# EMPLOYEE ENROLLMENT FORM

*Classique Concierge Home Health Care*

## Section 1 – Employee Pay Setup – To Be Completed by Employee's Supervisor / Manager

**Employee Name (Last, First, MI):**

**Original Date of Hire:** **Job Title:**

**Employment Status:** ☐ Full-time ☐ Part-time **Primary Pay Type:** ☐ Salary ☐ Hourly

**Workers' Comp Code:** **Pay Frequency:** ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

**Supervisor, Manager or Authorized Representative:** *Signature* *Date*

**Print Name:** **Title:**

## Section 2 – Employee Information

**Employee Legal Name (Last, First, MI):** **SS No.:**

**Address:**

**City:** **State:** **Zip:**

**Email:** **Telephone:** **Date of Birth:**

**Emergency Contact:** **Phone:** **Relationship:**

Are you prevented from lawfully being employed in this country because of Visa or Immigration Status? ☐ Yes ☐ No

## Section 3 – EEO Statement

*Voluntary completion of this section will assist us in complying with the U.S. Equal Employment Opportunity Commission reporting requirements. We adhere to a policy of providing equal employment opportunities without regard to race, color, sex, religion, national origin, age, disability/handicap, marital status and any other classification protected under applicable federal, state, or local law.*

**Gender:** ☐ Female ☐ Male

**Ethnicity:** ☐ White ☐ Black/African American ☐ Native Hawaiian/Pacific ☐ Asian
☐ Hispanic/Latino ☐ Indian or Alaskan Native ☐ Islander Two or more races ☐ I prefer not to disclose

## Please Read The Following Statements Before Signing Below

I, the undersigned, acknowledge that I am applying for at-will employment with Classique Concierge Home Health Care and that either party may terminate the relationship at any time, for any reason. I have received and agree to abide by the Agency's policies and procedures, understanding they may be updated at any time.

Introductory Period: All new employees are subject to a 90-day introductory period during which either party may end the employment relationship at any time. Completion of this period does not guarantee continued employment.

I certify that all information provided is true and complete. Any misrepresentation may result in disqualification or termination.

**IMPORTANT — PLEASE NOTE:**

Federal law requires that employers must complete and maintain a fully completed Employment Eligibility Verification Form (Form I-9) for every employee. Classique Concierge Home Health Care can provide this form as well as instructions and assistance. Form I-9 is available at https://www.uscis.gov/i-9

***CLASSIQUE CONCIERGE HOME HEALTH CARE DOES NOT RETAIN COMPLETED I-9 FORMS***

**Date:** **Employee Name:** *Employee Signature*

# DIRECT DEPOSIT AUTHORIZATION

*Classique Concierge Home Health Care*

| EMPLOYEE INFORMATION | PLEASE CHECK ONE: |
|---|---|
| **Employee Name:** | ○ New / Replace existing account on file |
| **Social Security Number:** | ○ Add to existing account on file |
| **Employer:** | ○ Cancel / Stop |

## COMPLETE FOR DIRECT DEPOSIT

| Account 1 | Account 2 |
|---|---|
| **Bank Name:** | **Bank Name:** |
| **Routing Number:** | **Routing Number:** |
| **Account Number:** | **Account Number:** |
| ○ Checking ○ Savings | ○ Checking ○ Savings |
| ○ Entire Net Pay | ○ Entire Net Pay |
| ○ Percentage of Net Pay % | ○ Percentage of Net Pay % |
| ○ Specific Dollar Amount $ | ○ Specific Dollar Amount $ |

*Please attach a voided check or deposit slip for verification of bank data.*

## EMPLOYEE AUTHORIZATION

I hereby authorize Classique Concierge Home Health Care to deposit my earnings directly into my checking and/or savings account(s) as indicated above and agree that such credit to these accounts constitutes payment and receipt by me. Classique Concierge Home Health Care reserves the right to recall funds sent in error and to interrupt or discontinue direct deposits and issue live checks to any and all employees at any time for any reason. I am always responsible for verifying that funds have been credited into the proper account and are available prior to writing checks or otherwise withdrawing funds from this account. I am aware that this authority will remain in full effect until Classique Concierge Home Health Care receives ten (10) days prior written notification from me of change or termination.

**Employee Signature:** **Date:**

*By signing above, I am agreeing that I am either the account holder or have authority of the account holder to authorize Classique Concierge Home Health Care to make direct deposits into the above account(s).*