

JOB APPLICATION

To Apply send a copy of this application
, Resume and Cover Letter via email to:
Support@theArkofRefuge.org

Ark of Refuge ,Inc
500 Capitol Mall, Sacramento, California 95814
866-676-0070

Ark Of Refuge ,Inc is an equal opportunity employer. This application will not be used for limiting or excluding any applicant from consideration for employment on a basis prohibited by local, state, or federal law. Should an applicant need reasonable accommodation in the application process, he or she should contact a company representative.

Please fill out all of the sections below:

Applicant Information

Applicant Name:

Address:

City, State and Zip Code:

Telephone Number:

Email Address:

Date of Application:

Employment Position

Position(s) applying for:

How did you hear about this position?

What hours or shift are you available for work?

If needed, are you available to work overtime?

On what date can you start working if you are hired?

Do you have reliable transportation to and from work?

Salary desired:

Personal Information

Have you ever applied to or worked for Ark of Refuge ,Inc before?

Yes

No

If yes, when?

Do you have any friends, relatives, or acquaintances working for Ark of Refuge ,Inc

Yes

No

If yes, state name & relationship:

Are you 18 years of age or older?

Yes

No

Are you a U.S. citizen or approved to work in the United States?

Yes

No

What document can you provide as proof of citizenship or legal status?

Will you consent to a mandatory controlled substance test?

Yes

No

Do you have any condition which would require job accommodations?

Yes

No

If yes, please describe accommodations required below.

Have you ever been convicted of a criminal offense (felony or misdemeanor)?

Yes

No

If yes, please state the nature of the crime(s), when and where convicted and disposition of the case:

(Note: No applicant will be denied employment solely on the grounds of conviction of a criminal offense. The date of the offense, the nature of the offense, including any significant details that affect the description of the event, and the surrounding circumstances and the relevance of the offense to the position(s) applied for may, however, be considered.)

Job Skills/Qualifications

Please list below the skills and qualifications you possess for the position for which you are applying:

(Note: Ark of Refuge ,Inc complies with the ADA and considers reasonable accommodation measures that may be necessary for eligible applicants/employees to perform essential functions.)

Education and Training

High School

Name	Location (City, State)	Year Graduated	Degree Earned

College/University

Name	Location (City, State)	Year Graduated	Degree Earned

Vocational School/Specialized Training

Name	Location (City, State)	Year Graduated	Degree Earned

Military:

Are you a member of the Armed Services?

What branch of the military did you enlist?

What was your military rank when discharged?

How many years did you serve in the military?

What military skills do you possess that would be an asset for this position?

Previous Employment

Employer Name:

Job Title:

Supervisor Name:

Employer Address:

City, State and Zip Code:

Employer Telephone:

Dates Employed:

Reason for leaving:

Employer Name:

Job Title:

Supervisor Name:

Employer Address:

City, State and Zip Code:

Employer Telephone:

Dates Employed:

Reason for leaving:

Employer Name:

Job Title:

Supervisor Name: _____

Employer Address: _____

City, State and Zip Code: _____

Employer Telephone: _____

Dates Employed: _____

Reason for leaving: _____

References

Please provide 2 personal and professional reference(s) below:

Reference	Contact Information

Additional Information:

Do you have any philanthropic experience?

If yes to the previous question please list organization , frequency and title.

AT-WILL EMPLOYMENT

The relationship between you and the Ark of Refuge ,Inc is referred to as "employment at will." This means that your employment can be terminated at any time for any reason, with or without cause, with or without notice, by you or the Ark of Refuge ,Inc. No representative of Ark of Refuge ,Inc has authority to enter into any agreement contrary to the foregoing "employment at will" relationship. You understand that your employment is "at will," and that you acknowledge that no oral or written statements or representations regarding your employment can alter your at-will employment status, except for a written statement signed by you and either our Executive Vice-President/Chief Operations Officer or the Company's President.

Applicant Signature: _____ **Dated:** _____

CONFIDENTIAL

Background Check Authorization

Print Name: _____
(First) (Middle) (Last)

Former Name(s) and Dates Used: _____

Current Address Since: _____
(Mo/Yr) (Street) (City) (Zip/State)

Previous Address From: _____
(Mo/Yr) (Street) (City) (Zip/State)

Previous Address From: _____
(Mo/Yr) (Street) (City) (Zip/State)

Social Security Number: _____ DOB: _____

Telephone Number: _____

Drivers License Number/State: _____

The information contained in this application is correct to the best of my knowledge.

I hereby authorize The Ark of Refuge, Inc and its designated agents and representatives to conduct a comprehensive review of my background causing a consumer report and/or an investigative consumer report to be generated for employment and/or volunteer purposes. I understand that the scope of the consumer report/ investigative consumer report may include, but is not limited to the following areas: verification of social security number; credit reports, current and previous residences; employment history, education background, character references; drug testing, civil and criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions; driving records, birth records, and any other public records.

I further authorize any individual, company, firm, corporation, or public agency to divulge any and all information, verbal or written, pertaining to me, to The Ark of Refuge, Inc or its agents. I further authorize the complete release of any records or data pertaining to me which the individual, company, firm, corporation, or public agency may have, to include information or data received from other sources. The Ark of refuge, Inc and its designated agents and representatives shall maintain all information received from this authorization in a confidential manner in order to protect the applicants personal information, including, but not limited to, addresses, social security numbers, and dates of birth.

Signature: _____ Date: _____

Notice to California, Minnesota and Oklahoma Residents:

Please check the box below if you wish to receive a copy of a consumer report that is requested.

☐ I wish to receive a copy of any Background Check Report on me that is requested.

Employee's Withholding Certificate**2020**

- **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
 ► **Give Form W-4 to your employer.**
 ► **Your withholding is subject to review by the IRS.**

Step 1:
Enter
Personal
Information

(a) First name and middle initial	Last name	(b) Social security number
Address		► Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
City or town, state, and ZIP code		
(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly (or Qualifying widow(er)) <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

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

Step 2:**Multiple Jobs**
or Spouse
Works

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

Do **only one** of the following.

- (a) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3–4); **or**
 (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**
 (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld ► ☐

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Step 3:**Claim**
Dependents

If your income will be \$200,000 or less (\$400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by \$2,000 ► \$

Multiply the number of other dependents by \$500 ► \$

Add the amounts above and enter the total here **3** \$

Step 4
(optional):**Other**
Adjustments

(a) **Other income (not from jobs).** If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income **4(a)** \$

(b) **Deductions.** If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here **4(b)** \$

(c) **Extra withholding.** Enter any additional tax you want withheld each pay period . . . **4(c)** \$

Step 5:**Sign**
Here

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

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

Employers
Only

Employer's name and address	First date of employment	Employer identification number (EIN)
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General Instructions

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to www.irs.gov/FormW4.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505.

Exemption from withholding. You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 **and** you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2020 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2021.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

When to use the estimator. Consider using the estimator at www.irs.gov/W4App if you:

1. Expect to work only part of the year;
2. Have dividend or capital gain income, or are subject to additional taxes, such as the additional Medicare tax;
3. Have self-employment income (see below); or
4. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at www.irs.gov/W4App to figure the amount to have withheld.

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

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

If you (and your spouse) have a total of only two jobs, you may instead check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.



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

Step 3. Step 3 of Form W-4 provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2020 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet (Keep for your records.)

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

Note: If more than one job has annual wages of more than \$120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at www.irs.gov/W4App.

- 1 Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 **1** \$ _____
- 2 Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
 - a** Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a **2a** \$ _____
 - b** Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b **2b** \$ _____
 - c** Add the amounts from lines 2a and 2b and enter the result on line 2c **2c** \$ _____
- 3** Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3** _____
- 4 Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) **4** \$ _____

Step 4(b)—Deductions Worksheet (Keep for your records.)

- 1** Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income **1** \$ _____
- 2** Enter: $\left\{ \begin{array}{l} \bullet \$24,800 \text{ if you're married filing jointly or qualifying widow(er)} \\ \bullet \$18,650 \text{ if you're head of household} \\ \bullet \$12,400 \text{ if you're single or married filing separately} \end{array} \right\}$ **2** \$ _____
- 3** If line 1 is greater than line 2, subtract line 2 from line 1. If line 2 is greater than line 1, enter "-0-" . . . **3** \$ _____
- 4** Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040 or 1040-SR)). See Pub. 505 for more information . . . **4** \$ _____
- 5 Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 **5** \$ _____

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

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

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

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

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$220	\$850	\$900	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,210	\$1,870	\$1,870
\$10,000 - 19,999	220	1,220	1,900	2,100	2,220	2,220	2,220	2,220	2,410	3,410	4,070	4,070
\$20,000 - 29,999	850	1,900	2,730	2,930	3,050	3,050	3,050	3,240	4,240	5,240	5,900	5,900
\$30,000 - 39,999	900	2,100	2,930	3,130	3,250	3,250	3,440	4,440	5,440	6,440	7,100	7,100
\$40,000 - 49,999	1,020	2,220	3,050	3,250	3,370	3,570	4,570	5,570	6,570	7,570	8,220	8,220
\$50,000 - 59,999	1,020	2,220	3,050	3,250	3,570	4,570	5,570	6,570	7,570	8,570	9,220	9,220
\$60,000 - 69,999	1,020	2,220	3,050	3,440	4,570	5,570	6,570	7,570	8,570	9,570	10,220	10,220
\$70,000 - 79,999	1,020	2,220	3,240	4,440	5,570	6,570	7,570	8,570	9,570	10,570	11,220	11,240
\$80,000 - 99,999	1,060	3,260	5,090	6,290	7,420	8,420	9,420	10,420	11,420	12,420	13,260	13,460
\$100,000 - 149,999	1,870	4,070	5,900	7,100	8,220	9,320	10,520	11,720	12,920	14,120	14,980	15,180
\$150,000 - 239,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,190	16,050	16,250
\$240,000 - 259,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,520	17,170	18,170
\$260,000 - 279,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	13,120	15,120	17,120	18,770	19,770
\$280,000 - 299,999	2,040	4,440	6,470	7,870	9,190	10,720	12,720	14,720	16,720	18,720	20,370	21,370
\$300,000 - 319,999	2,040	4,440	6,470	8,200	10,320	12,320	14,320	16,320	18,320	20,320	21,970	22,970
\$320,000 - 364,999	2,720	5,920	8,750	10,950	13,070	15,070	17,070	19,070	21,290	23,590	25,540	26,840
\$365,000 - 524,999	2,970	6,470	9,600	12,100	14,530	16,830	19,130	21,430	23,730	26,030	27,980	29,280
\$525,000 and over	3,140	6,840	10,170	12,870	15,500	18,000	20,500	23,000	25,500	28,000	30,150	31,650

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$460	\$940	\$1,020	\$1,020	\$1,470	\$1,870	\$1,870	\$1,870	\$1,870	\$2,040	\$2,040	\$2,040
\$10,000 - 19,999	940	1,530	1,610	2,060	3,060	3,460	3,460	3,460	3,640	3,830	3,830	3,830
\$20,000 - 29,999	1,020	1,610	2,130	3,130	4,130	4,540	4,540	4,720	4,920	5,110	5,110	5,110
\$30,000 - 39,999	1,020	2,060	3,130	4,130	5,130	5,540	5,720	5,920	6,120	6,310	6,310	6,310
\$40,000 - 59,999	1,870	3,460	4,540	5,540	6,690	7,290	7,490	7,690	7,890	8,080	8,080	8,080
\$60,000 - 79,999	1,870	3,460	4,690	5,890	7,090	7,690	7,890	8,090	8,290	8,480	9,260	10,060
\$80,000 - 99,999	2,020	3,810	5,090	6,290	7,490	8,090	8,290	8,490	9,470	10,460	11,260	12,060
\$100,000 - 124,999	2,040	3,830	5,110	6,310	7,510	8,430	9,430	10,430	11,430	12,420	13,520	14,620
\$125,000 - 149,999	2,040	3,830	5,110	7,030	9,030	10,430	11,430	12,580	13,880	15,170	16,270	17,370
\$150,000 - 174,999	2,360	4,950	7,030	9,030	11,030	12,730	14,030	15,330	16,630	17,920	19,020	20,120
\$175,000 - 199,999	2,720	5,310	7,540	9,840	12,140	13,840	15,140	16,440	17,740	19,030	20,130	21,230
\$200,000 - 249,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
\$250,000 - 399,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
\$400,000 - 449,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,450	19,940	21,240	22,540
\$450,000 and over	3,140	6,230	8,810	11,310	13,810	15,710	17,210	18,710	20,210	21,700	23,000	24,300

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$830	\$930	\$1,020	\$1,020	\$1,020	\$1,480	\$1,870	\$1,870	\$1,930	\$2,040	\$2,040
\$10,000 - 19,999	830	1,920	2,130	2,220	2,220	2,680	3,680	4,070	4,130	4,330	4,440	4,440
\$20,000 - 29,999	930	2,130	2,350	2,430	2,900	3,900	4,900	5,340	5,540	5,740	5,850	5,850
\$30,000 - 39,999	1,020	2,220	2,430	2,980	3,980	4,980	6,040	6,630	6,830	7,030	7,140	7,140
\$40,000 - 59,999	1,020	2,530	3,750	4,830	5,860	7,060	8,260	8,850	9,050	9,250	9,360	9,360
\$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,780	10,980	11,180	11,580	12,380
\$80,000 - 99,999	1,900	4,300	5,710	7,000	8,200	9,400	10,600	11,180	11,670	12,670	13,580	14,380
\$100,000 - 124,999	2,040	4,440	5,850	7,140	8,340	9,540	11,360	12,750	13,750	14,750	15,770	16,870
\$125,000 - 149,999	2,040	4,440	5,850	7,360	9,360	11,360	13,360	14,750	16,010	17,310	18,520	19,620
\$150,000 - 174,999	2,040	5,060	7,280	9,360	11,360	13,480	15,780	17,460	18,760	20,060	21,270	22,370
\$175,000 - 199,999	2,720	5,920	8,130	10,480	12,780	15,080	17,380	19,070	20,370	21,670	22,880	23,980
\$200,000 - 249,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
\$250,000 - 349,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
\$350,000 - 449,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,900	25,200
\$450,000 and over	3,140	6,840	9,560	12,140	14,640	17,140	19,640	21,530	23,030	24,530	25,940	27,240



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

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

► **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):

<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 (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 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)	
<p>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.</p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p>	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)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code



Employer Completes Next Page





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

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

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

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

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Title of Employer or Authorized Representative Clerk	
Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name The Ark of Refuge, Inc	
Employer's Business or Organization Address (Street Number and Name) 500 Capitol Mall	City or Town Sacramento	State CA	ZIP Code 95814

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
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LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

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

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"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 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 		<ol style="list-style-type: none"> 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 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 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority For persons under age 18 who are unable to present a document listed above: 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record 	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 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 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security

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

Refer to the instructions for more information about acceptable receipts.

STATEMENT OF INTENT TO EMPLOY A MINOR AND REQUEST FOR A WORK PERMIT—CERTIFICATE OF AGE

CDE Form B1-1 (Rev. 02-14)

A “STATEMENT OF INTENT TO EMPLOY A MINOR AND REQUEST FOR A WORK PERMIT—CERTIFICATE OF AGE” form (CDE Form B1-1) shall be completed in accordance with California *Education Code* 49162 and 49163 as notification of intent to employ a minor. This form is also a Certificate of Age pursuant to California *Education Code* 49114.

(Print Information)

Minor's Information

_____ Minor's Name (<i>First and Last</i>)		_____ Home Phone	_____ Grade
_____ Home Address		_____ City	_____ Zip Code
_____ Birth Date	_____ Social Security Number	_____ Age	_____ Student's Signature

School Information

_____ School Name	_____ School Phone
_____ School Address	_____ City
	_____ Zip Code

To be filled in and signed by parent or legal guardian

This minor is being employed at the place of work described with my full knowledge and consent. I hereby certify that to the best of my knowledge and belief, the information herein is correct and true.

_____ Parent's Name (<i>Print First and Last</i>)	_____ Parent's Signature	_____ Date
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To be filled in and signed by employer

_____ Business Name or Agency of Placement	_____ Business Phone	_____ Supervisor's Name
_____ Business Address	_____ City	_____ Zip Code
Employer's Maximum Expected Work Hours: _____ hours per day _____ hours per week		
Describe nature of work to be performed: _____		

In compliance with California labor laws, this employee is covered by workers' compensation insurance. This business does not discriminate unlawfully on the basis of race, ethnic background, religion, sex, sexual orientation, color, national origin, ancestry, age, physical handicap, or medical condition. I hereby certify that, to the best of my knowledge, the information herein is correct and true.

_____ Employer's Name (<i>Print First and Last</i>)	_____ Employer's Signature	_____ Date
--	-------------------------------	---------------

For authorized work permit issuer use ONLY

Maximum number of work hours when school is in session:								Maximum number of work hours when school is not in session:							
Mon	Tues	Wed	Thur	Fri	Sat	Sun	Total	Mon	Tues	Wed	Thur	Fri	Sat	Sun	Total
_____ Proof of Minor's Age (<i>Evidence Type</i>)								Check Permit Type: <input type="checkbox"/> Full-time <input type="checkbox"/> Restricted <input type="checkbox"/> General <input type="checkbox"/> Work Experience Education, Vocational Education, or Personal Attendant <input type="checkbox"/> Workability							
_____ Verifying Authority's Name and Title (<i>Print</i>)															
_____ Verifying Authority's Signature															

For more information about child labor laws, contact the U.S. Department of Labor at <http://www.dol.gov/>, and the State of California Department of Industrial Relations, Division of Labor Standards Enforcement at <http://www.dir.ca.gov/DLSE/dlse.html>.

STATEMENT AND ACKNOWLEDGEMENT OF AT-WILL EMPLOYMENT

As an employee of The Ark of Refuge, Inc, your employment has been and continues to be “at-will.” This means that during the course of employment with the Company, employees are free to terminate their employment with the Company at any time, with or without a reason, and the Company has the right to terminate employees at any time, with or without a reason. Although the Company may choose to terminate an employee for cause, cause is not required.

No one other than the President of the Company has the authority to alter this at-will employment arrangement, to enter into an agreement for employment for a specified period of time, or to make any agreement contrary to this at-will arrangement. Furthermore, any such agreement must be in writing and must be signed by the President of the Company.

By signing in the space provided below, you hereby acknowledge that you have been given a copy of the Company’s Statement and Acknowledgement of At-Will Employment, that you have read the Statement and that you understand its contents, and that you further understand that the Statement supersedes any and all previous agreements, policies, practices or guidelines, whether oral or written.

EMPLOYEE

Name: _____

Date: _____

Signature: _____

Note to Employee: The original of this form will go into your personnel file.

ACKNOWLEDGEMENT OF POLICIES

Dear Future Employee,

During your employment, you will be paid a base salary with accruals sick leave at the rate of 1 hour per 30 worked.

Sick Leave/Paid Time Off:

By signing this form you acknowledge that no federal or state law requires employers to provide paid or unpaid vacation time to employees. Additionally, you acknowledge that you can work up to 12 days in a row in California without a day off dependent upon the weekday of your rest day.

At-Will Employment: Your employment with the Company is "at will," and thus you or the Company may terminate our employment relationship at any time, with or without cause or advance notice. The Company reserves the right, in its sole discretion, to change your compensation and/or employee benefits at any time on a prospective basis.

Additional Agreements: As a condition of your employment, you agree to execute any additional agreements required by the Company at the start of your employment. This includes any agreements that relate to your confidentiality or intellectual property assignment obligations to the Company. You further agree that at all times during your employment (and afterwards as applicable), you will be bound by, and will fully comply with, these additional agreements.

Entire Agreement: This employment agreement, along with the Confidentiality Agreement, sets forth the terms and conditions of your employment with the Company, and supersedes any prior representations or agreements concerning your employment with the Company, whether written or oral. You acknowledge and agree that you are not relying on any statements or representations concerning the Company or your employment with the Company except those made in this agreement. This employment agreement may not be modified or amended except by a written agreement signed by you and an authorized officer of the Company.

[Applicant Signature]

[Print Name of Signatory]

[Date]

TIME OF HIRE PAMPHLET

This pamphlet, or a similar one that has been approved by the Administrative Director, must be given to all newly hired employees in the State of California. Employers and claims administrators may use the content of this document and put their logos and additional information on it. The content of this pamphlet applies to all industrial injuries that occur on or after January 1, 2013.

WHAT IS WORKERS' COMPENSATION?

If you get hurt on the job, your employer is required by law to pay for workers' compensation benefits. You could get hurt by:

One event at work. Examples: hurting your back in a fall, getting burned by a chemical that splashes on your skin, getting hurt in a car accident while making deliveries.

—or—

Repeated exposures at work. Examples: hurting your wrist from using vibrating tools, losing your hearing because of constant loud noise.

—or—

Workplace crime. Examples: you get hurt in a store robbery, physically attacked by an unhappy customer.

Discrimination is illegal

It is illegal under Labor Code section 132a for your employer to punish or fire you because you:

- File a workers' compensation claim
- Intend to file a workers' compensation claim
- Settle a workers' compensation claim
- Testify or intend to testify for another injured worker.

If it is found that your employer discriminated against you, he or she may be ordered to return you to your job. Your employer may also be made to pay for lost wages, increased workers' compensation benefits, and costs and expenses set by state law.

WHAT ARE THE BENEFITS?

- **Medical care:** Paid for by your employer to help you recover from an injury or illness caused by work. Doctor visits, hospital services, physical therapy, lab tests and x-rays are some of the medical services that may be provided. These services should be necessary to treat your injury. There are limits on some services such as physical and occupational therapy and chiropractic care.

- **Temporary disability benefits:** Payments if you lose wages because your injury prevents you from doing your usual job while recovering. The amount you may get is up to two-thirds of your wages. There are minimum and maximum payment limits set by state law. You will be paid every two weeks if you are eligible. For most injuries, payments may not exceed 104 weeks within five years from your date of injury. Temporary disability (TD) stops when you return to work, or when the doctor releases you for work, or says your injury has improved as much as it's going to.
- **Permanent disability benefits:** Payments if you don't recover completely. You will be paid every two weeks if you are eligible. There are minimum and maximum weekly payment rates established by state law. The amount of payment is based on:
 - Your doctor's medical reports
 - Your age
 - Your occupation
- **Supplemental job displacement benefits:** This is a voucher for up to \$6,000 that you can use for retraining or skill enhancement at an approved school, books, tools, licenses or certification fees, or other resources to help you find a new job. You are eligible for this voucher if:
 - You have a permanent disability.
 - Your employer does not offer regular, modified, or alternative work, within 60 days after the claims administrator receives a doctor's report saying you have made a maximum medical recovery.
- **Death benefits:** Payments to your spouse, children or other dependents if you die from a job injury or illness. The amount of payment is based on the number of dependents. The benefit is paid every two weeks at a rate of at least \$224 per week. In addition, workers' compensation provides a burial allowance.

OTHER BENEFITS

You may file a claim with the Employment Development Department (EDD) to get state disability benefits when workers' compensation benefits are delayed, denied, or have ended. There are time restrictions so for more information contact the local office of EDD or go to their web site www.edd.ca.gov.

If your injury results in a permanent disability (PD) and the state determines that your PD benefit is disproportionately low compared to your earning loss, you may qualify for additional money from the Department of Industrial Relation's special earnings loss supplement program also known as the return to work program. If you have questions or think you qualify, contact the Information & Assistance Unit by going to www.dwc.ca.gov and looking under "Workers'

Compensation programs and units” for the “Information & Assistance Unit” link or visit the DIR web site at www.dir.ca.gov.

Workers’ compensation fraud is a crime

Any person who makes or causes to be made any knowingly false statement in order to obtain or deny workers’ compensation benefits or payments is guilty of a felony. If convicted, the person will have to pay fines up to \$150,000 and/or serve up to five years in jail.

WHAT SHOULD I DO IF I HAVE AN INJURY?

Report your injury to your employer

Tell your supervisor right away no matter how slight the injury may be. Don’t delay – there are time limits. You could lose your right to benefits if your employer does not learn of your injury within 30 days. If your injury or illness is one that develops over time, report it as soon as you learn it was caused by your job.

If you cannot report to the employer or don’t hear from the claims administrator after you have reported your injury, contact the claims administrator yourself.

Workers’ compensation insurance company or if employer is self-insured, person responsible for handling the claim is:

The Ark of Refuge, Inc -Fryar Insurance

Address: 500 Capitol Mall Suite 2350 Sacramento Ca

Phone: +1866-676-0070.

You may be able to find the name of your employer’s workers’ compensation insurer at www.caworkcompcoverage.com. If no coverage exists or coverage has expired, contact the Division of Labor Standards Enforcement at www.dir.ca.gov/DLSE as all employees must be covered by law.

Get emergency treatment if needed

If it’s a medical emergency, go to an emergency room right away. Tell the medical provider who treats you that your injury is job related. Your employer may tell you where to go for follow up treatment.

Emergency telephone number: Call 911 for an ambulance, fire department or police. For non-emergency medical care, contact your employer, the workers' compensation claims administrator or go to this facility:

_____.

Fill out DWC 1 claim form and give it to your employer

Your employer must give you a [DWC 1 claim form](#) within one working day after learning about your injury or illness. Complete the employee portion, sign and give it back to your employer. Your employer will then file your claim with the claims administrator. Your employer must authorize treatment within one working day of receiving the DWC 1 claim form.

If the injury is from repeated exposures, you have one year from when you realized your injury was job related to file a claim.

In either case, you may receive up to \$10,000 in employer-paid medical care until your claim is either accepted or denied. The claims administrator has up to 90 days to decide whether to accept or deny your claim. Otherwise your case is presumed payable.

Your employer or the claims administrator will send you “benefit notices” that will advise you of the status of your claim.

MORE ABOUT MEDICAL CARE

What is a Primary Treating Physician (PTP)?

This is the doctor with overall responsibility for treating your injury or illness. He or she may be:

- The doctor you name in writing *before* you get hurt on the job
- A doctor from the medical provider network (MPN)
- The doctor chosen by your employer during the first 30 days of injury if your employer does not have an MPN or
- The doctor you chose after the first 30 days if your employer does not have an MPN.

What is a Medical Provider Network (MPN)?

An MPN is a select group of health care providers who treat injured workers. Check with your employer to see if they are using an MPN.

If you have not named a doctor before you get hurt and your employer is using an MPN, you will see an MPN doctor. After your first visit, you are free to choose another doctor from the MPN list.

What is Predesignation?

Predesignation is when you name your regular doctor to treat you if you get hurt on the job. The doctor must be a medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or a medical group with an M.D. or D.O. You must name your doctor in writing *before* you get hurt or become ill.

You may predesignate a doctor if you have health care coverage for non-work injuries and illnesses. The doctor must have:

- Treated you
- Maintained your medical history and records before your injury and
- Agreed to treat you for a work-related injury or illness before you get hurt or become ill.

You may use the “predesignation of personal physician” form included with this pamphlet. After you fill in the form, be sure to give it to your employer.

If your employer does not have an approved MPN, you may name your chiropractor or acupuncturist to treat you for work related injuries. The notice of personal chiropractor or acupuncturist must be in writing *before* you get hurt. You may use the form included in this pamphlet. After you fill in the form, be sure to give it to your employer.

With some exceptions, state law does not allow a chiropractor to continue as your treating physician after 24 visits. Once you have received 24 chiropractic visits, if you still require medical treatment, you will have to select a new physician who is not a chiropractor. The term “chiropractic visit” means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management.

Exceptions to the prohibition on a chiropractor continuing as your treating physician after 24 visits include postsurgical physical medicine visits prescribed by the surgeon, or physician designated by the surgeon, under the postsurgical component of the Division of Workers’ Compensation’s Medical Treatment Utilization Schedule, or if your employer has authorized additional visits in writing.

WHAT IF THERE IS A PROBLEM?

If you have a concern, speak up. Talk to your employer or the claims administrator handling your claim and try to solve the problem. If this doesn’t work, get help by trying the following:

Contact the Division of Workers’ Compensation (DWC) Information and Assistance (I&A) Unit

All 24 DWC offices throughout the state provide information and assistance on rights, benefits and obligations under California's workers' compensation laws. I&A officers help resolve disputes without formal proceedings. Their goal is to get you full and timely benefits. Their services are free.

To contact the nearest I&A Unit, go to www.dwc.ca.gov and under “Workers’ Compensation programs and units”, click on “Information & Assistance Unit.” At this site you will find fact sheets, guides and information to help you.

The nearest I&A Unit is located at:

Address: _____

Phone number: _____.

Consult with an attorney

Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fees may be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their website at www.californiaspecialist.org. You may get a list of attorneys from your local I&A Unit or look in the yellow pages.

Warning

Your employer may not pay workers' compensation benefits if you get hurt in a voluntary off-duty recreational, social or athletic activity that is not part of your work-related duties.

Additional rights

You may also have other rights under the Americans with Disabilities Act (ADA) or the Fair Employment and Housing Act (FEHA). For additional information, contact FEHA at (800) 884-1684 or the Equal Employment Opportunity Commission (EEOC) at (800) 669-4000.

The information contained in this pamphlet conforms to the informational requirements found in Labor Code sections 3551 and 3553 and California Code of Regulation, Title 8, sections 9880 and 9883. This document is approved by the Division of Workers' Compensation administrative director.

Revised 6/17/14 and effective for dates of injuries on or after 1/1/13

PREDESIGNATION OF PERSONAL PHYSICIAN

In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or medical group if:

- on the date of your work injury you have health care coverage for injuries or illnesses that are not work related;
- the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment, and retains your medical records;
- your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries;
- prior to the injury your doctor agrees to treat you for work injuries or illnesses;
- prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor's name and business address.

You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work-related injury or illness and the above requirements are met.

NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN

Employee: Complete this section.

To: _____ (name of employer) If I have a work-related injury or illness, I choose to be treated by:

(name of doctor)(M.D., D.O., or medical group)

(street address, city, state, ZIP)

(telephone number)

Employee Name (please print):

Employee's Address:

Name of Insurance Company, Plan, or Fund providing health coverage for nonoccupational injuries or illnesses:

Employee's Signature _____ Date: _____

Physician: I agree to this Predesignation:

Signature: _____ Date: _____

(Physician or Designated Employee of the Physician or Medical Group)

The physician is not required to sign this form, however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

§ 9783.1. DWC Form 9783.1 Notice of Personal Chiropractor or Personal Acupuncturist.

NOTICE OF PERSONAL CHIROPRACTOR OR PERSONAL ACUPUNCTURIST

If your employer or your employer's insurer does not have a Medical Provider Network, you may be able to change your treating physician to your personal chiropractor or acupuncturist following a work-related injury or illness. In order to be eligible to make this change, you must give your employer the name and business address of a personal chiropractor or acupuncturist in writing prior to the injury or illness. Your claims administrator generally has the right to select your treating physician within the first 30 days after your employer knows of your injury or illness. After your claims administrator has initiated your treatment with another doctor during this period, you may then, upon request, have your treatment transferred to your personal chiropractor or acupuncturist.

NOTE: If your date of injury is January 1, 2004 or later, a chiropractor cannot be your treating physician after you have received 24 chiropractic visits unless your employer has authorized additional visits in writing. The term "chiropractic visit" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management. Once you have received 24 chiropractic visits, if you still require medical treatment, you will have to select a new physician who is not a chiropractor. This prohibition shall not apply to visits for postsurgical physical medicine visits prescribed by the surgeon, or physician designated by the surgeon, under the postsurgical component of the Division of Workers' Compensation's Medical Treatment Utilization Schedule.

You may use this form to notify your employer of your personal chiropractor or acupuncturist.

Your Chiropractor or Acupuncturist's Information:

(name of chiropractor or acupuncturist)

(street address, city, state, zip code)

(telephone number)

Employee Name (please print):

Employee's Address:

Employee's Signature _____ Date: _____

NOTICE TO EMPLOYEE
Labor Code section 2810.5

EMPLOYEE

Employee Name: _____

Start Date: _____

EMPLOYER

Legal Name of Hiring Employer: The Ark of Refuge, Inc

Is hiring employer a staffing agency/business (e.g., Temporary Services Agency; Employee Leasing Company; or Professional Employer Organization [PEO])? ☐ Yes ☐ No

Other Names Hiring Employer is "doing business as" (if applicable):

None

Physical Address of Hiring Employer's Main Office:

500 Capitol Mall , Sacramento CA , 95814

Hiring Employer's Mailing Address (if different than above):

2416 Moraine Circle Suite 23, Rancho Cordova CA 95670

Hiring Employer's Telephone Number: +1-866-676-0070

If the hiring employer is a staffing agency/business (above box checked "Yes"), the following is the other entity for whom this employee will perform work:

Name: _____

Physical Address of Main Office: _____

Mailing Address: _____

Telephone Number: _____

WAGE INFORMATION

Rate(s) of Pay: _____ Overtime Rate(s) of Pay: _____

Rate by (check box): ☐ Hour ☐ Shift ☐ Day ☐ Week ☐ Salary ☐ Piece rate ☐ Commission

☐ Other (provide specifics): _____

Does a written agreement exist providing the rate(s) of pay? (check box) ☐ Yes ☐ No

If yes, are all rate(s) of pay and bases thereof contained in that written agreement? ☐ Yes ☐ No

Allowances, if any, claimed as part of minimum wage (including meal or lodging allowances):

(If the employee has signed the acknowledgment of receipt below, it does not constitute a "voluntary written agreement" as required under the law between the employer and employee in order to credit any meals or lodging against the minimum wage. Any such voluntary written agreement must be evidenced by a separate document.)

Regular Payday: _____

WORKERS' COMPENSATION

Insurance Carrier's Name: Fryars Insurance

Address: 500 Capitol Mall, Sacramento CA 95814

Telephone Number: +1-866-676-0070

Policy No.: _____

☐ Self-Insured (Labor Code 3700) and Certificate Number for Consent to Self-Insure: _____

PAID SICK LEAVE

Unless exempt, the employee identified on this notice is entitled to minimum requirements for paid sick leave under state law which provides that an employee:

- a. May accrue paid sick leave and may request and use up to 3 days or 24 hours of accrued paid sick leave per year;
- b. May not be terminated or retaliated against for using or requesting the use of accrued paid sick leave; and
- c. Has the right to file a complaint against an employer who retaliates or discriminates against an employee for
 1. requesting or using accrued sick days;
 2. attempting to exercise the right to use accrued paid sick days;
 3. filing a complaint or alleging a violation of Article 1.5 section 245 et seq. of the California Labor Code;
 4. cooperating in an investigation or prosecution of an alleged violation of this Article or opposing any policy or practice or act that is prohibited by Article 1.5 section 245 et seq. of the California Labor Code.

The following applies to the employee identified on this notice: *(Check one box)*

- ☒ 1. Accrues paid sick leave only pursuant to the minimum requirements stated in Labor Code §245 et seq. with no other employer policy providing additional or different terms for accrual and use of paid sick leave.
- ☐ 2. Accrues paid sick leave pursuant to the employer's policy which satisfies or exceeds the accrual, carryover, and use requirements of Labor Code §246.
- ☐ 3. Employer provides no less than 24 hours (or 3 days) of paid sick leave at the beginning of each 12-month period.
- ☐ 4. The employee is exempt from paid sick leave protection by Labor Code §245.5. (State exemption and specific subsection for exemption): _____

ACKNOWLEDGEMENT OF RECEIPT

(Optional)

(PRINT NAME of Employer representative)

(PRINT NAME of Employee)

(SIGNATURE of Employer Representative)

(SIGNATURE of Employee)

(Date)

(Date)

The employee's signature on this notice merely constitutes acknowledgement of receipt.

Labor Code section 2810.5(b) requires that the employer notify you in writing of any changes to the information set forth in this Notice within seven calendar days after the time of the changes, unless one of the following applies: (a) All changes are reflected on a timely wage statement furnished in accordance with Labor Code section 226; (b) Notice of all changes is provided in another writing required by law within seven days of the changes.



About California Paid Family Leave

For many working Californians, finding time to be with a loved one when they need it most can be difficult. California's Paid Family Leave program was created for those moments that matter – when you are bonding with a new child or caring for a seriously ill family member.

Fast Facts About California Paid Family Leave

- Provides partial wage replacement benefits to bond with a new child (either by birth, adoption, or foster care placement) or to care for a seriously ill family member (child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, or registered domestic partner).
- Doesn't have to be taken all at once.
- Provides approximately 60 to 70 percent of your salary during your leave.
- Funded through your State Disability Insurance tax withholding, so you are most likely eligible if you've paid into State Disability Insurance (noted as "CASDI" on paystubs) or a qualifying voluntary plan in the past 5 to 18 months.
- To bond with a new child, leave can be taken anytime within the first 12 months of a child entering your family.
- Citizenship and immigration status do not affect eligibility.

CALIFORNIA PAID FAMILY LEAVE

moments matter.

Paid Family Leave:

Giving Californians the benefits they need to be there for the moments that matter.

English	1-877-238-4373
Spanish	1-877-379-3819
Cantonese	1-866-692-5595
Vietnamese	1-866-692-5596
Armenian	1-866-627-1567
Punjabi	1-866-627-1568
Tagalog	1-866-627-1569
TTY	1-800-445-1312

Individuals can also visit a Paid Family Leave or Disability Insurance office to obtain claim forms, receive information, or speak to a representative.

Visit a [State Disability Insurance office](https://edd.ca.gov/Disability/Contact_SD.html) (edd.ca.gov/Disability/Contact_SD.html) near you.



For more information, visit:
CaliforniaPaidFamilyLeave.com

The EDD is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Requests for services, aids, and/or alternate formats need to be made by calling 1-866-490-8879 (voice). TTY users, please call the California Relay Service at 711.



CALIFORNIA PAID FAMILY LEAVE

Helping Californians be present for the moments that matter.



Do I Qualify For California Paid Family Leave?

To qualify for Paid Family Leave benefits, **you must meet** the following requirements:

- Need to take time off from work to care for a seriously ill family member or to bond with a new child.
- Be covered by State Disability Insurance (or a voluntary plan in lieu of State Disability Insurance).
- Have earned at least \$300 in the past 5 to 18 months.
- Submit your claim no later than 41 days after you begin your family leave. Do not file before your first day of leave.

If required by your employer, you must use up to two weeks of unused vacation leave or paid time off. Check with your human resources department to confirm your employer's requirements.

How Are Benefit Amounts Calculated?

California Paid Family Leave provides approximately 60 to 70 percent of your weekly salary (from \$50 up to \$1,300 weekly).

The benefit amount is calculated from your highest quarterly earnings over the past 5 to 18 months, before the start of your claim. The Employment Development Department (EDD) has an online calculator that can help you estimate your weekly benefit amount. Visit the [Disability Insurance and Paid Family Leave Calculator \(edd.ca.gov/PFL_Calculator\)](https://edd.ca.gov/PFL_Calculator) to estimate your benefit.

If you are found eligible to receive benefits, you have an option on how you receive your benefit payments: by the EDD Debit CardSM through Bank of America or by check, mailed from the EDD.



Does Paid Family Leave Provide Job Protection?

California Paid Family Leave does not provide job protection or a right to return to work.

However, job protection may be provided under other laws such as the federal Family and Medical Leave Act, the California Family Rights Act, or the New Parent Leave Act (if you qualify).

Notify your employer of your plan to take leave and the reason for taking leave according to your company's policy.

How Do I Apply For Benefits?

Apply for Paid Family Leave benefits by visiting [SDI Online \(edd.ca.gov/SDI_Online\)](https://edd.ca.gov/SDI_Online).

You may also apply using a paper form. Visit [EDD Forms and Publications \(edd.ca.gov/Forms\)](https://edd.ca.gov/Forms) to request a *Claim for Paid Family Leave (PFL) Benefits* (DE 2501F) form.

For caregiving claims, you must provide medical certification showing that the care recipient has a serious health condition and requires your care. This needs to be completed by the care recipient's physician/practitioner. Information about the care recipient and their signature are also required.

For bonding claims, you must provide documentation showing proof of relationship between you and the child (e.g., a copy of the child's birth certificate, adoptive placement agreement, or foster care placement record).

If you are currently receiving pregnancy-related Disability Insurance benefits, it is not necessary to request a Paid Family Leave claim form. The form to file for bonding will be sent through your SDI Online account or by mail when your pregnancy-related disability claim ends.

If you are covered by a voluntary plan, contact your employer for information about your coverage and instructions on how to apply for benefits.

If your claim is denied, you have the right to:

- Know the reason for denial.
- Appeal decisions about your eligibility for benefits. Visit [Appeals \(edd.ca.gov/Disability/Appeals.htm\)](https://edd.ca.gov/Disability/Appeals.htm) for information.

All claim information is confidential except for purposes allowed by law.

DI Office Locations and Mailing Addresses

- Chico 645 Salem Street
(PO Box 8190, Chico, CA 95927-8190)
- Chino Hills ... 15315 Fairfield Ranch Road, Ste. 100
(PO Box 60006, City of Industry, CA 91716-0006)
- Fresno 2555 S. Elm Avenue
(PO Box 32, Fresno, CA 93707-0032)
- Long Beach ... 4300 Long Beach Blvd., Ste. 600
(PO Box 469, Long Beach, CA 90801-0469)
- Los Angeles 888 S. Figueroa Street, Ste. 200
(PO Box 513096, Los Angeles, CA 90051-1096)
- Oakland 7677 Oakport Street, Ste. 325
(PO Box 1857, Oakland, CA 94606-1857)
- Sacramento 5009 Broadway
(PO Box 13140, Sacramento, CA 95813-3140)
- San Bernardino 371 West 3rd Street
(PO Box 781, San Bernardino, CA 92402-0781)
- San Diego ... 9246 Lightwave Avenue, Bldg. A, Ste. 300
(PO Box 120831, San Diego, CA 92112-0831)
- San Francisco 745 Franklin Street, Rm. 300
(PO Box 193534, San Francisco, CA 94119-3534)
- San Jose..... 297 West Hedding Street
(PO Box 637, San Jose, CA 95106-0637)
- Santa Ana 2 MacArthur Place, Suite 400
(PO Box 1466, Santa Ana, CA 92702-1466)
- Santa Barbara 128 East Ortega Street
(PO Box 1529, Santa Barbara, CA 93102-1529)
- Santa Rosa 606 Healdsburg Avenue
(PO Box 700, Santa Rosa, CA 95402-0700)
- Stockton 3127 Transworld Dr., Ste. 150
(PO Box 201006, Stockton, CA 95201-9006)
- California State Government Employees
(PO Box 2168, Stockton, CA 95201-2168)
- Van Nuys 15400 Sherman Way, Rm. 500
(PO Box 10402, Van Nuys, CA 91410-0402)



STATE OF CALIFORNIA

LABOR AND WORKFORCE DEVELOPMENT AGENCY

EMPLOYMENT DEVELOPMENT DEPARTMENT

*This pamphlet is for general information only,
and does not have the force and effect of the law,
rule or regulation.*

The EDD is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Requests for services, aids, and/or alternate formats need to be made by calling DI at 1-866-490-8879 (voice), or through the California Relay Services at 711.



DISABILITY
INSURANCE
PROVISIONS



Disability is an illness or injury, either physical or mental, which prevents customary work. Disability includes elective surgery, pregnancy, childbirth, or related medical conditions.

Disability Insurance (DI) is a component of the State Disability Insurance (SDI) program, designed to partially replace wages lost due to a non-work-related disability (see “Other Programs,” for job-related disabilities).

SDI contributions are paid by California workers covered by the SDI program. Contribution rates may vary from year to year. For current rates, visit the DI website at www.edd.ca.gov/disability, or contact the Employment Development Department (EDD) Disability Insurance customer service at 1-800-480-3287 or EDD employment tax customer service at 1-888-745-3886.

DI Plans

- State Plan. The DI state plan is covered in this brochure.
- Voluntary Plan (VP). A private plan, approved by the Director of the EDD, which may be substituted for the State Plan. Voluntary Plans may be established if the employer and majority of employees agree to do so. VP information and filing a claim may be done through your employer. If you are covered by a VP, the provisions of this brochure may not apply to you. Obtain information about your coverage and file a VP claim through your employer.
- Elective Coverage (EC). Employers and self-employed persons, including general partners, may elect coverage. The method of computing benefits for EC participants is not the same as for mandatory rate payers. The cost of participating, which is set annually, can be obtained from your local EDD Employment Tax Customer Service Office.

EC claims are filed in the same manner as State Plan claims; however, there are some differences in eligibility requirements from those listed in this pamphlet.

- For additional information or to apply for coverage, contact EDD DI customer service at 1-800-480-3287, EDD employment tax customer service at 1-888-745-3886, or visit our website at www.edd.ca.gov/disability.

- How to Claim State Plan Benefits**
1. Use **SDI Online** to securely file for benefits or request a paper claim form online.
 - By Internet: www.edd.ca.gov/disability.
 - By phone: **1-800-480-3287**.
 - By mail: EDD, Disability Insurance, PO Box 989777, West Sacramento, CA 95798-9777.
 - In person by visiting any of the DI offices listed under “DI Office Locations.”
 - California state government employees covered by SDI should call **1-866-352-7675**.
 2. When filing using SDI Online, complete all required fields. A receipt number will be generated when your claim is submitted.

If using a paper *Claim for Disability Insurance (DI) Benefits* (DE 2501) form, complete and sign Part A-Claimant’s Statement. Print clearly, and verify your answers are complete and correct as errors delay payment.
 3. Have your physician/practitioner complete the Part B - Physician/Practitioner’s Certificate online or use the paper claim form. If filing online, your physician/practitioner will need your receipt number to complete the Part B - Physician/Practitioner’s Certificate.

Usually a claim cannot begin more than seven days before you were examined by or under the care of a physician/practitioner. Certification may be made by a licensed medical or osteopathic physician and surgeon, nurse practitioner, physician assistant, chiropractor, dentist, podiatrist, optometrist, designated psychologist, or an authorized medical officer of a United States government facility. Certification may also be made by a licensed nurse-midwife or licensed midwife for disabilities related to normal pregnancy or childbirth.
 4. File online or submit your paper claim form within 49 days from the date your disability begins. If your claim is late, you may lose benefits unless your explanation of the delay is accepted as reasonable.

How Benefits Are Paid

- You have an option on how you receive benefit payments. If you are eligible to receive benefits, the EDD issues benefit payments by the EDD Debit CardSM through Bank of America or by check, mailed from the EDD. You do not have to accept the EDD Debit Card. Please allow 7 to 10 days for delivery of checks in the mail.
- Most properly completed claims are processed within 14 days.
- The first seven days of your DI claim are a non-payable waiting period. If a claim is filed for the same or related cause or condition within 60 days of the initial claim, it will be processed as a continuation of the initial claim for which a waiting period was already served. There will not be a new waiting period in such cases.

Benefits are paid as quickly as possible after all information to determine eligibility is received. If you meet all eligibility requirements, benefits will be authorized. If you are eligible for further benefits, you will be authorized for additional benefits electronically or sent a *Claim For Continued Disability Benefits* (DE 2500A) certification form for you to complete for the next benefit period. Usually these benefit periods are for two-week intervals. However, DI pays benefits based on daily eligibility within a seven-day calendar week. Partial weeks are paid at a daily rate. This rate is one-seventh of your weekly benefit amount. Please allow 10 days from the date you mail or electronically submit a certification for receipt of payment.

How Your Benefit Rate is Determined

Benefit amounts are based on wages paid during a specific 12-month **base period**, determined by the date your claim begins. Consider when to start your claim since this may affect your weekly benefit rate, your maximum benefit amount, and the period of your benefit eligibility. Only **base period** wages subject to the SDI contributions can be used in computing your benefits. To qualify, you must have earned at least \$300 during your base period. The month your claim begins determines which four consecutive quarters are used.

If your claim begins in:

- **January, February, or March, your base period is the 12 months ending last September 30.** (Example: A claim beginning February 14, 2017, uses a base period of October 1, 2015, through September 30, 2016.)
- **April, May, or June, your base period is the 12 months ending last December 31.** (Example: A claim beginning June 20, 2017, uses a base period of January 1, 2016, through December 31, 2016.)
- **July, August, or September, your base period is the 12 months ending last March 31.** (Example: A claim beginning September 27, 2017, uses a base period of April 1, 2016, through March 31, 2017.)
- **October, November, or December, your base period is the 12 months ending last June 30.** (Example: A claim beginning November 2, 2017, uses a base period of July 1, 2016, through June 30, 2017.)

Exceptions: If your claim is determined to be invalid, but you were unemployed and seeking work for 60 days or more in any quarter of your base period, you may be able to substitute wages paid in prior quarters.

You may be entitled to substitute wages paid in prior quarters to either validate your claim or increase your benefit amount, if during your base period you:

- Were in the military service.
- Received workers’ compensation benefits.
- Did not work because of a labor dispute.

If your situation fits any of the above, include a letter and supporting documentation with your claim form.

Wage Continuation. If your employer continues to pay you wages during your DI claim, your DI benefits may be affected. DI benefits plus wages cannot exceed your regular weekly wage. DI benefits are not affected by vacation pay you may receive.

Maximum Benefits. The maximum benefit amount is 52 times the weekly rate, but not more than your total base period wages. Exception: For employers and self-employed individuals who elect SDI coverage, the maximum benefit amount is 39 times the weekly rate.

Additionally, benefits are payable only for a limited period to a resident in an alcoholic recovery home or drug-free residential facility that is both licensed and certified by the state in which the facility is located. However, disabilities related to or caused by acute or chronic alcoholism or drug abuse, being medically treated, do not have this limitation.

Pregnancy. As with any medical condition, your disability period begins the first day you are unable to do your regular or customary work. DI benefits are based on the period of time your physician/practitioner certifies you are unable to do your regular or customary work. Do not send in your claim for pregnancy-related DI benefits until the date your physician/practitioner certifies you are unable to work.

NOTE: For information on Paid Family Leave (PFL) bonding benefits, see the “Other Programs” section of this brochure.

You May Not be Eligible for Benefits

- If you are receiving Unemployment Insurance or PFL benefits.
- If you are not working or looking for work at the time your disability begins.
- If you are in custody due to conviction of a crime.
- If your full wages are paid.
- If you are receiving workers’ compensation at a weekly rate equal to or greater than the DI rate. If workers’ compensation benefits are paid at a lower rate than your DI rate, you may be paid the difference.
- For the amount of time a claim is late (without good cause).
- If you make a false statement or fail to report a material fact. (A 30 percent penalty may be assessed if benefits are overpaid because you willfully withheld a material fact or made a false statement.)
- If you fail to attend an independent medical examination when requested. (Fees for such examinations are paid by the EDD.)

The California Unemployment Insurance Code provides for penalties consisting of fines, imprisonment, and loss of benefit rights for fraud against the SDI program.

Your Rights. You are entitled to:

- Know the reason and basis for any decision that affects your benefits.
- Appeal any decision about your eligibility for benefits. (Appeals must be sent to the DI office in writing.)
- Request an appeal hearing before an Administrative Law Judge (ALJ). You may further appeal the ALJ’s decision to the California Unemployment Insurance Appeals Board and the courts.
- Privacy – all claim information will be kept confidential except for the purposes allowed by law.

Your Obligations. Your responsibilities:

- Complete your claim and other forms correctly, completely, and truthfully.
- Submit your claim and other forms according to time limits on forms. If your claim is submitted late and you believe you have a good reason for being late, you should include a written explanation of the reason(s) with the form.
- Contact DI if you do not understand a question or how to answer it.
- Include your name and claim identification number on letters to DI.

Contact DI

- By **email** at <https://askedd.edd.ca.gov>.
- By phone at:
 - English 1-800-480-3287
 - Spanish 1-866-658-8846
- By **U.S. mail** addressed to PO Box 13140, Sacramento, CA 95813-3140. If you do not have a current claim, you may write to any DI office. Note: Do not mail claim forms to this PO Box.
- By **TTY** (teletypewriter for deaf, hearing-impaired, and speech-impaired persons only) at 1-800-563-2441.
- **In person** by visiting any of the DI offices listed under “DI Office Locations.”

Other Programs

If you are injured on the job or become ill as a result of your occupation, notify your employer.

If you are able and available to work but unemployed, contact the Unemployment Insurance program of the EDD through the website at www.edd.ca.gov/unemployment, or by phone at 1-800-300-5616 (TTY 1-800-815-9387).

If you need help in finding work, job training, retraining, or other services in order to return to work, visit your local America’s Job Center of CaliforniaSM formerly known as One-Stop Career Centers listed at www.servicelocator.org, or in the white pages of your phone directory.

If your disability is permanent or is expected to continue for a year or more, contact the U.S. Social Security Administration at www.ssa.gov, or by phone at 1-800-772-1213 (TTY 1-800-325-0778).

If you take time off work to care for a family member or if you take time off from work to bond with a new child, including newly adopted, newly placed foster children, or those of your registered domestic partner, contact the EDD PFL program at www.edd.ca.gov/disability, or by phone at 1-877-238-4373, or through the California Relay Service at 711.

Note: A PFL bonding claim form will be sent automatically with the final benefit payment to new mothers receiving DI benefits.

If you are a victim of a crime, contact the California Victim Compensation program at 1-800-777-9229 (TTY 1-800-735-2929). You may also contact your county Victim/Witness Assistance Center.

Questions about spousal or parental support obligations should be directed to the district attorney’s office for the county that issued the court order.

Questions about child support obligations should be directed to the Department of Child Support Services at 1-866-901-3212 (TTY 1-866-399-4096).



SEXUAL HARASSMENT

THE FACTS

Sexual harassment is a form of discrimination based on sex/ gender (including pregnancy, childbirth, or related medical conditions), gender identity, gender expression, or sexual orientation. Individuals of any gender can be the target of sexual harassment. Unlawful sexual harassment does not have to be motivated by sexual desire. Sexual harassment may involve harassment of a person of the same gender as the harasser, regardless of either person's sexual orientation or gender identity.

THERE ARE TWO TYPES OF SEXUAL HARASSMENT

- ① *"Quid pro quo"* (Latin for "this for that") sexual harassment is when someone conditions a job, promotion, or other work benefit on your submission to sexual advances or other conduct based on sex.
- ② *"Hostile work environment"* sexual harassment occurs when unwelcome comments or conduct based on sex unreasonably interfere with your work performance or create an intimidating, hostile, or offensive work environment. You may experience sexual harassment even if the offensive conduct was not aimed directly at you.

The harassment must be severe or pervasive to be unlawful. That means that it alters the conditions of your employment and creates an abusive work environment. A single act of harassment may be sufficiently severe to be unlawful.

BEHAVIORS THAT MAY BE SEXUAL HARASSMENT:

- 1 *Unwanted sexual advances*
- 2 *Offering employment benefits in exchange for sexual favors*
- 3 *Leering; gestures; or displaying sexually suggestive objects, pictures, cartoons, or posters*
- 4 *Derogatory comments, epithets, slurs, or jokes*
- 5 *Graphic comments, sexually degrading words, or suggestive or obscene messages or invitations*
- 6 *Physical touching or assault, as well as impeding or blocking movements*

Actual or threatened retaliation for rejecting advances or complaining about harassment is also unlawful.

Employees or job applicants who believe that they have been sexually harassed or retaliated against may file a complaint of discrimination with DFEH within one year of the last act of harassment or retaliation. DFEH serves as a neutral fact-finder and attempts to help the parties voluntarily resolve disputes. If DFEH finds sufficient evidence to establish that discrimination occurred and settlement efforts fail, the Department may file a civil complaint in state or federal court to address the causes of the discrimination and on behalf of the complaining party. DFEH may seek court orders changing the employer's policies and practices, punitive damages, and attorney's fees and costs if it prevails in litigation. Employees can also pursue the matter through a private lawsuit in civil court after a complaint has been filed with DFEH and a Right-to-Sue Notice has been issued.

If you have a disability that prevents you from submitting a written pre-complaint form on-line, by mail, or email, the DFEH can assist you by scribing your pre-complaint by phone or, for individuals who are Deaf or Hard of Hearing or have speech disabilities, through the California Relay Service (711), or call us through your VRS at (800) 884-1684 (voice).

To schedule an appointment, contact the Communication Center at (800) 884-1684 (voice or via relay operator 711) or (800) 700-2320 (TTY) or by email at contact.center@dfeh.ca.gov.

The DFEH is committed to providing access to our materials in an alternative format as a reasonable accommodation for people with disabilities when requested.

Contact the DFEH at (800) 884-1684 (voice or via relay operator 711), TTY (800) 700-2320, or contact.center@dfeh.ca.gov to discuss your preferred format to access our materials or webpages.

FOR MORE INFORMATION

Department of Fair Employment and Housing

Toll Free: (800) 884-1684

TTY: (800) 700-2320

Online: www.dfeh.ca.gov

Also find us on:



EMPLOYER RESPONSIBILITY & LIABILITY

All employers, regardless of the number of employees, are covered by the harassment provisions of California law. Employers are liable for harassment by their supervisors or agents. All harassers, including both supervisory and non-supervisory personnel, may be held personally liable for harassment or for aiding and abetting harassment. The law requires employers to take reasonable steps to prevent harassment. If an employer fails to take such steps, that employer can be held liable for the harassment. In addition, an employer may be liable for the harassment by a non-employee (for example, a client or customer) of an employee, applicant, or person providing services for the employer. An employer will only be liable for this form of harassment if it knew or should have known of the harassment, and failed to take immediate and appropriate corrective action.

Employers have an affirmative duty to take reasonable steps to prevent and promptly correct discriminatory and harassing conduct, and to create a workplace free of harassment.

A program to eliminate sexual harassment from the workplace is not only required by law, but it is the most practical way for an employer to avoid or limit liability if harassment occurs.

ALL EMPLOYERS MUST TAKE THE FOLLOWING ACTIONS TO PREVENT HARASSMENT AND CORRECT IT WHEN IT OCCURS:

- ① Distribute copies of this brochure or an alternative writing that complies with Government Code 12950. This pamphlet may be duplicated in any quantity.
- ② Post a copy of the Department's employment poster entitled "California Law Prohibits Workplace Discrimination and Harassment."
- ③ Develop a harassment, discrimination, and retaliation prevention policy in accordance with 2 CCR 11023. The policy must:
 - Be in writing.
 - List all protected groups under the FEHA.
 - Indicate that the law prohibits coworkers and third parties, as well as supervisors and managers with whom the employee comes into contact, from engaging in prohibited harassment.
 - Create a complaint process that ensures confidentiality to the extent possible; a timely response; an impartial and timely investigation by qualified personnel; documentation and tracking for reasonable progress; appropriate options for remedial actions and resolutions; and timely closures.
 - Provide a complaint mechanism that does not require an employee to complain directly to their immediate supervisor. That complaint mechanism must include, but is not limited to including: provisions for direct communication, either orally or in writing, with a

designated company representative; and/or a complaint hotline; and/or access to an ombudsperson; and/or identification of DFEH and the United States Equal Employment Opportunity Commission as additional avenues for employees to lodge complaints.

- Instruct supervisors to report any complaints of misconduct to a designated company representative, such as a human resources manager, so that the company can try to resolve the claim internally. Employers with 50 or more employees are required to include this as a topic in mandated sexual harassment prevention training (see 2 CCR 11024).
 - Indicate that when the employer receives allegations of misconduct, it will conduct a fair, timely, and thorough investigation that provides all parties appropriate due process and reaches reasonable conclusions based on the evidence collected.
 - Make clear that employees shall not be retaliated against as a result of making a complaint or participating in an investigation.
- ④ Distribute its harassment, discrimination, and retaliation prevention policy by doing one or more of the following:
 - Printing the policy and providing a copy to employees with an acknowledgement form for employees to sign and return.
 - Sending the policy via email with an acknowledgment return form.
 - Posting the current version of the policy on a company intranet with a tracking system to ensure all employees have read and acknowledged receipt of the policy.
 - Discussing policies upon hire and/or during a new hire orientation session.
 - Using any other method that ensures employees received and understand the policy.
 - ⑤ If the employer's workforce at any facility or establishment contains ten percent or more of persons who speak a language other than English as their spoken language, that employer shall translate the harassment, discrimination, and retaliation policy into every language spoken by at least ten percent of the workforce.
 - ⑥ In addition, employers who do business in California and employ 50 or more part-time or full-time employees must provide at least two hours of sexual harassment training every two years to each supervisory employee and to all new supervisory employees within six months of their assumption of a supervisory position.

CIVIL REMEDIES

- 1 *Damages for emotional distress from each employer or person in violation of the law*
- 2 *Hiring or reinstatement*
- 3 *Back pay or promotion*
- 4 *Changes in the policies or practices of the employer*

**EMPLOYERS MUST PROVIDE THIS INFORMATION TO NEW WORKERS
WHEN HIRED AND TO OTHER WORKERS WHO ASK FOR IT**

**RIGHTS OF VICTIMS OF DOMESTIC VIOLENCE,
SEXUAL ASSAULT AND STALKING**

Your Right to Take Time Off:

- You have the right to take time off from work to get help to protect you and your children's health, safety or welfare. You can take time off to get a restraining order or other court order.
- If your company has 25 or more workers, you can take time off from work to get medical attention or services from a domestic violence shelter, program or rape crisis center, psychological counseling, or receive safety planning related to domestic violence, sexual assault, or stalking.
- You may use available vacation, personal leave, accrued paid sick leave or compensatory time off for your leave unless you are covered by a union agreement that says something different. Even if you don't have paid leave, you still have the right to time off.
- In general, you don't have to give your employer proof to use leave for these reasons.
- If you can, you should tell your employer before you take time off. Even if you cannot tell your employer before, your employer cannot discipline you if you give proof explaining the reason for your absence within a reasonable time. Proof can be a police report, court order or doctor's or counselor's note or similar document.

Your Right to Reasonable Accommodation:

- You have the right to ask your employer for help or changes in your workplace to make sure you are safe at work. Your employer must work with you to see what changes can be made. Changes in the workplace may include putting in locks, changing your shift or phone number, transferring or reassigning you, or help with keeping a record of what happened to you. Your employer can ask you for a signed statement certifying that your request is for a proper purpose, and may also request proof showing your need for an accommodation. Your employer cannot tell your coworkers or anyone else about your request.

Your Right to Be Free from Retaliation and Discrimination:

Your employer cannot treat you differently or fire you because:

- You are a victim of domestic violence, sexual assault, or stalking.
- You asked for leave time to get help.
- You asked your employer for help or changes in the workplace to make sure you are safe at work.

You can file a complaint with the Labor Commissioner's Office against your employer if he/she retaliates or discriminates against you.

For more information, contact the California Labor Commissioner's Office. We can help you by phone at 213-897-6595, or you can find a local office on our website: www.dir.ca.gov/dlse/DistrictOffices.htm. If you do not speak English, we will provide an interpreter in your language at no cost to you. This Notice explains rights contained in California Labor Code sections 230 and 230.1. Employers may use this Notice or one substantially similar in content and clarity.