
Document Number	Expiration Date

Permanent Address

Address		
City	State	Zip
Date of Residence: FROM _____ /_____ /_____ TO Current		

Mailing Address ☐Same as Permanent Address

Address		
City	State	Zip

Previous Out-of-State Addresses within the last 5 years ☐ I have not lived out-of-state within the last 5 years

Address		
City	State	Zip
Dates of Residence: FROM_____(year) TO _____(year)		

Address		
City	State	Zip
Dates of Residence: FROM _____ (year) TO _____ (year)		

I understand that having direct contact services to people receiving services is a requirement of the position I am being considered for and that having and maintaining a satisfactory record with the Department of Human Services is a condition of my employment with BELLA MENTE.

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I agree to release BELLA MENTE, its employees, and those who supplied you with the information from any liability for any damage which may result from furnishing the requested information or my failure to be hired for the position for which I am applying.

I certify that all elements of the personal data I have provided are true, accurate and complete. I understand and agree that any omission, false statement, misleading statement, or answer made by me on this form or any supplements to it will be sufficient grounds for rejection of employment and my discharge after employment.

I authorize BELLA MENTE to submit the above information to DHS to investigate my criminal background as part of the hiring process. I have received a copy of the Privacy Notice, Acceptable Forms of Identification for DHS Background Studies, and Fingerprint and Photo Information for DHS Background Study Subjects.

_____	_____	_____
Printed Name	Applicant Signature	Date

Form W-4 (2017)

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

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

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

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

The exceptions don't apply to supplemental wages greater than $1,000,000.

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

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

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

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

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

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

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

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

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A**
B	Enter "1" if: • You're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	**B**
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C**
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D**
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	**E**
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F**
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child.	**G**
H	Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ►	**H**

For accuracy, complete all worksheets that apply.

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

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

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074

2017

1	Your first name and middle initial	Last name	**2** Your social security number
	Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
	City or town, state, and ZIP code	**4** If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ► ☐	
5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)		**5**
6	Additional amount, if any, you want withheld from each paycheck		**6** $
7	I claim exemption from withholding for 2017, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ►		**7**

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

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

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

Deductions and Adjustments Worksheet

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

1 Enter an estimate of your 2017 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% of your income, and miscellaneous deductions. For 2017, you may have to reduce your itemized deductions if your income is over $313,800 and you're married filing jointly or you're a qualifying widow(er); $287,650 if you're head of household; $261,500 if you're single, not head of household and not a qualifying widow(er); or $156,900 if you're married filing separately. See Pub. 505 for details . . . . . 1 $

2 Enter: { $12,700 if married filing jointly or qualifying widow(er) / $9,350 if head of household / $6,350 if single or married filing separately } . . . . . 2 $

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

4 Enter an estimate of your 2017 adjustments to income and any additional standard deduction (see Pub. 505) 4 $

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2017 Form W-4* worksheet in Pub. 505.) . . . . . 5 $

6 Enter an estimate of your 2017 nonwage income (such as dividends or interest) . . . . . 6 $

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

8 **Divide** the amount on line 7 by $4,050 and enter the result here. Drop any fraction 8

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

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

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

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

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

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

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

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

4 Enter the number from line 2 of this worksheet 4

5 Enter the number from line 1 of this worksheet 5

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

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

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

9 Divide line 8 by the number of pay periods remaining in 2017. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2017. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 $

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $7,000	0	$0 - $8,000	0
7,001 - 14,000	1	8,001 - 16,000	1
14,001 - 22,000	2	16,001 - 26,000	2
22,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 70,000	5
44,001 - 55,000	6	70,001 - 85,000	6
55,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 95,000	10	140,001 and over	10
95,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$610	$0 - $38,000	$610
75,001 - 135,000	1,010	38,001 - 85,000	1,010
135,001 - 205,000	1,130	85,001 - 185,000	1,130
205,001 - 360,000	1,340	185,001 - 400,000	1,340
360,001 - 405,000	1,420	400,001 and over	1,600
405,001 and over	1,600		

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

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

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

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

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Employment Eligibility Verification USCIS Department of Homeland Security

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: _____
OR

2. Form I-94 Admission Number: _____
OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

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

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Last Name *(Family Name)*	First Name *(Given Name)*		
Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification USCIS Department of Homeland Security

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

Additional Information

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

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

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

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

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

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

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

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

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

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

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

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

Form I-9 11/14/2016 N

Bella Mente
1418 E US Highway 169
Grand Rapids MN 55744
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thejourney@bellamentegroup.com

EMPLOYMENT AGREEMENT
PCA CHOICE

Agreement made by and between BELLA MENTE a Minnesota Corporation, hereinafter called "BELLA MENTE" and _____, hereinafter called the "Employee". RECITALS

A. ("Responsible Party") has responsibility for a Client who has been screened by a public health nurse and found to be eligible for Personal Care Assistant services.

B. The Responsible Party and the Client may be the same person.

C. The Responsible Party has asked BELLA MENTE to assist in employing the Personal Care Attendant (herein referred to as the 'Employee'), paying the Employee and billing for services.

D. BELLA MENTE wishes to employ the Employee, and the Employee wishes to be employed by BELLA MENTE to provide assistance to the Responsible Party.

E. An Employee under PCA Choice may not be the:

- Paid legal guardian of an adult
- Legal guardian of a minor
- Parent or stepparent of a minor child recipient
- Recipient of PCA services
- Responsible party of a recipient
- Spouse of a recipient

TERMS

In consideration of the promises and conditions contained herein, the parties agree as follows:

1. Employment. BELLA MENTE will employ the Employee to assist the Client and the Responsible Party, and the Employee shall accept such employment in accordance with the terms and conditions of this Agreement. **No individual will be considered an Employee of BELLA MENTE until all requirements to become an employee have been fulfilled *and* the Responsible Party has received notification of the hire date.** The Responsible Party agrees to not engage the Employee in work before the official hire date.

2. Job Assignment.
   a. Responsible Party has developed a written job description, a copy of which is attached. The conditions of employment outlined in the job description may be amended periodically by the Responsible Party: BELLA MENTE must be furnished with a copy of these amendments.
   b. The Responsible Party will establish location of work, specific job duties and working conditions. The Employee will be responsible for following the requirements and duties as stated in the job description developed and written by the Responsible Party.

c. The Employee is expected to perform his/her duties in an ethical manner, preserving and respecting the rights and dignity of the Clients served.
d. Hours of work may vary from week to week and will be established by the Responsible Party.

3. Supervision. The Responsible Party will assume the responsibility for the quality of the services that the Employee provides and will supervise and evaluate the Employee, in cooperation with BELLA MENTE. The Responsible Party will also perform disciplinary actions and terminations, if necessary.

4. Compensation. The Employee will receive $ _____ per hour as compensation for services rendered. BELLA MENTE will issue paychecks to the Employee every two weeks, provided that signed time sheets are received by BELLA MENTE at its Grand Rapids by the due dates as shown on the current payroll calendar.

5. **Maximum number of hours allowed. An Employee cannot work over 40 hours per week and/or cannot work more than 275 hours in total, per month. (The work week begins on Sunday and ends on Saturday.) The State of Minnesota tracks all of the hours worked by each PCA, across all of the PCA agencies the Employee happens to work for. If a PCA exceeds the limits stated above, BELLA MENTE will take disciplinary action which will include termination.**

6. Employment-At-Will. The employment relationship between Employee and BELLA MENTE will be employment-atwill; this means that BELLA MENTE may terminate this employment relationship at any time and for any or no reason. BELLA MENTE will attempt to give the Employee at least two weeks advanced notice of termination. BELLA MENTE requests that the Employee also attempts to give at least two weeks advanced notice of termination.

7. Employee Relations. It is the policy of BELLA MENTE to be fair and honest with its personnel and respect the individual rights of all Employees. BELLA MENTE will strive to achieve mutual respect in working relationships and insist that Responsible Parties strive to carry out the policy. Each Employee and each Responsible Party must realize harmonious relationships are not entirely a matter of rules but the outgrowth of daily decisions and cooperative attitudes. In fulfilling one's duties as an Employee, it is mandatory that tact, patience, diplomacy, and understanding go along with the Employee's demonstrated competence.

Employees are expected to provide wholehearted service during work hours and not engage in conduct which is immoral, unethical, or illegal. Employees are to be respectful of authority and abide fully by the regulations that govern their employment.

8. Dispute Resolution and BELLA MENTE's Grievance Policy.

Bella Mente
1418 E US Highway 169
Grand Rapids MN 55744
888-735-3555
thejourney@bellamentegroup.com

GRIEVANCE POLICY
BELLA MENTE's PARTICIPANT DIRECTED SERVICES (CDS) DEPARTMENT

If at any time in your use of, or in your association with, BELLA MENTE, you are dissatisfied with the services being provided to you, you or your authorized representative should contact BELLA MENTE's representative. If you are not satisfied with the outcome, you should put your concern **in writing**. The address is:

BELLA MENTE
1415 E US Highway 169
Grand Rapids MN 55744
218-327-8294

The representative will speak with you to discuss the issue within ten (10) working days of receiving the grievance and will respond to your grievance within ten (10) working days following the meeting. If the grievance has not been resolved to your satisfaction, you may contact the Director; Meghann Lewis, 218-327-8294, thejourney@therockhhc.com. You will receive a written response to your meeting with Meghann Lewis within ten (10) days following the meeting. If the grievance still has not been resolved to your satisfaction, the grievance may be submitted to BELLA MENTE's Chief Executive Officer, Joel McDaniel ***in writing*** – ***phone calls will not be accepted***. Joel McDaniel will contact you to address the issue within ten (10) working days of receipt of the grievance. You will receive an answer from Joel McDaniel within ten (10) working days following the discussion or hearing. Bella Mente Board of Directors has delegated the authority to the Chief Executive Officer to make decisions concerning grievances and is considered to be the highest level of authority at BELLA MENTE.

This grievance policy does not preclude recourse to protection under state or federal civil rights act; nor does it prevent the utilization of consumer advocates.

9. Employment discrimination. BELLA MENTE's policy of providing Equal Opportunity to all staff members and applicants for employment is in accordance with all applicable Equal Employment Opportunity/Affirmative Action laws, directives and regulations of Federal, State and Local governing bodies or agencies thereof, specifically Minnesota Statute 363.

   BELLA MENTE will not discriminate against or harass any staff member or applicant for employment because of race, color, creed, religion, national origin, sex, sexual orientation, disability, age, marital status, status with regard to public assistance or veteran's status.

   If an Employee of BELLA MENTE has a complaint about harassment, discrimination, any believed violation of state or federal law, or retaliation, a report should be made as soon as possible to BELLA MENTE's Human Resources Department. The Employee should make a written report and send it to: BELLA MENTE, Attention Human Resources Department, 1415 E US Highway 169, Grand Rapids MN, 55744. All reports will be confidential and will be recorded as a grievance. Timelines for a response from BELLA MENTE are the same as described above in #8.

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10. Workers' Compensation and Unemployment. The Employee is covered by workers' compensation insurance and unemployment compensation insurance.
However, if you are injured by working outside of your job description, it may impact your ability to be covered by workers' compensation.

11. Training/ Orientation. BELLA MENTE will provide Orientation Training Materials to the employee. The employee is expected to read and understand the following topics: BELLA MENTE Mission, Employment Policy, EEO Statement, Harassment in the Workplace, Verbal and Physical Abuse Policy, Relationships, Statement of Policies and Human Rights for Clients, Data Privacy,Vulnerable Adults Act, Child Protection/ Minor's Act, Bloodborne Pathogens/ Communicable Diseases, First Aid, Right to Know, BELLA MENTE False Claims Policy, HIPAA Summary for New Employees. For questions on any of the training materials, you may contact Logan Parenteau, Training Coordinator at 218-327-8294 Ext. 119.

12. Reporting Accidents. The Employee must immediately report to BELLA MENTE, all incidents and accidents involving the Employee during scheduled work hours. It is also important for the Responsible Party to be immediately informed of any significant incidents or accidents. These reports are important because of potential workers' compensation issues.

13. Medical Administration Procedures. If the Client requires assistance with medication administration, instruction and training must come from the Responsible Party. Also, the Employee, the Client and the Responsible Party must be aware that ***the assistance with medication that the Employee can provide is very limited***. Please contact BELLA MENTE for the program rules.

14. Support. The Employee has been recruited, selected and will be oriented and trained by the Responsible Party. BELLA MENTE supplies the Responsible Party with a number of services, which ensure compliance with applic

15. able laws and regulations. The Responsible Party acts in consultation with BELLA MENTE staff. Both the Employee and the Responsible Party have access to BELLA MENTE staff for information and clarification. Staff can be reached at 1-218-327-8294.

16. Documentation. The Employee will document all Time Sheets and Activity Records with accurate information. Any documentation with false information will result in disciplinary action that may include termination. It is a federal crime to provide false information on Personal Care Assistant billings for Medical Assistance payment. Your signature verifies the time and services provided are accurate and that the services were performed as specified in the PCA Care Plan.

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18 . Drug/ Alcohol Policy. Employees cannot possess, consume, or be under the influence of alcohol or illegal drugs, controlled substances or unauthorized drugs when reporting to work or while working. This includes unauthorized use of legal drugs or prescriptions. Smoking is not permitted while working with the participant. The use of intoxicants, legal and illegal drugs, in any manner which impairs an employee's ability to safely and efficiently perform their job is unacceptable and will subject the employee to disciplinary action, including termination. The employee should discuss with a physician or pharmacist the nature of the employee's duties and the potential adverse effects of prescribed medications. The employee can never be on-duty while under the influence. The employee should be able to safely perform their job at all times.

IN WITNESS WHEREOF, the parties have executed this Agreement, the day and year as written below.

To be completed by employee

_____	_____	_____
Employee Printed Name	Employee Signature	Date

To be completed by BELLA MENTE

_____	_____
Printed Name of BELLA MENTE Staff	Date

_____
BELLA MENTE Staff Signature

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APPLICATION FOR EMPLOYMENT

Personal Information

First Name	Middle Name	Last Name
Phone Number	Email Address	
Address		
City	State	Zip
Are You legally authorized to work in the U.S.? ☐ Yes ☐No		

Employment Experiences (list most recent experience first)

Company Name	Phone
Contact Person	Employed from _____To_____
Position	Reason for Leaving

Company Name	Phone
Contact Person	Employed from _____To_____
Position	Reason for Leaving

Company Name	Phone
Contact Person	Employed from _____To_____
Position	Reason for Leaving

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References	
Name	Relationship
Phone number	Years known
Name	Relationship
Phone number	Years known

Applicant Statement

I understand that employment offered by BELLA MENTE is at-will. I hereby certify that the answers and statements in this application are true and correct, and I further understand that falsification of information may be the cause of non-hire or discharge.

I authorize BELLA MENTE to conduct inquiries into any job-related information contained in this application, including educational institutions, previous employers and references. Moreover, I hereby release BELLA MENTE and any agent acting on its behalf from any and all liabilities of any nature by reason of requesting such information from any person.

I hereby authorize educational institutions, previous employers and references to furnish information concerning my personal character, habits or employment record.

If I am hired, I understand that I am free to resign at any time, with or without cause and with or without prior notice and BELLA MENTE reserves the same right to terminate my employment at any time with or without cause and with or without prior notice, except as may be required by law. This application does not constitute an agreement or contract for employment for any specified period of time or definite duration. I understand that no supervisor or representative of the employer is authorized to make any assurances to the contrary and that no implied, oral or written agreements contrary to the foregoing express language are valid unless they are in writing and signed by the Executive Director of BELLA MENTE.

If I am hired, I understand that I will be required to provide proof of identity and legal authority to work in the United States and that federal immigration laws require me to complete an I-9 form in this regard.

_____ _____ _____

Printed Name Applicant Signature Date

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Minnesota Health Care Programs (MHCP)

Individual PCA Enrollment Application

Complete this form online, print and then fax to MHCP. Complete at least all bolded fields to enroll an individual PCA. We will return incomplete forms to you.

- New hire (requires new background study and completion of PCA training)
- Rehire (requires new background study and completion of PCA training) -PREVIOUS EMPLOYMENT END DATE: _____
- Previously used for managed care organization (MCO) claims only (new background study not required)

PROVIDER TYPE **38 - INDIVIDUAL**	LEGAL NAME (FIRST)	FULL MIDDLE NAME	LAST NAME	SOCIAL SECURITY NUMBER
ADDRESS (RESIDENTIAL ADDRESS ONLY - DO NOT ENTER A PO BOX)	CITY	STATE	ZIP CODE	
COUNTY OF RESIDENCE	PHONE NUMBER	DATE OF BIRTH	UMPI (if requesting reinstatement)	
INDIVIDUAL PCA TRAINING DATE PASSED: CERTIFICATION NUMBER:		Is the individual 18 years old or older? *May affiliate with only one agency		
If previously used for claims, has this individual maintained continuous employment with your agency? Yes No		BGS NUMBER or APPLICATION ID		

Individual PCA Provider Statement

I have reviewed and certify the information provided above is true and correct to the best of my knowledge. I will notify the Minnesota Department of Human Services Provider Enrollment of any additions or changes to the information. By signing this form, I acknowledge I have read and understand the Application and Background Study Privacy Notice. I also authorize the Minnesota Department of Human Services to use the information collected about me according with the Privacy Notice.

NAME OF PCA (print or type)	SIGNATURE OF PCA	DATE SIGNED

Group Affiliation Information

You have the option to affiliate or enroll the individual PCA named above, if 18 years old or older, with other agencies you directly own without completing another application and agreement. Do you want to affiliate the above named individual PCA with any other agencies you own?
OYes ONO (If yes, enter information below.)

ORGANIZATION OR AGENCY NAME	AGENCY NPI OR UMPI	STUDY ID

Agency Information

AGENCY NAME	AGENCY NPI OR UMPI	AGENCY FAX
AGENCY PERSONNEL COMPLETING FORM	AGENCY SIGNATURE	

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Minnesota Department of **Human Services**

DHS-4611-ENG

DHS-4611-ENG 4-15

Minnesota Health Care Programs

Provider Agreement – Individual Support Worker (CDCS, CSG, PCA)

As a participating provider in health service programs administered by the Minnesota Department of Human Services (the Department), the Provider agrees to:

A. Submit documentation to your affiliated agency that fully discloses the extent of services provided to individuals under these programs. The documentation must be legible and meet the requirements of Minnesota Statutes Section 256B.0659, subdivision 12 for all individual support workers in CDCS, CSG, and PCA.

B. Furnish the Department, the Secretary of the U.S. Department of Health and Human Services (DHHS), or the Minnesota Medicaid Fraud Control Unit with such information as it may request regarding payments claimed for services provided under these programs.

C. Comply with all federal and state statutes and rules relating to the delivery of services to individuals and to the submission of claims for such services.

D. Accept as payment in full, amounts paid in accordance with schedules established by the Department, except where payment by the recipient has been authorized by the Department.

E. Make full disclosure of any convictions(s) of program crimes as required by 42 C.F.R. § 455.106.

F. Comply with all federal statutes, implementing regulations and guidance prohibiting discrimination on the basis of race, color, national origin, sex, age, religion and disability in any program or activity receiving federal financial assistance from DHHS; and to comply with the Minnesota Human Rights Act.

G. Render to recipients services of the same scope and quality as would be provided to the general public, within Minnesota Health Care Programs (MHCP) guidelines.

H. Comply with the provisions of any fully executed agreement and/or addendum required by the Department, which is incorporated herein by reference.

I. Comply with the advance directive requirements as required by 42 C.F.R. §§ 489.100 and 417.436.

J. Properly handle and safeguard protected information collected, created, used, maintained, or disclosed on behalf of the Department. For purposes of this Agreement, "protected information" means data subject to any of the following laws:

   1. The Minnesota Government Data Practices Act (MGDPA), Minnesota Statutes Chapter 13, in particular § 13.46 ("welfare data");

   2. The Minnesota Health Records Act § 144.291 and § 144.298;

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3. The Health Insurance Portability and Accountability Act ("HIPAA"), including but not limited to the requirements of the Privacy Rule and the Security Regulations, 45 C.F.R. Part 160 and Part 164, subparts A and E.
4. Federal law and regulations that govern the use and disclosure of substance abuse treatment records, 42 U.S.C.S. § 290dd-2 and 42 C.F.R. § 2.1 to § 2.67; and
5. Any other applicable state and federal statutes, rules, and regulations affecting the collection, storage, use and dissemination of private or confidential information.

	DIRECT SUPPORT WORKER INITIALS

NAME OF SUPPORT WORKER	UMPI

K. Comply with the laws described in section J. This includes the Provider:

1. Not using or further disclosing protected information created, collected, received, stored, used, maintained or disseminated in the course or performance of this Agreement other than as necessary to perform its obligations under this Agreement, or as required by law, either during the period of this Agreement or hereafter. See, respectively, 45 C.F.R. §§ 164.502(b) and 164.514(d), and Minn. Stats. § 13.05 subd. 3.
2. Using appropriate administrative, physical, and technical safeguards to prevent use or disclosure of the protected information other than as provided for by this Agreement and to ensure the confidentiality, integrity, and availability of any electronic protected health information (PHI) that it creates, receives, maintains, or transmits on behalf of the Department. Provider will not transmit PHI over the Internet or any other unsecure or open communications channel unless such information is encrypted or otherwise safeguarded using procedures no less stringent than those described in 45 C.F.R. § 164.312. If the Provider stores or maintains PHI in encrypted form, the provider shall, at the Department's request, promptly provide the Department with the key or keys to decrypt such information. The Provider shall not forward previously encrypted data to any other party, unless otherwise required by this Agreement.
3. Mitigating, to the extent practicable, any harmful effects known to the Provider of a use, disclosure, or breach of security with respect to protected information by the Provider in violation of this Agreement.

L. Agree that this Agreement may be immediately terminated at the discretion of the Department if it determines that the Provider has violated a material term of the Agreement, including but not limited to, non-compliance by the Provider with the HIPAA Privacy Rule and Security Standards. If termination is not feasible, the Department shall report the breach to the Secretary of DHHS.

Upon termination of this Agreement, all of the protected information provided by the Department to Provider, or created or received by the Provider on behalf of the Department, that the Provider still maintains in any form, including information that is in the hands of subcontractors or agents of the Provider, shall be destroyed or returned to the Department, and the Provider shall retain no copies of such information. If it is infeasible to return or destroy the information, the Provider shall

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provide the Department notification of the conditions that make return or destruction infeasible, and shall extend the protections of this Agreement to such information and limit further use and disclosure of such information to those purposes that make return or destruction infeasible, for as long as the Provider maintains the information.

M. Agree that any ambiguity in this Agreement shall be resolved to permit the Department to comply with HIPAA, MDGPA, and other applicable state and federal statutes, rules, and regulations affecting the collection, storage, use and dissemination of private or confidential information and other state and federal laws and regulations.

Upon signature, this Provider Agreement supersedes and replaces all former Provider Agreements the Provider has with the Department.

An individual applicant must personally sign the Provider Agreement. Please sign and date below, initial page 1, and return both page 1 and page 2 of this agreement. **Please retain a copy of the provider agreement for your files, and return the original to the Department of Human Services.**

NAME OF SUPPORT WORKER **(TYPE OR PRINT)**	TITLE
SIGNATURE OF SUPPORT WORKER	DATE

Please return page 1 and page 2 of this document

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Personal Care Assistance (PCA) Training

As a PCA, this information about training APPLIES DIRECTLY TO YOU.

Minnesota Health Care Programs (MHCP) requires that all individual PCAs successfully complete a mandated, standardized training in order to enroll with MHCP. Potential PCAs may take the training and test as often as needed. BELLA MENTE is *unable to pay you* until you have successfully obtained your certificate, passed your background study and completed all required employment forms.

Cost: This online training is free

Persons taking the online training must have:

- Access to a computer and internet connection
- A valid e-mail address

Registration

- Website: http://registrations.dhs.state.mn.us/
- Review the Individualized Personal PCA Training Course modules (as often as needed)
- Register for and take the Individualized Personal Care Assistance Training, online test (as often as needed)
- Use the confirmation number only for canceling the registration

Successful Completion

After the individual PCA passes this one-time test, they will be able to print their certificate. DHS will also send a copy to the e-mail address used to register for the test. **The individual PCA is responsible to give a copy of the completion certificate to the employer agency/agencies. **BELLA MENTE is NOT able to access your Certificate, or see if you have completed the course****

Submitting Your Certificate

Email: thejourney@therockhhc.com

Fax: (888) 291-6818

Mail: BELLA MENTE
1418 E US Highway 169
Grand Rapids MN 55744

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WAGE PAYMENT ELECTION AND CONSENT FORM

☐ **New Authorization**

☐ **Change of Authorization**

First Name	Middle Initial	Last Name
Last 4 of SSN	Phone	

☐ **Direct Deposit** *(indicate amount of deposit to each account type and provide bank information and/or voided check)*

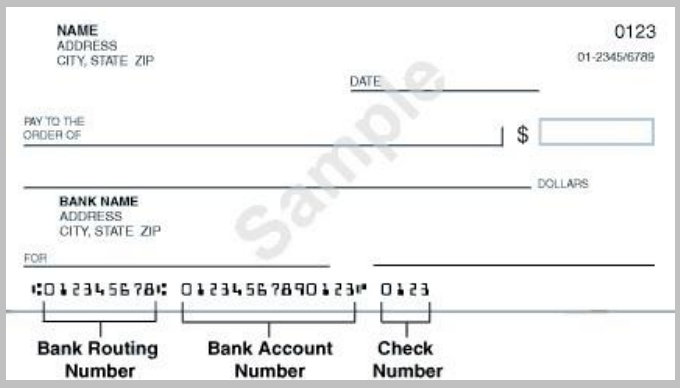
Direct Deposit #1 $ _____ Direct Deposit #2 $ _____

☐ Checking ☐ Savings ☐ Checking ☐ Savings

Routing # _____ Routing # _____

Account # _____ Account # _____

ATTACH VOIDED CHECK HERE



Consent to Deposit Wages

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888-735-3555
thejourney@bellamentegroup.com

I authorize my employer (or its payroll service provider) to initiate credit entries each pay date to deposit my pay (either net or a portion thereof) into the checking, savings or Card account selected in this election and consent (the "Account"). If funds to which I am not entitled are deposited to my Account, I authorize my employer (or its payroll service provider), to initiate any action to reverse or correct an erroneous credit entry to my Account and to direct the bank to return said funds to my employer (either directly or through its payroll service provider), to the extent permitted by applicable law. I will review my pay statement to ensure that my wages are being deposited correctly into my Account each payroll period. I understand that I can change my election at any time by contacting my employer and that this authorization replaces any previous authorizations and will remain in full force and effect until my employer (or its payroll service provider) has received written notification from me of its termination and my employer (or its payroll service provider) and the bank has had a reasonable opportunity to act on said termination.

_____
Employee Signature

Return this completed form to:

Email: thejourney@bellamentegroup.com

Fax: 888-291-6818

Mail: BELLA MENTE
1418 E US Highway 169
Grand Rapids MN 55744

Bella Mente
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888-735-3555
thejourney@bellamentegroup.com

Self-Identification Form

BELLA MENTE is an Equal Opportunity/Affirmative Action Employer and needs your cooperation in the completion of this form. Collection of this data enables BELLA MENTE to report accurate information to both the state and federal government. The information is used for compliance and record-keeping purposes in accordance with state and federal laws. We encourage you to respond to this voluntary questionnaire so we may analyze our effectiveness in recruiting and selecting qualified employees without regard to race, color, creed, sex, sexual orientation, age, national origin, disability or status with regard to public assistance. This information will not be made available to any person involved in decisions affecting an individual's appointment or promotion to a position.

1. Position for which you were hired:_____

2. Race and Ethnic Identification

- ☐ Hispanic or Latino – A person of Cuban, Mexican, Puerto Rican, South or Central America, or other Spanish culture or origin regardless of race.
- ☐ White (Not Hispanic or Latino) – A person having origins in any of the original peoples of Europe, the Middle East or North Africa.
- ☐ Black or African American (Not Hispanic or Latino) – A person having origins in any of the black racial groups of Africa.
- ☐ Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino) – A person having origins in any of the peoples of Hawaii, Guam, Samoa or other Pacific Islands.
- ☐ Asian (Not Hispanic or Latino) – A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.
- ☐ American Indian or Alaska Native (Not Hispanic or Latino) – A person having origins in any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment.
- ☐ Two or more races (Not Hispanic or Latino) – All persons who identify with more than one of the above five races.

3. Gender

- ☐ Male
- ☐ Female

Please return this form with your employment packet. Thank You. BELLA MENTE is An Equal Opportunity/Affirmative Action Employer

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1418 E US Highway 169
Grand Rapids MN 55744
888-735-3555
thejourney@bellamentegroup.com

Dear Applicant,

Congratulations! You have now completed the employee packet! Please refer to the checklist on the front of this packet to ensure you have completed all documents. Please call BELLA MENTE with any questions on the employee packet. Remember to send all documents, along with a photocopy of a form of ID to:

Email: thejourney@bellamentegroup.com

Fax: 888-291-6818

Mail: Bella Mente
1418 E US Highway 169
Grand Rapids MN 55744

The Human Resources Department will reach out to you and the Managing Party with the next steps in the employment process. Employee packets are always processed within 24 business hours.

The following documents are announcements and policies that you should review prior to starting your employment. If you have any questions, please contact the Human Resources Department. We are looking forward to starting your employment!

Sincerely,

Human Resources