



## TAX EXEMPT FORM

I, \_\_\_\_\_ hereby acknowledge that I am an Independent Contractor. Therefore, I am responsible for my social security and other taxes, and will receive an IRS 1099 Form for the preceding year by February of each year which is also sent to the Internal Revenue Services (IRS).

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Social Security number

\_\_\_\_\_  
Position

Home Care USA, Inc.



## EMPLOYEE CONTRACT

Please select:  Direct Employee  Independent Contractor

This contract is made this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ between our Home Health Agency \_\_\_\_\_ herein named the "Agency" and \_\_\_\_\_ herein named the "Employee/Contractor".

### TERMS

By this contract, both the Agency and the Employee/Contractor agree to the following terms:

- (I) The Agency is the Employer and \_\_\_\_\_ is the Employee/Contractor.
- (II) The Employee/Contractor is a contract employee ( Direct Employee  Independent Contractor).
- (III) The Employee/Contractor shall perform **all such duties/services** as are assigned to him/her by the Agency:  
\_\_\_\_\_  
(See Job Description attached), following the Agency's Policy & Procedures.
- (IV) The Agency  shall  shall not deduct all taxes from the Employee/Contractor's salary.
- (V) The Employee/Contractor shall maintain a proper liability insurance and make copy available to Our Agency, if applicable.  Required  Not Required
- (VI) The Agency shall evaluate the Employee/Contractor performance at the end of the 90 days probation period, and yearly thereafter, following all Agency and Personnel Policy and Procedures.
- (VII) Whenever applicable, the Employee/Contractor shall be required to submit progress and clinical notes to the Agency's Administrator or Director of Nursing, within 1-3 week of service rendered, between Monday-Tuesday during regular business hours.
- (VIII) Jobs to be performed by the Employee/Contractor shall be assigned by the Agency only.
- (IX) Both parties to this contract understand and agree that **patients are accepted for care only by this Agency.**
- (X) Both parties **agree that the Employee/Contractor shall participate in developing of the Plan of Care, conform to all applicable Agency policies, including personnel qualifications.** All Patient's health information must maintained as CONFIDENTIAL as HIPAA requirements.
- (XI) Both parties agree that this Agency shall coordinate all job-related activities of the Employee/Contractor, control all job-related activities of the Employee/Contractor, and shall evaluate the Employee/Contractor's job performance just as we do that of other Employee/Contractors.
- (XII) Both parties agree that the **Employee/Contractor shall be paid** an hourly rate of \$ \_\_\_\_\_ or per visit rate of \$ \_\_\_\_\_, during regular pay period of:  weekly  biweekly  monthly
- (XIII) The duration of this contract is one year commencing from the date both parties sign this contract. Upon termination or disciplinary action, this contract is canceled, and a new contract must be reinstated.
- (XIV) This contract is subject to automatic annual renewal, if not canceled for any party.
- (XV) Our Agency has full responsibility over all contracted services.
- (XVI) Our Agency has full responsibility to retain and maintain all clinical records of patients served by this Contract.
- (XVII) The second party must submit evidence of liability and insurance coverage.

## PROFESSIONAL RESPONSIBILITY

Nothing in this Agreement shall construed to interfere with or otherwise affect the rendering of services by the Employee/Contractor in accordance with his independent and professional judgment. This Agreement shall be subject to our Policies and Procedures, the rules and regulations of any and all professional organizations or associations to which Employee/Contractor may from time to time belong and the laws and regulations governing said practice in this State.

Our Agency has full responsibility to retain and maintain all clinical records of patients served by this Contract.

**Both parties agree that the Employee/Contractor shall submit clinical notes and progress reports to the Director of Nursing once every three week or more often if requested, and shall conform with prescribed scheduling of visits and, periodic patient evaluation.** Both parties agree that this Agency shall coordinate all job-related activities of the Employee/Contractor, and control all job-related activities of the Employee/Contractor.

Both parties agree that the Employee/Contractor participate in our Performance Improvement Program, by suggest according they daily practices, ways to improve our services, treatment, relationship with patients/family/physicians, report needs and expectations of patients and families.

**Both parties agree that patients are accepted for care, the service will be controlled, coordinated, and evaluated, only by our Agency,** the Employee/Contractor must comply with all scheduling of visits according Physician order and initial admission assessment, and report any need of schedule change to the Agency immediately identified the need. Participate in periodic patient evaluation to improve our services and the goals of the Patient Plan of Care compliance, including but no limited to Participate in Case Conference, create progress/deterioration reports, periodic communication with the Agency's Supervisor and Care Managers. Participate in the Developing of the Plan of Care, suggest any change needed to achieve the treatment goals, make suggestion for improving services and patient care and safety.

## SIGNATURES

Our Agency. (Employer):  
Administrator or Director of Nursing

Employee/Contractor: \_\_\_\_\_

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

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



W-9

Form (Rev. October 2007) Department of the Treasury Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Name (as shown on your income tax return) Business name, if different from above Check appropriate box: Individual/Sole proprietor Corporation Partnership Limited liability company... Other (see instructions) Address (number, street, and apt. or suite no.) City, state, and ZIP code List account number(s) here (optional) Requester's name and address (optional) Exempt payee

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. Social security number or Employer identification number

Part 11 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). 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.

Sign Here Signature of U.S. person Date

General Instructions

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

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

- 1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
An estate (other than a foreign estate), or
A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,