NCCSC
North County Coastal Substitute Consortium
Cardiff • Del Mar • Encinitas
Rancho Santa Fe • Solana Beach

NEW SUBSTITUTE PAPERWORK

Thank you for serving as a substitute for the North County Coastal Substitute Consortium (NCCSC). We rely heavily on our substitute teachers and greatly appreciate the support you provide to our staff at all of the districts and schools within the NCCSC.

Please Note: The employment information you complete on each form will be given to the following districts within the NCCSC: Cardiff School District, Del Mar Union School District, Encinitas Union School District, Rancho Santa Fe School District, Solana Beach School District. Each District maintains their own payroll system and you will be paid by each school district you substitute for in the NCCSC.

Please complete in PEN or via PDF and be sure to use your name exactly as it is listed on your social security card.

SUBSTITUTE INFORMATION					
Last:		First:		Mid:	
Signature:			Date:		

PLEASE COMPLETE:

- ☐ Substitute Information Form
- ☐ Federal W-4 Form
- ☐ State DE4 Form
- ☐ I-9 Form*
- ☐ Social Security Form
- ☐ STRS Permissive Election*_____
- ☐ Voluntary Employee ID
- ☐ Designation of Beneficiary
- ☐ Oath or Affirmation
- ☐ Workers' Compensation
- ☐ Notification of Reasonable Assurance
- ☐ Acknowledgements
- ☐ Direct Deposit (Optional)*
- ☐ I-30 Form (For Retirees Only)

Please list other languages you speak fluently:

_____

Have you previously worked for NCCSC or any of its districts?

_____

Do you have children attending schools within NCCSC?

_____

Are you a student teacher within NCCSC?

_____

PLEASE PROVIDE:

- ☐ Drivers' License *(Original)*
- ☐ Social Security Card *(Signed Original)*
- ☐ TB Test Results *(Copy)*
- ☐ Completed I-30 Form *(Retirees Only)*

DISTRICT USE ONLY

- ☐ San Diego County Clearinghouse Fingerprints
- ☐ Cred/Permit _____ EXP…._____/_____/_____
- ☐ TB Test Expiration…….._____/_____/_____
- ☐ Orientation Date...……..._____/_____/_____
- ☐ Review & Sign Paperwork
- ☐ Add to Frontline: _____-TBD
- ☐ Add to Master List
- ☐ Scan to Electronic Files
- ☐ MAND & BBP Enrollment
- ☐ Enter in Payroll, 1st Sub Day…..._____/_____/_____
- ☐ Submit STRs or I-30
- ☐ Direct Deposit to Payroll
- ☐ Complete EDD
- ☐ EMPL ID: _____
- ☐ Removed from Pool……_____/_____/_____
- ☐ Reason: _____
- ☐ Last Day Worked……_____/_____/_____

***I-9:** Do NOT list a P.O. Box on this form.

***STRS Permissive Election:** As a certificated employee, you have the right of election into STRS even though you do not meet the mandatory enrollment requirement of 50% FTE or more or are not already a member of STRS. As an employer, we are required to enroll you as an employee into a retirement system either Social Security or STRS for all Certificated employees. STRS is now offering you the opportunity of electing membership in their STRS Defined Benefit Plan. If you do not elect membership in STRS, you will automatically be subject to Social Security coverage until such time that you qualify for mandatory enrollment into STRS. The election to membership in the STRS Defined Benefit Plan is irrevocable for all future employment to perform creditable service. This election may be cancelled only by terminating all creditable service and receiving a refund of accumulated employee's retirement contribution. For additional information about STRS, you may call STRS directly at 1-800-228-5453.

***Direct Deposit:** If you have multiple direct deposit accounts set up across San Diego County School Districts, the payroll system will look at all auto-deposits when paying you in any one district. Please verify all accounts are true & accurate and notify district immediately if account has been closed.

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SUBSTITUTE INFORMATION FORM

*Please Note, this form will be in place with the following school districts within the North County Coastal Substitute Consortium: Cardiff School District, Del Mar Union School District, Encinitas Union School District, Rancho Santa Fe School District, Solana Beach School District.

SUBSTITUTE INFORMATION					
Last:		First:		Middle:	
Address:		City, St:		Zip:	
Phone (Cell):		Phone (Home):			
Birthdate:	☐ Male ☐ Female	Email:			
☐ Single ☐ Married	Spouse's Name:				

EMERGENCY INFORMATION (In case of emergency, please contact…)					
First Name:		Last Name:			
Phone:		Relationship:			
Address:		City, St:		Zip:	

CALIFORNIA PUBLIC RETIREMENT SYSTEM

Are you currently a member of:

- ☐ STRS – State Teachers Retirement System (Certificated) - Monthly contribution of 10.25% of your salary.
- ☐ PERS – Public Employee Retirement System (Classified) - Monthly contribution of 7% of your salary.
- ☐ N/A – I am not a member of STRS or PERS.
- ☐ N/A – I am Retired.

IF YES:

Last Agency Served:		California County:	
Years of Service:		Were funds Withdrawn?	☐ No ☐ Yes, when? _____

The facts you have furnished as to your public agency retirement membership status are to enable the San Diego County Office of Education to determine and verify your retirement status with the retirement systems. Therefore, it is VERY important that you accurately complete this form. If you are a current member of STRS or PERS and have not indicated so on this form, you are immediately liable for retirement contributions not deducted from your earnings.

Employee's Signature Date

FOR DISTRICT USE ONLY					
First Sub Day:		Position:	**On-Call Substitute**		
Site:	**Various**			Hr/Wk:	**On-Call**
Salary Placement:	**CERTIFICATED: $125/Day (Day 1-10) $150/Day (After 10 Consecutive Days)**				

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

▶ **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.**

OMB No. 1545-0074

2020

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) ☐ **Single or Married filing separately**
☐ **Married filing jointly** (or Qualifying widow(er))
☐ **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)

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:
- $24,800 if you're married filing jointly or qualifying widow(er)
- $18,650 if you're head of household
- $12,400 if you're single or married filing separately

. . . . . **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

Clear Form

Employment Development Department
State of California

EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

Type or Print Your Full Name	Your Social Security Number
Home Address (Number and Street or Rural Route)	Filing Status Withholding Allowances ☐ SINGLE or MARRIED (with two or more incomes) ☐ MARRIED (one income) ☐ HEAD OF HOUSEHOLD
City, State, and ZIP Code	

1. Number of allowances for Regular Withholding Allowances, Worksheet A: 0
   Number of allowances from the Estimated Deductions, Worksheet B: 0
   Total Number of Allowances (A + B) when using the California Withholding Schedules for 2019: 0

   OR

2. Additional amount of state income tax to be withheld each pay period (if employer agrees), Worksheet C: _____

   OR

3. I certify under penalty of perjury that I am not subject to California withholding. I meet the conditions set forth under the Service Member Civil Relief Act, as amended by the Military Spouses Residency Relief Act. (Check box here) ☐

Under the penalties of perjury, I certify that the number of withholding allowances claimed on this certificate does not exceed the number to which I am entitled or, if claiming exemption from withholding, that I am entitled to claim the exempt status.

Signature _____ Date _____

Employer's Name and Address	California Employer Payroll Tax Account Number

cut here

Give the top portion of this page to your employer and keep the remainder for your records.

YOUR CALIFORNIA PERSONAL INCOME **TAX MAY BE UNDERWITHHELD** IF YOU DO NOT FILE THIS DE 4 FORM.

IF YOU RELY ON THE FEDERAL FORM W-4 FOR YOUR CALIFORNIA WITHHOLDING ALLOWANCES, YOUR CALIFORNIA STATE PERSONAL INCOME TAX MAY BE UNDERWITHHELD AND YOU MAY OWE MONEY AT THE END OF THE YEAR.

PURPOSE: This certificate, DE 4, is for **California Personal Income Tax (PIT) withholding** purposes only. The DE 4 is used to compute the amount of taxes to be withheld from your wages, by your employer, to accurately reflect your state tax withholding obligation.

You should complete this form if either:

(1) You claim a different marital status, number of regular allowances, or different additional dollar amount to be withheld for California PIT withholding than you claim for federal income tax withholding or,

(2) You claim additional allowances for estimated deductions.

THIS FORM WILL NOT CHANGE YOUR FEDERAL WITHHOLDING ALLOWANCES.

The federal Form W-4 is applicable for California withholding purposes if you wish to claim the same marital status, number of regular allowances, and/or the same additional dollar amount to be withheld for state and federal purposes. However, federal tax brackets and withholding methods do not reflect state PIT withholding tables. **If you rely on the number of withholding allowances you claim on your Form W-4 withholding allowance certificate for your state income tax withholding, you may be significantly underwithheld.** This is particularly true if your household income is derived from more than one source.

CHECK YOUR WITHHOLDING: After your Form W-4 and/or DE 4 takes effect, compare the state income tax withheld with your estimated total annual tax. For state withholding, use the worksheets on this form.

EXEMPTION FROM WITHHOLDING: If you wish to claim exempt, complete the federal Form W-4. You may claim exempt from withholding California income tax if you did not owe any federal income tax last year and you do not expect to owe any federal income tax this year. The exemption is good for one year. If you continue to qualify for the exempt filing status, a new Form W-4 designating EXEMPT must be submitted by February 15 each year to continue your exemption. If you are not having federal income tax withheld this year but expect to have a tax liability next year, you are required to give your employer a new Form W-4 by December 1.

EXEMPTION FROM WITHHOLDING (continued): Under the Service Member Civil Relief Act, as amended by the Military Spouses Residency Relief Act, you may be exempt from California income tax on your wages if (i) your spouse is a member of the armed forces present in California in compliance with military orders; (ii) you are present in California solely to be with your spouse; and (iii) you maintain your domicile in another state. If you claim exemption under this act, check the box on Line 3. You may be required to provide proof of exemption upon request.

IF YOU NEED MORE DETAILED INFORMATION, SEE THE INSTRUCTIONS THAT CAME WITH YOUR LAST CALIFORNIA RESIDENT INCOME TAX RETURN OR CALL THE FRANCHISE TAX BOARD (FTB).

IF YOU ARE CALLING FROM WITHIN THE UNITED STATES	1-800-852-5711 (voice) 1-800-822-6268 (TTY)
IF YOU ARE CALLING FROM OUTSIDE THE UNITED STATES (Not Toll Free)	1-916-845-6500

The *California Employer's Guide,* DE 44, provides the income tax withholding tables. This publication may be found on the Employment Development Department (EDD) website at **www.edd.ca.gov/Payroll_Taxes/Forms_and_Publications.htm**. To assist you in calculating your tax liability, please visit the FTB website at **www.ftb.ca.gov/individuals/index.shtml**.

NOTIFICATION: If the IRS instructs your employer to withhold federal income tax based on a certain withholding status, your employer is required to use the same withholding status for state income tax withholding.

The burden of proof rests with the employee to show the correct California Income Tax Withholding. Pursuant to section 4340-1(e) of Title 22, California Code of Regulations (CCR), the FTB or the EDD may, by special direction in writing, require an employer to submit a Form W-4 or DE 4 when such forms are necessary for the administration of the withholding tax programs.

PENALTY: You may be fined $500 if you file, with no reasonable basis, a DE 4 that results in less tax being withheld than is properly allowable. In addition, criminal penalties apply for willfully supplying false or fraudulent information or failing to supply information requiring an increase in withholding. This is provided by section 13101 of the California Unemployment Insurance Code and section 19176 of the Revenue and Taxation Code.

INSTRUCTIONS — 1 — ALLOWANCES*

When determining your withholding allowances, you must consider your personal situation:
— Do you claim allowances for dependents or blindness?
— Will you itemize your deductions?
— Do you have more than one income coming into the household?

TWO-EARNERS/MULTIPLE INCOMES: When earnings are derived from more than one source, underwithholding may occur. If you have a working spouse or more than one job, it is best to check the box "SINGLE or MARRIED (with two or more incomes)." Figure the total number of allowances you are entitled to claim on all jobs using only one DE 4 form. Claim allowances with **one** employer. Do **not** claim the same allowances with more than one employer. Your withholding will usually be most accurate when all allowances are claimed on the DE 4 or Form W-4 filed for the highest paying job and zero allowances are claimed for the others.

MARRIED BUT NOT LIVING WITH YOUR SPOUSE: You may check the "Head of Household" marital status box if you meet all of the following tests:
(1) Your spouse will not live with you **at any time** during the year;
(2) You will furnish over half of the cost of maintaining a home for the entire year for yourself and your child or stepchild who qualifies as your dependent; **and**
(3) You will file a separate return for the year.

HEAD OF HOUSEHOLD: To qualify, you must be unmarried or legally separated from your spouse and pay more than 50% of the costs of maintaining a home for the **entire** year for yourself and your dependent(s) or other qualifying individuals. Cost of maintaining the home includes such items as rent, property insurance, property taxes, mortgage interest, repairs, utilities, and cost of food. It does not include the individual's personal expenses or any amount which represents value of services performed by a member of the household of the taxpayer.

WORKSHEET A — REGULAR WITHHOLDING ALLOWANCES

(A)	Allowance for yourself — enter 1	(A)
(B)	Allowance for your spouse (if not separately claimed by your spouse) — enter 1	(B)
(C)	Allowance for blindness — yourself — enter 1	(C)
(D)	Allowance for blindness — your spouse (if not separately claimed by your spouse) — enter 1	(D)
(E)	Allowance(s) for dependent(s) — do not include yourself or your spouse	(E)
(F)	Total — add lines (A) through (E) above	(F) 0

INSTRUCTIONS — 2 — ADDITIONAL WITHHOLDING ALLOWANCES

If you expect to itemize deductions on your California income tax return, you can claim additional withholding allowances. Use Worksheet B to determine whether your expected estimated deductions may entitle you to claim one or more additional withholding allowances. Use last year's FTB Form 540 as a model to calculate this year's withholding amounts.

Do not include deferred compensation, qualified pension payments, or flexible benefits, etc., that are deducted from your gross pay but are not taxed on this worksheet.

You may reduce the amount of tax withheld from your wages by claiming one additional withholding allowance for each $1,000, or fraction of $1,000, by which you expect your estimated deductions for the year to exceed your allowable standard deduction.

WORKSHEET B — ESTIMATED DEDUCTIONS

1.	Enter an estimate of your itemized deductions for California taxes for this tax year as listed in the schedules in the FTB Form 540		1.
2.	Enter $8,802 if married filing joint with two or more allowances, unmarried head of household, or qualifying widow(er) with dependent(s) or $4,401 if single or married filing separately, dual income married, or married with multiple employers	–	2.
3.	Subtract line 2 from line 1, enter difference	=	3. 0
4.	Enter an estimate of your adjustments to income (alimony payments, IRA deposits)	+	4.
5.	Add line 4 to line 3, enter sum	=	5. 0
6.	Enter an estimate of your nonwage income (dividends, interest income, alimony receipts)	–	6.
7.	If line 5 is greater than line 6 (if less, see below); Subtract line 6 from line 5, enter difference	=	7. 0
8.	Divide the amount on line 7 by $1,000, round any fraction to the nearest whole number Enter this number on line 1 of the DE 4. Complete Worksheet C, if needed.		8. 0
9.	If line 6 is greater than line 5; Enter amount from line 6 (nonwage income)		9.
10.	Enter amount from line 5 (deductions)		10. 0
11.	Subtract line 10 from line 9, enter difference **Complete Worksheet C**		11. 0

*Wages paid to registered domestic partners will be treated the same for state income tax purposes as wages paid to spouses for California PIT withholding and PIT wages. This law does not impact federal income tax law. A registered domestic partner means an individual partner in a domestic partner relationship within the meaning of section 297 of the Family Code. For more information, please call our Taxpayer Assistance Center at 1-888-745-3886.

WORKSHEET C **TAX WITHHOLDING AND ESTIMATED TAX**

1.	Enter estimate of total wages for tax year 2019	1.	
2.	Enter estimate of nonwage income (line 6 of Worksheet B)	2.	
3.	Add line 1 and line 2. Enter sum	3.	0
4.	Enter itemized deductions or standard deduction (line 1 or 2 of Worksheet B, whichever is largest)	4.	
5.	Enter adjustments to income (line 4 of Worksheet B)	5.	
6.	Add line 4 and line 5. Enter sum	6.	0
7.	Subtract line 6 from line 3. Enter difference	7.	0
8.	Figure your tax liability for the amount on line 7 by using the 2019 tax rate schedules below	8.	
9.	Enter personal exemptions (line F of Worksheet A x $129.80)	9.	0
10.	Subtract line 9 from line 8. Enter difference	10.	0
11.	Enter any tax credits. (See FTB Form 540)	11.	
12.	Subtract line 11 from line 10. Enter difference. This is your total tax liability	12.	0
13.	Calculate the tax withheld and estimated to be withheld during 2019. Contact your employer to request the amount that will be withheld on your wages based on the marital status and number of withholding allowances you will claim for 2019. Multiply the estimated amount to be withheld by the number of pay periods left in the year. Add the total to the amount already withheld for 2019	13.	
14.	Subtract line 13 from line 12. Enter difference. If this is less than zero, you do not need to have additional taxes withheld	14.	0
15.	Divide line 14 by the number of pay periods remaining in the year. Enter this figure on line 2 of the DE 4	15.	

NOTE: Your employer is not required to withhold the additional amount requested on line 2 of your DE 4. If your employer does not agree to withhold the additional amount, you may increase your withholdings as much as possible by using the "single" status with "zero" allowances. If the amount withheld still results in an underpayment of state income taxes, you may need to file quarterly estimates on Form 540-ES with the FTB to avoid a penalty.

THESE TABLES ARE FOR CALCULATING WORKSHEET C AND FOR 2019 ONLY

SINGLE PERSONS, DUAL INCOME MARRIED WITH MULTIPLE EMPLOYERS

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER . . .		PLUS
$0	$8,544 ...	1.100%	$0	$0.00
$8,544	$20,255 ...	2.200%	$8,544	$93.98
$20,255	$31,969 ...	4.400%	$20,255	$351.62
$31,969	$44,377 ...	6.600%	$31,969	$867.04
$44,377	$56,085 ...	8.800%	$44,377	$1,685.97
$56,085	$286,492 ...	10.230%	$56,085	$2,716.27
$286,492	$343,788 ...	11.330%	$286,492	$26,286.91
$343,788	$572,980 ...	12.430%	$343,788	$32,778.55
$572,980	$1,000,000 ...	13.530%	$572,980	$61,267.12
$1,000,000	and over...	14.630%	$1,000,000	$119,042.93

MARRIED FILING JOINT OR QUALIFYING WIDOW(ER) TAXPAYERS

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER . . .		PLUS
$0	$17,088 ...	1.100%	$0	$0.00
$17,088	$40,510 ...	2.200%	$17,088	$187.97
$40,510	$63,938 ...	4.400%	$40,510	$703.25
$63,938	$88,754 ...	6.600%	$63,938	$1,734.08
$88,754	$112,170 ...	8.800%	$88,754	$3,371.94
$112,170	$572,984 ...	10.230%	$112,170	$5,432.55
$572,984	$687,576 ...	11.330%	$572,984	$52,573.82
$687,576	$1,000,000 ...	12.430%	$687,576	$65,557.09
$1,000,000	$1,145,961 ...	13.530%	$1,000,000	$104,391.39
$1,145,961	and over	14.630%	$1,145,961	$124,139.90

UNMARRIED HEAD OF HOUSEHOLD

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER . . .		PLUS
$0	$17,099 ...	1.100%	$0	$0.00
$17,099	$40,512 ...	2.200%	$17,099	$188.09
$40,512	$52,224 ...	4.400%	$40,512	$703.18
$52,224	$64,632 ...	6.600%	$52,224	$1,218.51
$64,632	$76,343 ...	8.800%	$64,632	$2,037.44
$76,343	$389,627 ...	10.230%	$76,343	$3,068.01
$389,627	$467,553 ...	11.330%	$389,627	$35,116.96
$467,553	$779,253 ...	12.430%	$467,553	$43,945.98
$779,253	$1,000,000 ...	13.530%	$779,253	$82,690.29
$1,000,000	and over	14.630%	$1,000,000	$112,557.36

IF YOU NEED MORE DETAILED INFORMATION, SEE THE INSTRUCTIONS THAT CAME WITH YOUR LAST CALIFORNIA RESIDENT INCOME TAX RETURN OR CALL THE FTB:

IF YOU ARE CALLING FROM WITHIN THE UNITED STATES 1-800-852-5711 (voice)
1-800-822-6268 (TTY)

IF YOU ARE CALLING FROM OUTSIDE THE UNITED STATES
(Not Toll Free) 1-916-845-6500

The DE 4 information is collected for purposes of administering the PIT law and under the authority of Title 22, CCR, section 4340-1, and the California Revenue and Taxation Code, including section 18624. The Information Practices Act of 1977 requires that individuals be notified of how information they provide may be used. Further information is contained in the instructions that came with your last California resident income tax return.

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):

☐ 1. A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

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

Last Name *(Family Name)*	First Name *(Given Name)*

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

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

Additional Information

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

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

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

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative Substitute Consortium Coordinator
Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State / ZIP Code

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

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

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

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

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

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

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
1. U.S. Passport or U.S. Passport Card		**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		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**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		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**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. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (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.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		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:		
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		**10.** School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

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 Concerning Your Employment in a Job Not Covered by Social Security

Employee Name _____ **Employee ID#** _____

Employer Name Cardiff, Del Mar, Encinitas Rancho Santa Fe, Solana Beach **Employer ID#** _____

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

Windfall Elimination Provision

Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2013, the maximum monthly reduction in your Social Security benefit as a result of this provision is $395.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to Social Security Publication, “Windfall Elimination Provision.”

Government Pension Offset Provision

Under the Government Pension Offset Provision, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of $600 based on earnings that are not covered under Social Security, two-thirds of that amount, $400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a $500 widow(er) benefit, you will receive $100 per month from Social Security ($500 - $400=$100). Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to Social Security Publication, “Government Pension Offset.”

For More Information

Social Security publications and additional information, including information about exceptions to each provision, are available at www.socialsecurity.gov. You may also call toll free 1-800-772-1213, or for the deaf or hard of hearing call the TTY number 1-800-325-0778, or contact your local Social Security office.

I certify that I have received Form SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security Benefits.

Signature of Employee _____ **Date** _____

Information about Social Security Form SSA-1945 Statement Concerning Your Employment in a Job Not Covered by Social Security

New legislation [Section 419(c) of Public Law 108-203, the Social Security Protection Act of 2004] requires State and local government employers to provide a statement to employees hired January 1, 2005 or later in a job not covered under Social Security. The statement explains how a pension from that job could affect future Social Security benefits to which they may become entitled.

Form SSA-1945, **Statement Concerning Your Employment in a Job Not Covered by Social Security,** is the document that employers should use to meet the requirements of the law. The SSA-1945 explains the potential effects of two provisions in the Social Security law for workers who also receive a pension based on their work in a job not covered by Social Security. The Windfall Elimination Provision can affect the amount of a worker's Social Security retirement or disability benefit. The Government Pension Offset Provision can affect a Social Security benefit received as a spouse, surviving spouse, or an ex-spouse.

Employers must:

- Give the statement to the employee prior to the start of employment;
- Get the employee's signature on the form; and
- Submit a copy of the signed form to the pension paying agency.

Social Security will not be setting any additional guidelines for the use of this form.

Copies of the SSA-1945 are available online at the Social Security website, www.socialsecurity.gov/online/ssa-1945.pdf. Paper copies can be requested by email at ofsm.oswm.rqct.orders@ssa.gov or by fax at 410-965-2037. The request must include the name, complete address and telephone number of the employer. Forms will not be sent to a post office box. Also, if appropriate, include the name of the person to whom the forms are to be delivered. The forms are available in packages of 25. Please refer to Inventory Control Number (ICN) 276950 when ordering.

Permissive Membership-Instructions

If you are employed to perform creditable service in a position that is excluded from mandatory membership in the CalSTRS' Defined Benefit (DB) Program, you may use this form to elect DB Program membership at any time while employed to perform creditable service.

A permissive election of membership in the DB Program applies to all future creditable service performed for the same or another employer, including any non-member or CalSTRS Cash Balance Benefit (CB) Program service you are currently performing. You may be entitled to elect coverage by the CB Program or California Public Employees' Retirement System (CalPERS) for future eligible service as allowed by law. Please work with your employer if you believe you are entitled to make one of these elections.

A permissive election of membership in the DB Program is irrevocable. Membership may only be cancelled if you terminate all employment to perform creditable service and refund your accumulated retirement contributions from the CalSTRS DB Program.

SECTION 1: EMPLOYEE INFORMATION (TO BE COMPLETED BY EMPLOYEE)

Provide the following information:

- CalSTRS Client ID* or Social Security Number
- Last Name, First Name and Middle Initial
- Mailing Address**, City, State and Zip Code
- Date of Birth
- Email Address
- Telephone Number

*If you have already been employed to perform creditable service you will have a CalSTRS Client ID, even if you were not formerly a member. Please provide your CalSTRS Client ID, if you have one, in lieu of your Social Security Number.

**To establish residency for tax purposes, we ask that you provide a street address. Be sure to include any street, apartment or suite number. If your post office does not deliver mail to your street address, you may enter your box number instead. If you reside outside the United States, use the CITY – STATE – ZIP field to provide your foreign address. If you receive your mail in care of a third party, enter "c/o" followed by the third party's name and address.

SECTION 2: EMPLOYEE ELECTION (TO BE COMPLETED BY EMPLOYEE)

If you want to elect membership in the CalSTRS DB Program:

- Check the appropriate box
- Provide your requested membership date***

***You will begin contributing to the DB Program as of your membership date. Your membership date can be no earlier than the first day of the pay period in which your election is made, or your first day of employment, whichever is later. Work with your employer to select the most beneficial, valid membership date you are eligible for. Electing an invalid membership date will require a revision to your election form and may result in delayed contributions to CalSTRS.

If you do not want to elect membership in the CalSTRS DB Program at this time, check the appropriate box.

SECTION 3: REQUIRED SIGNATURE (TO BE COMPLETED BY EMPLOYEE)

Sign the form and date your signature.
Return the form to your employer.

SECTION 4: EMPLOYEE POSITION INFORMATION (TO BE COMPLETED BY EMPLOYER)

Provide the position hire date – the date in which the employee was hired to perform creditable service in the position they are making this election for. CalSTRS defers to the employer as to the date in which you consider an employee to be hired. Provide the position title – the title of the position the employee is performing creditable service in.

SECTION 5: EMPLOYER INFORMATION AND CERTIFICATION (TO BE COMPLETED BY EMPLOYER)

Verify the employee is eligible for the requested membership date.

Provide the following information:

- The employer (county or district) name
- County and district code
- Name and title of employer official completing the form

Sign the form and date your signature.
Submit the form to CalSTRS and retain a copy.

Permissive Membership
ES 0350 REV 03/20

[For CalSTRS' Official Use Only]

California State Teachers' Retirement System
P.O. Box 15275, MS 17
Sacramento, CA 95851-0275
800-228-5453
CalSTRS.com

PERMISSIVE MEMBERSHIP ELECTION AND/OR ACKNOWLEDGEMENT OF RECEIPT OF CALSTRS DEFINED BENEFIT PROGRAM MEMBERSHIP INFORMATION

This form is used to permissively elect membership in the CalSTRS Defined Benefit Program and/or to acknowledge receipt of information provided by an employer about the right to elect membership in the CalSTRS Defined Benefit Program. Please read all instructions before completing the form.

Section 1: Employee Information (to be completed by employee)

Provide either your CalSTRS Client ID or Social Security number.

CLIENT ID

SOCIAL SECURITY NUMBER

LAST NAME

FIRST NAME

MI

ADDRESS (number, street, apt or suite no.)

CITY

STATE

ZIP CODE

DATE OF BIRTH (MM/DD/YYYY)

EMAIL ADDRESS

TELEPHONE

Section 2: Employee Election (to be completed by employee)

Check One:

☐ **I elect membership in the CalSTRS Defined Benefit Program as of:** _____

MEMBERSHIP DATE (MM/DD/YYYY)**

I understand this election applies to all future creditable service performed for any current or future employer unless another election is made as allowed by law. I understand my membership is irrevocable and may only be cancelled by terminating all employment to perform creditable service and receiving a refund of my accumulated retirement contributions from the CalSTRS Defined Benefit Program.

**Membership Date may be no earlier than the first day of the pay period in which the election is made, or the first day of employment, whichever is later. Please work with your employer to select the most beneficial, valid membership date.

☐ **I decline membership in the CalSTRS Defined Benefit Program at this time**

I understand that I can elect membership in the CalSTRS Defined Benefit Program at any time while I am employed to perform creditable service.

ES0350

Section 3: Required Signature (to be completed by employee)

I certify that I have received information from my employer concerning the CalSTRS Defined Benefit Program and understand the criteria for membership in the program.

I understand it is a crime to fail to disclose a material fact or to make any knowingly false material statement, including a false statement regarding my marital status, for the purpose of using it, or allowing it to be used, to obtain, receive, continue, increase, deny or reduce any benefit administered by CalSTRS and it may result in penalties, including restitution, of up to one year in jail and/or a fine of up to $5,000 (Education Code section 22010). It may also result in any document containing such false representation being voided. I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I understand that perjury is punishable by imprisonment for up to four years (Penal Code section 126).

EMPLOYEE SIGNATURE	DATE (MM/DD/YYYY)

Section 4: Employee Position Information (to be completed by employer)

POSITION TITLE	POSITION HIRE DATE

Section 5: Employer Information and Certification (to be completed by employer)

Required Signature

I certify that the above-named employee was provided information about their right to elect membership in the CalSTRS Defined Benefit Program and, if electing membership, is eligible to elect membership in the CalSTRS Defined Benefit Program as of the membership date provided.

I understand it is a crime to fail to disclose a material fact or to make any knowingly false material statement for the purpose of using it, or allowing it to be used, to obtain, receive, continue, increase, deny or reduce any benefit administered by CalSTRS and it may result in penalties, including restitution, of up to one year in jail and/or a fine of up to $5,000 (Education Code section 22010). It may also result in any document containing such false representation being voided. I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I understand that perjury is punishable by imprisonment for up to four years (Penal Code section 126).

EMPLOYER OFFICIAL'S SIGNATURE	DATE (MM/DD/YYYY)
EMPLOYER NAME	COUNTY AND DISTRICT CODE
EMPLOYER OFFICIAL'S NAME AND TITLE	

NCCSC
North County Coastal Substitute Consortium
Cardiff • Del Mar • Encinitas
Rancho Santa Fe • Solana Beach

VOLUNTARY EMPLOYEE ID FORM

*Please Note, this form will be in place with the following school districts within the North County Coastal Substitute Consortium: Cardiff School District, Del Mar Union School District, Encinitas Union School District, Rancho Santa Fe School District, Solana Beach School District.

SUBSTITUTE INFORMATION					
Last:		First:		Middle:	
Title:	On-Call Substitute				
Gender:	☐ Male ☐ Female				

PART A – ETHNICITY *(Select only one)*

Are you Hispanic or Latino? *(The federal government definition of Hispanic/Latino is a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)*

☐ YES ☐ NO

PART B – RACE

(Regardless of your answer to Part A, you may select one of more of the following categories that apply to you.)

CATEGORY	DEFINITION OF CATEGORY
☐ American Indian or Alaska Native	A person having origins in any of the original peoples of North and South America (including Central America) who maintains cultural identification through tribal affiliation or community attachment.
Asian ☐ Asian Indian ☐ Korean ☐ Cambodian ☐ Laotian ☐ Chinese ☐ Vietnamese ☐ Filipino ☐ Other Asian ☐ Japanese	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
☐ Black or African American	A person having origins in any of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander ☐ Guamanian ☐ Samoan ☐ Hawaiian ☐ Other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Guamanian Samoa, or other Pacific Islands.
☐ White	A person having origins in any of the original people of Europe, the Middle Ear, or North Africa.

PART C

Handicapped/Disabled: ☐ YES ☐ NO	Indicate type & extent of handicap:	

Please check the box(es) which best describe how you received information regarding this position:

☐ Employee of NCCSC ☐ Work Site in NCCSC ☐ NCCSC Website ☐ edjoin.org
☐ Facebook ☐ Twitter ☐ Other: _____

The Equal Employment Opportunity Commission (EEOC) required organizations with 100 or more employees to invite applicants to self-identify gender and race and complete an EEO-1 report each year. Completion of this data is voluntary and will not affect your opportunity for employment, or terms or conditions of employment. This form will be used for EEO-1 reporting purposes only and will be kept separate from all other personnel records only accessed by the Human Resources department. Please return complete forms to the HR department.

NCCSC
North County Coastal Substitute Consortium
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EMPLOYEE'S DESIGNATION OF BENEFICIARY UNDER GOVERNMENT CODE SECTION 53245

*Please Note, this form will be in place with the following school districts within the North County Coastal Substitute Consortium: Cardiff School District, Del Mar Union School District, Encinitas Union School District, Rancho Santa Fe School District, Solana Beach School District.

This is to inform you that in the event of my death, I hereby designate the person listed below as the person entitled to receive and negotiate all warrants or checks that will be payable to me from the following districts in the North County Coastal Substitute Consortium: Cardiff School District, Del Mar Union School District, Encinitas Union School District, Rancho Santa Fe School District, Solana Beach School District.

Last:		First:		Middle:	
Address:		City, St:		Zip:	
Phone:	☐ Cell ☐ Home	Social Security:			
Date of Birth:	☐ Male ☐ Female	Place of Birth:			
Relationship:	☐ Spouse ☐ Parent ☐ Child ☐ Other (Please Specify): _____				
Email:					

I understand that it is my responsibility to keep this designation current, and further, I understand that this designation is in addition to, and separate from the beneficiary designation filed with the State Teachers Retirement System, the California Public Employees Retirement System, or any other will, codicils or like documents.

Last:		First:		Middle:	
Signature:			Date:		

Government Code Section 53245 States: "Any person now or hereafter employed by a county, city, municipal corporation, district, or other public agency may file with his appointing power a designation of a person who, notwithstanding any other provision of law, shall, on the death of the employee, be entitled to receive all warrants or checks that would have been payable to the decedent had he survived. The employee may change the designation from time to time. A person so designated shall claim such warrants or checks from the appointing power. On sufficient proof of identity, the appointing power shall deliver the warrants or checks to the claimant. A person who receives a warrant or check pursuant to this section is entitled to negotiate it as if he were the payee."

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OATH OR AFFIRMATION

*Please Note, this form will be in place with the following school districts within the North County Coastal Substitute Consortium: Cardiff School District, Del Mar Union School District, Encinitas Union School District, Rancho Santa Fe School District, Solana Beach School District.

I,					
Last:		First:		Middle:	

do solemnly swear (or affirm) that I will support and defend the Constitution of the United States and the Constitution of the State of California against all enemies, foreign and domestic; that I will bear true faith and allegiance to the Constitution of the United States and the Constitution of the State of California; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties upon which I am about to enter.

I further swear (or affirm) that I am a citizen of the United States of America.

I understand that as a public employee I am a disaster service worker pursuant to Government Code 3100 and 3102 and that I am required to take this oath before entering the duties of my employment. In the event of natural, manmade or war-caused emergencies which result in conditions of disaster or extreme peril to life, property and resources, I am subject to disaster services activities assigned to me by my supervisor.

Signature:		Date:	
CERTIFIED BY:			
Name:		Title:	**Substitute Consortium Coordinator**

Risk Management JPA
Fringe Benefits Consortium

SAN DIEGO COUNTY AND IMPERIAL COUNTY SCHOOLS

This is to acknowledge receipt of information regarding California Workers' Compensation laws and rights in addition to notice regarding the Medical Provider Network that my employer utilizes.

I HAVE READ THE ATTACHED INFORMATION AND UNDERSTAND MY RIGHTS AND BENEFITS UNDER THE WORKERS' COMPENSATION PROGRAM. I AGREE TO REPORT ALL WORK RELATED INJURIES AND ILLNESSES TO MY SUPERVISOR/EMPLOYER IMMEDIATELY AFTER THEY OCCUR.

EMPLOYEE NAME_____ **DATE**_____
(PLEASE PRINT)

EMPLOYEE SIGNATURE_____

DISTRICT: **CARDIFF SCHOOL DISTRICT**
DEL MAR UNION SCHOOL DISTRICT
ENCINITAS UNION SCHOOL DISTRICT
RANCHO SANTA FE SCHOOL DISTRICT
SOLANA BEACH SCHOOL DISTRICT

Risk Management JPA
Fringe Benefits Consortium

SAN DIEGO COUNTY AND IMPERIAL COUNTY SCHOOLS

EMPLOYEE NOTICE
WORKERS' COMPENSATION BENEFITS

This is to notify you of benefits, available to you through the California Workers' Compensation system.

Almost every employee in California is protected by workers' compensation laws, but there are a few exceptions. People in business for themselves, independent contractors, and unpaid volunteers may not be covered. Maritime workers and federal employees are covered by similar laws. These benefits are paid for by your employer, who is permissibly self-insured. You may be entitled to workers' compensation benefits if you are injured or become ill because of your job. Workers' compensation covers most work-related physical or mental injuries and illnesses. An injury or illness can be caused by one event (such as hurting your back in a fall) or by repeated exposures, such as repetitive motion over time. Everything from first-aid type injuries to serious accidents are covered. Some injuries from voluntary, off-duty recreational, social or athletic activity may not be covered. There is no qualifying period. Coverage begins the first minute you are on the job.

What you have to do

If you have a work injury or illness always report it immediately to your supervisor. Your employer will provide you with a claim form (DWC1). Complete the "Employee" section of the claim form, keep one copy for yourself and give it to your employer, who will complete the "Employer" section of the form and give you a signed and dated copy as well as provide one copy to the claims administrator, who is responsible for handling your claim and notifying you about your eligibility for benefits. State law requires employers to authorize medical treatment within one working day of receiving a claim form, and employers may be liable for as much as $10,000 in treatment until a claim is accepted or rejected. Delays in reporting may delay workers' compensation benefits and you may not be able to receive benefits if you don't file a claim within one year of the date of injury, the same date you knew the injury was work related, or the date benefits were last provided.

Benefits

The California workers' compensation law guarantees you three kinds of benefits:

- All reasonable and necessary medical care for your injury or illness, with no deductibles. Medical benefits may include treatment by a doctor, hospital services, lab test, x-rays, physical therapy, and medication. State law makes non-emergency medical services subject to preauthorization and limits some medical services.
- Tax-free payments to help replace lost wages while you are temporarily disabled. Additional payments are made if the injury causes permanent disability or death.

Medical Care-All medical expenses for reasonable and necessary treatment will be paid directly by the claims administrator, so you should never see a bill. The name and address of the claims administrator are at the end of this document and are posted at your workplace. Your employer has a Medical Provider Network (MPN), which will be explained further in this document.

Temporary Disability-If you are unable to work for more than three days, including weekends, you are entitled to temporary (TD) payments to help replace your lost wages. However, most of the districts have a return-to-work program, so check with your district to see if they have any transitional work that you can do with physical restrictions. Some positions with school districts have an industrial leave benefit. Check with your employer to see if you are entitled to those benefits. If you are entitled to receive TD directly, payments will begin approximately 14 days from the reported date of the injury. Payments won't be made for the first three days unless you are hospitalized or off work more than 14 days. The amount of these checks will be two-thirds your average wage, subject to minimums and maximums set by the state legislature. TD payments for a single injury may not extend for more than 104 compensable weeks within two years from the date of the first payment; or for more than 240 weeks within five years from the date of injury for a few long-term injuries such as severe burns or chronic lung disease.

Permanent Disability-If your doctor says your injury or illness will always leave you somewhat limited in your ability to work, you may receive permanent disability payments. The amount depends on the doctor's report, how much of the permanent disability was directly caused by your work, and factors such as your age, occupation, type of injury, and date of injury. Your benefit payment also may be affected by whether or not your employer makes a suitable return-to-work offer. The minimum and maximum amounts are set by state law, and may vary by injury date, but if you have a permanent disability, your claims administrator will send you a letter explaining how the benefit was calculated and how it will be paid.

Death Benefits-If the injury or illness causes death, payments may be made to your relatives or household members who were financially dependent on you. These benefits are set by state law and the amount depends on the number of dependents. The payments are made at the same rate as temporary disability payments. In addition, workers' compensation provides a burial allowance.

Supplemental Job Displacement Benefits-If you receive temporary disability payments, within 30 days after that benefit ends, your claims administrator will

send a letter advising whether your employer has a modified job or alternative work for you, and explaining your potential rights to a supplemental job displacement benefit. If your employer does not offer modified or alternative work, you cannot return to work for the employer within 60 days after your temporary disability ends, and it is determined that you have a permanent disability, you may choose to receive a nontransferable voucher to use at a state accredited school for education-related retraining or skill enhancement. If you qualify for the supplemental job displacement benefit, your claims administrator will provide a voucher up to a max set by state law:

A) Up to $4,000 for permanent disability awards of more than 0 but less than 15%
B) Up to $6,000 for permanent disability awards between 15% and 25%
C) Up to $8,000 for permanent disability awards between 26% and 49%
D) Up to $10,000 for permanent disability awards between 50% and 99%

More about Medical Care

- If emergency care is needed, call 911 for immediate help.
- If first-aid is available at your workplace, seek immediate treatment.
- To make sure your medical bills get paid and you get all of your benefits, report the injury immediately.
- You can be treated by your own personal physician immediately if your employer offers group health coverage, you complete a pre-designation request form (attached), and have your doctor sign the form, indicating he/she agrees to treat you for work related injuries or illnesses and follow the state reporting requirements as outlined in Rules and Regulations 9785 of the California Labor Code. The physician must have treated you previously and have your medical records.
- Your employer offers a Medical Provider Network (MPN), therefore, unless you pre-designate a treating physician, you must treat with a physician or clinic within the network. You can change doctors at any time upon notice to the claims administrator and as long as the new physician is also in the network. You will be provided with separate information regarding your rights and how to access the MPN. Since your employer has an MPN, if you have not pre-designated a physician you cannot declare a personal Chiropractor or Acupuncturist to change to after treating with the MPN physician.

If you have questions

. . . .ask your supervisor, employer representative or contact the Third Party Administrator (TPA) claims administrator directly.

You can also contact the Information and Assistance Officer at the State Division of Workers' Compensation (DWC). Information and Assistance Officers are available at no charge to answer questions, review problems and provide additional written information about workers' compensation. They can be reached at: **800-736-7401.**

MPN Notification Letter

In order to provide you with the best medical care for your workplace injuries, San Diego and Imperial County Schools Risk Management JPA has chosen to utilize CorVel's customized SD JPA MPN (medical provider network) for all California based workers' compensation injuries.

Unless you pre-designate a physician or medical group, your new work injuries arising on or after 11/01/2008 will be treated by providers in the SD JPA MPN. If you have an existing injury, you may be required to change to a provider in the new MPN. Check with your claims adjuster.

You may obtain more information about the MPN from the workers' compensation poster or from your employer.

Revised 10/2010

EMPLOYEE MPN INFORMATION

This information is being provided to you to explain your rights and responsibilities should you have an accident at work. You will also receive a copy of this notice at the time of injury.

- The California Workers' Compensation Regulation requires employees to utilize the Medical Provider Network (doctors, hospitals, ancillary services) who are part of a Medical Provider Network or MPN. The Medical Provider Network has been selected for treatment of **work related injuries.**

Employer Contact: San Diego and Imperial County Schools Risk Management JPA
Contact Name: Felicia Amenta, Workers' Compensation Program Manager
Telephone Number: 858.571.7221
Address: 6401 Linda Vista Rd., #505
City, State, Zip: San Diego, CA 92111-7399

If you are injured on the job...

1. Report your injury to your supervisor/manager *immediately.*
   IN CASE OF EMERGENCY SEEK IMMEDIATE MEDICAL ATTENTION AT THE NEAREST EMERGENCY FACILITY.
2. You may be asked to provide information such as....
   - Your Name
   - Your Home Address, City, State, Zip, County, Telephone Number
   - Date of Birth
   - Social Security Number
   - Date, Time, Location and Nature of Injury
3. If you require medical treatment, A **Medical Provider Network physician** (or other health care provider) is available for you to see. The MPN network provider will become your primary care physician and will provide the necessary and appropriate treatment for your work related injury. Your primary care physician will direct your care overall and refer to specialists as required within the MPN. A **CorVel** nurse may be assigned to interact with you, your provider and employer. The MPN network, listing of the health care providers, is available from your employer MPN contact person, your claims adjuster, or online at http://mpn.corvel.com/sdcoejpa/MPNSearch.aspx. At any time you are choosing a physician, you have the right to select from the entire MPN.
4. If you are on Business-Related Travel or away from your work site when an injury occurs, call your supervisor/manager to report your injury immediately. They will help you in seeking medical attention. **In case of emergency seek immediate medical attention at the nearest emergency facility.**
5. If you are traveling, or now live outside the MPN geographical area, you will be supplied with at least three physicians within the access standards to choose from for your medical treatment. If there are not three MPN physicians within the access standards available to treat you, you may be allowed to use a non-MPN provider. You have the right to change physicians and obtain a 2nd or 3rd opinion from among the referred physicians.
6. You may only use physicians within the MPN. See exceptions in Transfer of Care and Continuity of Care policies.
7. If you are having trouble scheduling an appointment with a provider within the MPN, contact your employer MPN contact, claims adjuster, or your case manager, if assigned, for assistance in getting an appointment scheduled for you.
8. If you require a referral to a specialist, (orthopedist, dermatologist, etc.), contact your employer MPN contact, claims adjuster, or your case manager, if assigned, for assistance in selecting and scheduling an appointment with a specialist.
9. Appointments for initial treatment will be available within 3 business days of your request. Non-emergency appointments with specialists will be available within 20 business days or receipt of referral.

ADDITIONAL INFORMATION REGARDING YOUR RIGHTS UNDER THE CALIFORNIA MPN.
You will be provided notification upon transfer into the MPN. You may go to a specialist outside the MPN if your primary treating MPN physician refers you to a specialist outside the network. You may also choose your own specialist from within the MPN network independent of any referral by your treating physician or provider.

EMPLOYEE REQUEST FOR A SECOND/THIRD MEDICAL OPINION

You have the opportunity to request and obtain a second and a third medical opinion within the provider network if you have a disagreement with the treatment or diagnosis. During this process, you must continue to receive your treatment with your current treating physician, or another provider of your choice within the MPN. To view the entire list of MPN providers, you may log onto www.corvel.com as described in page 1, number 3. This process is as follows:

1. If you disagree with the treatment plan or diagnosis you can request a 2nd or 3rd medical opinion.
2. A request is generated from the employee either by phone or in writing to the Claims Adjuster.
3. The request is received by the Claims Adjuster who will provide a regional area listing of providers within the network for you to choose from. At any time you have the right to choose a physician from the entire MPN network or from the list provided.
4. You must schedule an appointment with one of the physicians from the supplied list or from the entire MPN within (60) sixty days, or it shall be deemed that you have waived your right to the second opinion process with regard to this disputed diagnosis or treatment. At any time you are choosing a physician, you have the right to select from the entire MPN.
5. Once you have obtained an appointment, you must notify your claims adjuster of the physician, the appointment date and time.
6. If the appointment is not made within 60 days of receipt of the list of available MPN providers, then you shall be deemed to have waived the second and/or third opinion process.
7. During this process, you are required to continue your treatment with the treating physician or a physician of your choice within the MPN.
8. If the 2nd or 3rd opinion physician determines that your injury is outside the scope of their practice, you will be provided with a new list of MPN providers and/or specialists.
9. If you disagree with the 2nd opinion, then you can request a 3rd opinion and follow Steps 2-5 as above.
10. If you disagree with the diagnosis or treatment of the third opinion physician, you may request an Independent Medical Review. At the time you request a third opinion, your employer, MPN contact or adjuster will give you information on requesting an Independent Medical Review and the form.
11. At the time of your selection of your third opinion physician, you will be supplied with information on how to request an independent medical review, along with an application for Independent Medical Review for you to complete, should you disagree with the third opinion.
12. The claims adjuster will contact the treating physician, provide a copy of the medical records or send the necessary records to the second and/or third opinion physician prior to the appointment date. Upon your request, you can receive a copy of the medical records from your claims adjuster.
13. The second/third opinion physician will be notified in writing that he or she has been selected to provide a second/third opinion and the nature of the dispute with a copy to you.
14. A copy of the written report shall be provided to the employee, the person designated by the employer or insurer, and the treating physician within 20 days of the date of the appointment or receipt of the results of the diagnostic tests, whichever is later.
15. You may obtain the recommended treatment within the MPN. If you choose you may obtain the recommended treatment by changing physicians to the second opinion physician, third opinion physician, or another MPN physician.

CHANGING YOUR PHYSICIAN

You are allowed to change to another provider if you would like to change providers for any other reason than listed above under Employee Request for a Second/Third Opinion. Your request may be directed to your Nurse case Manager or your Claims Adjuster. The provider must be within the Medical Provider Network. If you require a referral to a specialist, (orthopedist, dermatologist, etc.), contact your employer MPN contact, claims adjuster, or your case manager, if assigned, for assistance in selecting and scheduling an appointment with a specialist. The specialist you choose can be from the entire MPN.

TRANSFER OF ONGOING CARE INTO MPN

If you are being treated for an occupational injury or illness by a physician or provider prior to your enrollment into your employer's medical provider network (MPN), and your physician or provider becomes a provider or already is an MPN provider, the MPN/employer will notify you that your treatment is being provided by your physician or provider under the provisions of the MPN. You may request a complete copy of the Transfer of Ongoing Care policy from your employer or MPN. Some circumstances that may allow continued treatment with the terminated provider include an acute condition, a serious chronic condition, a terminal illness, or performance of a surgery or other procedure that is authorized by the insurer or employer as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the MPN coverage effective date.

A dispute resolution policy is included in the Transfer of Ongoing Care policy. You may request a complete copy of the Transfer of Ongoing Care policy from your employer or MPN.

ACCESS STANDARDS

You have a right to access to MPN providers that are located within reasonable distances of your residence or workplace. The MPN must have a primary care physician and a hospital for emergency care within 30 minutes or 15 miles of your residence or workplace and providers of occupational health services and specialists within 60 minutes or 30 miles of your residence or workplace. If at any time you reside or work in a portion of the service area in which health care facilities are located outside the MPN access standards, the employer or MPN treating physician will assist the you in identifying a minimum of three (3) non-MPN providers in the specialty needed and within the access standard distance." If there are not three (3) providers in the needed specialty within the access standard distance you may choose a non-MPN provider.

CONTINUITY OF CARE

If you are treating in a medical provider network and the provider is terminated from participation in the MPN network, you have certain rights to continue your treatment with this terminated provider subject to the conditions set forth in your employer's Continuity of Care policy. Some circumstances that may allow continued treatment with the terminated provider include an acute condition, a serious chronic condition, a terminal illness, or performance of a surgery or other procedure that is authorized by the insurer or employer as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date.

A dispute resolution policy is included in the Continuity of Care policy. You may request a complete copy of the Continuity of Care policy from your employer or MPN.

EMPLOYEE INFORMATION ON THE

INDEPENDENT MEDICAL REVIEW PROCESS

This notice is to inform you of your rights, responsibilities and process in obtaining an Independent Medical Review (IMR). If you disagree with your treatment plan or diagnosis that the third opinion physician rendered, you have the right to request an Independent Medical Review. At the time you request a physician for a third opinion, your MPN contact or Claims Adjuster will provide you with this form covering the Independent Medical Review process. You will also be provided with an "Application for Independent Medical Review" form. The MPN contact or Claims Adjuster will fill out the "MPN Contact section" for you. You will need to complete the "employee section" of the form, indicate on the form whether you are requesting an in-person examination or a records review. You may also list an alternative specialty, if any, that is different from the specialty of the treating physician.

The Administrative Director will select an IMR with an appropriate specialty within 10 business days of receiving your Application for Independent Medical Review form. The Administrative Director's selection of the IMR will be based on the specialty of your treating physician, the alternative specialties listed by you and the MPN contact, and the information submitted with the Application for Independent Medical Review.

If you request an in-person examination, the Administrative Director will randomly select a physician from a list of available independent medical reviewers, with an appropriate specialty, who has an office located within thirty miles of your residential address, to be your independent medical reviewer. If there is only one physician with an appropriate specialty within thirty miles of your residential address, that physician shall be selected to the independent medical reviewer. If there are no physicians with an appropriate specialty who have offices located within thirty miles of your residential address, the Administrative Director will search in increasing file mile increments, until one physician is located. If there are no available physicians with this appropriate specialty, the Administrative Director may choose another specialty based on the information submitted.

If you request a record review, then the Administrative Director will randomly select a physician with an appropriate specialty from the list of available independent medical reviewers to be the IMR. If there are no physicians with an appropriate specialty, the Administrative Director may choose another specialty based on the information submitted.

The Administrative Director will send written notification of the name and contact information of the IMR to you, your attorney, if any, the MPN contact and the IMR. The Administrative Director will send a copy of the completed Application for Independent Medical Review to the IMR.

You, the MPN Contact, or the selected IMR can object within 10 calendar days of receipt of the name of the IMR to the selection if there is a conflict of interest as defined by section 9768.2. If the IMR determines that they do not practice the appropriate specialty, the IMR shall withdraw within 10 calendar days of receipt of the notification of selection. If the conflict is verified or the IMR withdraws, the Administrative Director will select another IMR from the same specialty. If there are no available physicians with the same specialty, the Administrative Director may select an IMR with another specialty based on the information submitted and in accordance with the procedure set forth for an in-person examination and for a records review.

If you request an in-person examination, within sixty calendar days of receiving the name of the IMR, you must contact the IMR to arrange an appointment. If you fail to contact the IMR for an appointment with sixty calendar days of receiving the name of the IMR, then you will be deemed to have waived the IMR process with regard to this disputed diagnosis or treatment of this treating physician. The IMR shall schedule an appointment with you within thirty calendar days of the request for an appointment, unless all parties agree to a later date. The IMR shall notify the MPN contact of the appointment date.

Should you decide to withdraw the request for an independent medical review, you need to provide written notice to the Administrative Director and the MPN contact.

During this process, the employee shall remain within the MPN for treatment pursuant to section 9767.6.

The MPN Contact shall send all relevant medical records to the IMR. The MPN Contact shall also send a copy of the documents to the covered employee. The employee may furnish any relevant medical records or additional materials to the Independent Medical Reviewer, with a copy to the MPN contact as set forth in 8 CCR Section 9768.11(a). If you have requested an in-person examination and a special form of transportation is required because of your medical condition, the MPN contact will arrange it for you. The MPN Contact shall furnish transportation and arrange for an interpreter, if necessary, in advance of the in-person examination. All reasonable expenses of transportation shall be incurred by the insurer or employer pursuant to Labor Code section 4600. Except for the in-person examination itself, the independent medical reviewer shall have no ex parte contact with any party. Except for matters dealing with scheduling appointments, scheduling medical tests and obtaining medical records, all communications between the independent medical reviewer and any party shall be in writing with copies served on all parties.

If the IMR requires further tests, the IMR shall notify the MPN Contact within one working day of the appointment. All tests shall be consistent with the medical treatment utilization schedule adopted pursuant to Labor Code section 5307.27 or, prior to the adoption of this schedule, the ACOEM guidelines, and for all injuries not covered by the medical treatment utilization schedule or the ACOEM guidelines, in accordance with other evidence based medical treatment guidelines generally recognized by the national medical community and that are scientifically based.

The IMR may order any diagnostic tests necessary to make their determination regarding medical treatment or diagnostic services for the injury or illness but shall not request you to submit to an unnecessary exam or procedure. If a test duplicates a test already given, the IMR shall provide justification for the duplicative test in their report. If you fail to attend an examination with the IMR and fail to reschedule the appointment within five business days of the missed appointment, the IMR shall perform a review of the records and make a determination based on those records.

If you fail to attend an examination with the IMR and fail to reschedule the appointment within five business days of the missed appointment, the IMR shall perform a review of the records and make a determination based on those records.

The IMR will serve the report on the Administrative Director, the MPN Contact, you, your attorney, if any, within twenty days after the in-person examination or completion of the records review.

If the disputed health care service has not been provided and the IMR certifies in writing that an imminent and serious threat to the health of you exists, including, but not limited to, the potential loss of life, limb, or bodily function, or the immediate and serious deterioration of you, the report shall be expedited and rendered within three business days of the in-person examination by the IMR.

Subject to approval by the Administrative Director, reviews not covered above, may be extended for up to three business days in extraordinary circumstances or for good cause. Extensions for good cause shall be granted for; medical emergencies of the IMR or the IMR's family; death in the IMR's family; or natural disasters or other community catastrophes that interrupt the operation of the IMR's office operations.

Utilizing the medical treatment utilization schedule established pursuant to Labor Code section 5307.27 or, prior to the adoption of this schedule, the ACOEM guidelines, and taking into account any reports and information provided, the IMR shall determine whether the disputed health care service is consistent with the recommended standards. For injuries not covered by the medical treatment utilization schedule or by the ACOEM guidelines, the treatment rendered shall be in accordance with other evidence-based medical treatment guidelines which are generally recognized by the national medical community and scientifically based.

The IMR should not treat or offer to provide medical treatment for this injury or illness for which they have done an independent medical review evaluation for you unless a medical emergency arises during the in-person examination.

Neither you nor the employer not the insurer shall have any liability for payment for the independent medical review which was not completed within the required timeframes unless you and the employer each waive the right to a new independent medical review and elect to accept the original evaluation.

The Administrative Director shall immediately adopt the determination of the independent medical reviewer and issue a written decision within five business days of receipt of the report.

The parties may appeal the Administrative Director's written decision by filing a petition with the Workers' Compensation Appeals Board and serving a copy on the administrative Director, within twenty days after receipt of the decision.

If the IMR agrees with the diagnosis, diagnostic service or medical treatment prescribed by the treating physician, you shall continue to receive treatment with physicians within the MPN.

If the IMR does not agree with the disputed diagnosis, diagnostic service or medical treatment prescribed by the treating physician, you shall seek medical treatment with a physician of your choice either within or outside the MPN. If you choose to receive medical treatment with a physician outside the MPN, the treatment is limited to the treatment recommended by the IMR or the diagnostic service recommended by the IMR. The medical treatment shall be consistent with the medical treatment utilization schedule established pursuant to Labor Code section 5307.27 or, prior to the adoption of this schedule, the ACOEM guidelines. For injuries not covered by the medical treatment utilization schedule or by the ACOEM guidelines, the treatment rendered shall be in accordance with other evidence-based medical treatment guidelines which are generally recognized by the national medical community and scientifically based. The employer or insurer shall be liable for the cost of any approved medical treatment in accordance with Labor Code section 5307.1 or 5307.11.

OPTIONAL FORM

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).

Title 8, California Code of Regulations, section 9783.

NCCSC
North County Coastal Substitute Consortium
Cardiff • Del Mar • Encinitas
Rancho Santa Fe • Solana Beach

11232 El Camino Real
San Diego, CA 92130
(858) 755-9301 ext. 3678
substitute@dmusd.org

Notification of Reasonable Assurance

TO: On-Call Substitute

FROM: North County Coastal Substitute Consortium
Which Includes:
Cardiff School District
Del Mar Union School District
Encinitas Union School District
Rancho Santa Fe School District
Solana Beach School District

Dear On-Call Substitute,

You are hereby notified that you have reasonable assurance to return to work in a substitute capacity after the close of all holiday and recess periods during the current school year. Your services will not be needed during the recess periods.

Warm regards,

Jennifer Thomas
Substitute Consortium Coordinator

SUBSTITUTE INFORMATION					
Last:		First:		Middle:	
SIGNATURE:		Date:			

NCCSC
North County Coastal Substitute Consortium
Cardiff • Del Mar • Encinitas
Rancho Santa Fe • Solana Beach

ACKNOWLEDGEMENTS

*Please Note, this form will be in place with the following school districts within the North County Coastal Substitute Consortium: Cardiff School District, Del Mar Union School District, Encinitas Union School District, Rancho Santa Fe School District, Solana Beach School District.

I hereby acknowledge that I have received, read and understand the information below and agree to comply with their provisions. Furthermore, I understand that it is my responsibility to read and comply with the policies listed below and any revisions made to them. I further acknowledge that these are summaries of each policy and each district (Cardiff School District, Del Mar Union School District, Encinitas Union School District, Rancho Santa Fe School District, Solana Beach School District) may have their own policy in place that I am responsible to comply with as well.

*Please **initial** next to each below.*

_____ Child Abuse Law*

_____ Drug and Alcohol Free Workplace

_____ Sexual Harassment

_____ Safety in the Workplace

_____ Technology Use

*Additionally, California AB1432 Training for Mandatory Reporter will be required for all substitutes.

SUBSTITUTE INFORMATION					
Last:		First:		Middle:	
Signature:			Date:		

CHILD ABUSE LAW

NOTICE TO PROSPECTIVE EMPLOYEES

California Penal Code Section 11166.5 requires that employees performing certain jobs in the public schools sign a statement to the effect that he or she has knowledge of the provisions of Penal Code Section 11166 and will comply with its provisions regarding the obligation to report suspected cases of child abuse. Because the position which you are being employed is one of the positions to which this law applies, you must sign this statement before you can begin your employment.

Please read the following carefully:

Section 11166 of the Penal Code requires any child care custodian, medical practitioner, non-medical practitioner, or employee of a child protective agency who has knowledge of or observes a child in his or her progressional capacity or within the scope of his or her employment whom he or she knows or reasonably suspects has been the victim of a child abuse to report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

"Child care custodian" includes teachers, administrative officers, supervisors of child welfare and attendance, or certificated pupil personnel employees of any public or private school; administrators of a public or private day camp; licensed day care workers; administrators of community care facilities licensed to care for children; head start teachers; licensing workers or licensing evaluators; public assistance workers; employees of a child care institution including, but not limited to, foster parents, group home personnel and personnel of residential care facilities; and social workers or probation officers.

"Medical practitioner" includes physicians and surgeons, psychiatrists, psychologists, dentists, residents, interns, podiatrists, chiropractors, licensed nurses, dental hygienists, or any other person who is licensed under Division 2 (commencing with Section 500) of the Business and Professional Code.

"Non-medical practitioner" includes state or county public health employees who treat minors for venereal disease or any other condition; coroners; paramedics; marriage, family or child counselors; and religious practitioners who diagnose, examine, or treat children.

This is an important law. You are protected from having to pay damages in a lawsuit if you report suspected child abuse, unless you know the report is false; but you are subject to criminal prosecution if you fail to report an instance of child abuse when you know or reasonably should know it has taken place. Attached are copies of Penal Code 11165.7, 11166 and 11167. Please review these provisions.

Child abuse includes the following:

1) A physical injury inflicted by other than accidental means on a child by another person
2) The sexual abuse of a child (Penal Code 11165.1)
3) Neglect as defined in Penal Code 11165.2
4) Willful harming or injuring of a child or the endangering of the person or health of a child as defined in Penal Code 11165.3
5) Unlawful corporal punishment or injury as defined in Penal Code 11165.4

Refer to California Penal Code Section 11165 for more specific information.

California Penal Code Section 11166 also states that if you have knowledge of or reasonably suspect that mental suffering has been inflicted on a child or his or her emotional well-being is endangered in any other way you <u>may</u> report the matter to a child protective agency.

Please read this statement carefully. Please feel free to ask questions. If you should observe or become aware of a possible instance of child abuse, and if you have any questions regarding whether to report it, <u>you are directed to contact your supervisor.</u>

DRUG AND ALCOHOL-FREE WORKPLACE

NOTICE TO PROSPECTIVE EMPLOYEES

You are hereby notified that it is a violation of Board policy for any employee at a school district workplace to unlawfully manufacture, distribute, dispense, possess, use or be under the influence of any alcoholic beverage, drug or controlled substance as defined in the Controlled Substances Act and Code of Federal Regulations.

"School district workplace" is defined as any place where school district work is performed, including a school building or other school premises; any school-owned or school-approved vehicle used to transport students to and from school or school activities; any off-school sites when accommodating a school-sponsored or school-approved activity or function, such as a field trip or athletic event, where students are under district jurisdiction; or during any period of time when an employee is supervising students on behalf of the district or otherwise engaged in district business.

As a condition of your continued employment with the district, you will comply with the district's policy (Board Policy No. 4020) on Drug and Alcohol-Free Workplace and will, anytime you are convicted of any criminal drug or alcohol statue violation occurring in the workplace, notify your supervisor of this conviction no later than five days after such conviction.

The following drug and alcohol counseling, rehabilitation, and/or employee assistance programs are available locally:

District Health Insurance (check with your specific policy if you are benefited)
EASE/Employee Assistance Service for Education (see white & brown pamphlet)
Health Services, Department of San Diego County, Division of Alcohol Program

This is a summary of the Del Mar Union School District policy for Drug and Alcohol-Free Awareness. Complete policies are available in the District Office upon request.

SEXUAL HARASSMENT

NOTICE TO PROSPECTIVE EMPLOYEES

A. Introduction

The District recognizes that harassment on the basis of sex is a violation of both federal and state employment discrimination laws as well as this District Policy. The District will provide to all employees a work environment free from sexual harassment, and will not tolerate such conduct on the part of any employee.

Any individual with a complaint of sexual harassment should immediately report it to the Superintendent or the Principal at their site. If the Superintendent is the individual about whom the complaint is to be made, the employee should make the complaint directly to the Board President. All complaints of sexual harassment will be promptly and thoroughly investigated and properly resolved. No individual will suffer reprisals for reporting any incidents of sexual harassment or making any complaints.

B. Definitions of Sexual Harassment

Sexual harassment consists of unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature. It includes but is not limited to circumstances in which:

1. Submission to such conduct is made a term or condition of an individual's employment;
   Or
2. Submission to or rejection of such conduct is used as the basis fro employment decisions affecting such individual;
   Or
3. Such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive work environment. A hostile work environment is established where there is unwelcome sexual conduct that a reasonable person of the same gender as the complainant would consider sufficiently severe or pervasive to alter the conditions of employment and create an abusive working environment.

C. Forms of Sexual Harassment

Forms of sexual harassment include but are not limited to the following:

1. Oral harassment – Derogatory comments, jokes or slurs;

2. Physical harassment – Unnecessary or offensive touching or impeding or blocking movement;

3. Visual harassment – Derogatory or offensive posters, cards, cartoons, graffiti, drawings or gestures; and

4. Sexual favors – Unwelcome sexual advances, requests for sexual favors, and other oral or physical conduct of a sexual nature.

D. Complaint Procedure for All Illegal Harassment

If any employee perceives comments, gestures or actions from any other employee, including supervisors or members of management, to be offensive, the employee should notify the Superintendent or where appropriate, the Board President. No employee is required to file any complaint with the alleged harasser.

The District will promptly and thoroughly investigate any complaints of illegal harassment, and will take immediate action to resolve such complaints.

Upon notification or discovery of an illegal harassment complaint, the Superintendent or designee will:

1. Inform the complainant of any rights under any relevant complaint procedure or policy;

2. Authorize the investigation of the complaint and supervise and/or investigate the complaint. The investigation will include interviews with:
   a) the complainant

b) the accused harasser
c) any other persons who reasonably may have relevant knowledge concerning the complaint, such as witnesses and victims of similar conduct;

3. Review factual information gathered through the investigation to determine whether the alleged conduct constitutes harassment; giving consideration to all factual information, the totality of the circumstances, including the nature of the verbal, physical or visual aspects of the action and the context in which the alleged incidents occurred;

4. Report the results of the investigation and the determination as to whether harassment occurred to appropriate persons including to the complainant and the alleged harasser;

5. If harassment occurred, take and/or recommend to the Board prompt and effective remedial action against the harasser. This action will be commensurate with the severity of the offense and will be communicated to the complainant;

6. Reasonable steps will be taken to protect the victim and other potential victims from further harassment;

7. Reasonable steps will be taken to protect the victim from any retaliation as a result of communicating the complaint; and

8. Appropriate action will be taken whenever possible to alleviate the effects of the harassment.

E. <u>Dissemination of Policy</u>

1. All employees shall be notified of this policy.
2. A copy of this Policy shall be posted along with and in the same manner as is other material which is posted for the benefit or protection of employees.

F. <u>Available Legal Remedies and Additional Complaint Process</u>

1. Employees or job applicants who believe that they have been sexually or otherwise illegally harassed may, within one year of the harassment, file a complaint of discrimination with the California Department of Fair Employment and Housing. The Department serves as a neutral fact finder and attempts to help the parties voluntarily resolve disputes. If the Department finds evidence of harassment and settlement efforts fail, the Department may file a formal accusation against the employer and the harasser. The accusation will lead to either a public hearing before the Fair Employment and Housing commission or a lawsuit filed on the complainant's behalf. If the Commission finds that the harassment occurred, it can order remedies, including up to $50,000 in fines or damages for emotional distress for each employer or harasser charged. In addition, the Commission may order hiring or reinstatement, back pay, promotion, and changes in policies or practices of the involved employer. A court may order unlimited damages.

2. For more information, employees or job applicants may contact the
Department of Fair Employment and Housing.
1350 Front Street, Suite 3005
San Diego, CA 92101

SAFETY IN THE WORKPLACE

NOTICE TO PROSPECTIVE EMPLOYEES

EMPLOYEE SAFETY

The Governing Board is committed to maximizing employee safety and believes that safety is every employee's responsibility. Working conditions and equipment shall be maintained in compliance with standards prescribed by federal, state and local laws and regulations.

No employee shall be required or permitted to be in any place of employment which is unsafe or unhealthful. (Labor Code 6402)

The Board expects all employees to use safe work practices and to correct any unsafe conditions, which may occur. If an employee is unable to correct an unsafe condition, he/she shall immediately report the problem to the Superintendent or designee.

The Superintendent or designee shall promote safety and correct any unsafe work practice through education, training and enforcement.

The Superintendent or designee shall establish and implement a written injury and illness prevention program in accordance with law. (Labor Code 6401.7)

The Board shall ensure that the Superintendent or designee provides eye protective devices as specified in law and administrative regulation.

No employee shall be discharged or discriminated against for making complaints, instituting proceedings or testifying with regard to employee safety or health, or for participating in any occupational health and safety committee established pursuant to Labor Code 6401.7. (Labor Code 6310)

EACH EMPLOYEE'S RESPONSIBILITY

Safety can only be achieved through teamwork at the Del Mar Union School District. You must practice safety awareness by thinking defensively, anticipating unsafe situations and reporting unsafe conditions immediately.

Please observe the following precautions:

1. Notify your administrator of any emergency situation immediately. If you are injured or become sick at work, no matter how slightly, you must inform your administrator immediately.
2. The use of alcoholic beverages, tobacco products, illegal drug substances or the abuse of legal prescription drugs during working hours will not be tolerated. The possession of alcoholic beverages or illegal drug substances on District property is forbidden.
3. Use, adjust, and repair machines and equipment only if you are trained and qualified.
4. Get help when lifting or pushing heavy objects.
5. Understand your job fully and follow instructions. If you are not sure of the proper safety procedure, don't guess, ask your administrator.
6. Know the locations, contents and use of first aide and fire-fighting equipment.

A violation of a safety precaution is in itself an unsafe act. It is your responsibility to become familiar with emergency procedures.

TECHNOLOGY USE

NOTICE TO PROSPECTIVE EMPLOYEES

EMPLOYEE USE OF TECHNOLOGY

The Governing Board recognizes that technological resources can enhance employee performance by improving access to and exchange of information, offering effective tools to assist in providing a quality instructional program, and facilitating district and school operations. The Board expects all employees to learn to use the available technological resources that will assist them in the performance of their job responsibilities. As needed, employees shall receive training in the appropriate use of these resources.

Employees shall be responsible for the appropriate use of technology and shall use the district's technological resources only for purposes related to their employment. Such use is a privilege, which may be revoked at any time.

Employees should be aware that computer files and communications over electronic networks, including e-mail and voice mail, are not private. These technologies shall not be used to transmit confidential information about students, employees or district operations without authority.

The Superintendent or designee shall ensure that all district computers with Internet access have a technology protection measure that prevents access to visual depictions that are obscene or pornographic, and that the operation of such measures is enforced. The Superintendent or designee may disable the technology protection measure during use by an adult to enable access for bona fide research or other lawful purpose. (20 USC 6777; 47 USC 254)

To ensure proper use of the system, the Superintendent or designee may monitor the district's technological resources, including e-mail and voice mail systems, at any time without advance notice or consent. If passwords are used, they must be known to the Superintendent or designee, so that he/she may have system access.

The Superintendent or designee shall establish administrative regulations which outline employee obligations and responsibilities related to the use of district technology. He/she also may establish guidelines and limits on the use of technological resources. Inappropriate use shall result in a cancellation of the employee's user privileges, disciplinary action and/or legal action in accordance with law, Board policy and administrative regulations.

The Superintendent or designee shall provide copies of related policies, regulations and guidelines to all employees who use the district's technological resources. Employees shall be asked to acknowledge in writing that they have read and understood these policies, regulations and guidelines.

ADMINISTRATIVE REGULATION TO EMPLOYEE USE OF TECHNOLOGY

On-Line/Internet Services: User Obligations and Responsibilities

Employees are authorized to use district equipment to access the Internet or on-line services in accordance with Governing Board policy and the user obligations and responsibilities specified below.

1. The employee in whose name an on-line services account is issued is responsible for its proper use at all times. Employees shall keep account information, home addresses and telephone numbers private. They shall use the system only under their own account number.
2. Employees shall use the system responsibly and primarily for work-related purposes.
3. Employees shall not access, post, submit, publish or display harmful or inappropriate matter that is threatening, obscene, disruptive or sexually explicit, or that could be construed as harassment or disparagement of others based on their race/ethnicity, national origin, gender, sexual orientation, age, disability, religion or political beliefs.
4. Employees shall not use the system to promote unethical practices or any activity prohibited by law, Board policy or administrative regulations.
5. Copyrighted material shall not be placed on the system without the author's permission. Employees may download copyrighted material only in accordance with applicable copyright laws.
6. Employees shall not intentionally upload, download or create computer viruses and/or maliciously attempt to harm or destroy district equipment or materials or the data of any other user, including so-called "hacking."
7. Employees shall not read other users' electronic mail or files. They shall not attempt to interfere with other users' ability to send or receive electronic mail, nor shall they attempt to read, delete, copy, modify or forge other users' mail.
8. Users shall report any security problem or misuse of the services to the Superintendent or designee.

DIRECT DEPOSIT AUTHORIZATION
(SUBSTITUTE)

PRINT or TYPE

NAME _____ SOCIAL SECURITY NO./EMPLOYEE ID NO._____

DISTRICT Cardiff, Del Mar, Encinitas, Solana Beach, Rancho Santa Fe WORK SITE Various

Do you currently have an active Direct Deposit on file with another School District or Charter School within San Diego County? *Yes* ☐ *No* ☐

If yes, what District(s) and/or Charter School(s)? _____

I hereby authorize the above named School District(s), Charter School(s), and the San Diego County Office of Education (SDCOE) and/or their agents to initiate electronic deposits via the Automated Clearing House (ACH) and, as necessary, to debit corrections to previous deposits, to the account(s) specified below.

- Direct deposit status is not activated until my regular payroll cycle following a $0 test transaction (approx. 30 days).
- I must submit a new authorization form if I close/change my account (name, branch, etc.). Failure to do so may result in in a deposit delay.
- All new accounts must go through a Prenote verification (approx. 30 days), during which time a live warrant will be issued.
- Direct deposit status will be temporarily suspended if wages are garnished and/or the Credentials Unit at SDCOE places a hold on the warrant.
- It is my responsibility to keep apprised of any deposit(s) made to my account(s), including the date(s) and amount(s) of any such deposit(s).
- **I understand that I have only one direct deposit record for all active positions within a San Diego County School District, Charter School, or SDCOE, even if I am employed by more than one of these employers.**

I agree to hold harmless and indemnify the School District(s), Charter School(s), and SDCOE and their officers, employees, and agents from any claim or demand of whatever nature, including those based upon negligence of the District, School, or SDCOE and their officers, employees, and agents for failure or delay in making deposits and/or corrections to deposits as herein authorized.

This authorization replaces any previous agreements made by me and will remain in effect until changed or canceled by submission of a new Direct Deposit Authorization to the District, School, or SDCOE office in which I am currently employed. **All District, School, and SDCOE assignments, both current and future, will automatically be linked to the most recent Direct Deposit Authorization received by my current employer(s).**

Signature: _____ Date: _____

DEPOSIT INSTRUCTIONS: ☐ **New ACH Set Up (Prenote Needed)** ☐ **ACH Amount Change (No Prenote needed)** ☐ **ACH Cancellation**

Name of Financial institution _____

Address of Financial institution _____

Financial institution transit routing No. ☐☐☐☐☐☐☐☐☐

Checking

☐ Net Check, or

☐ $ _____

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Checking Account Number

Savings

☐ Net Check, or

☐ $ _____

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Savings account Number

ATTACH VOIDED, BLANK CHECK HERE, IF DEPOSITING TO A CHECKING OR SHARE DRAFT ACCOUNT

Jane A. Doe
1000 Main St.
Anywhere, U.S.A. 10001

_____ 20____

PAy t o the
o r Der of _____ $_____

_____ Doll Ar S

Me Mo _____ _____

⑆122233344⑆ 999111222⑈ 1234

t ransit r outing No. Account No. Check No.

Form 224 - Bu S
SDCOE 1/15

Payroll/HR Use Only:
If applicable - Payroll/HR Department has notified other District and/or Charter School of Direct Deposit update on _____ Date ____Initials

Bureau of Teacher Education and Certification
California State Board of Education
FORM I-30

Employee Name _____

Social Security No. _____

School District _____

CERTIFICATION OF FREEDOM FROM CONTAGIOUS OR INFECTIOUS DISEASE

(For use in the Employment of Retired Teachers - Education Code Section 44839.5 & 87408.5)

I herby certify that:

(1) I am licensed to practice as a physician and surgeon in California.

(2) On the date shown herein below I examined _____
(Name)

who gave _____ as his (her) date of birth and _____

_____ as his (her) address. On this date I found him/her) to be free from any contagious or infectious disease including freedom from active tuberculosis.

Date: _____

_____
Signature of Physician

_____
Typed or Printed Name of Physician

_____
State License Number

AUTHORIZATION

The following authorization signed by the person examined shall be set forth below the certificate:

Dr. _____

You are herby authorized to give the State Board of Education, any county superintendent of schools, the governing board of a school district to which the undersigned has applied for employment, and representatives of any of them, any and all information you may have regarding my physical or mental condition, including but not limited to the history, findings, diagnosis, treatment given, present condition, and prognosis.

_____
Date

_____
Signature of Person Examined

_____
Address

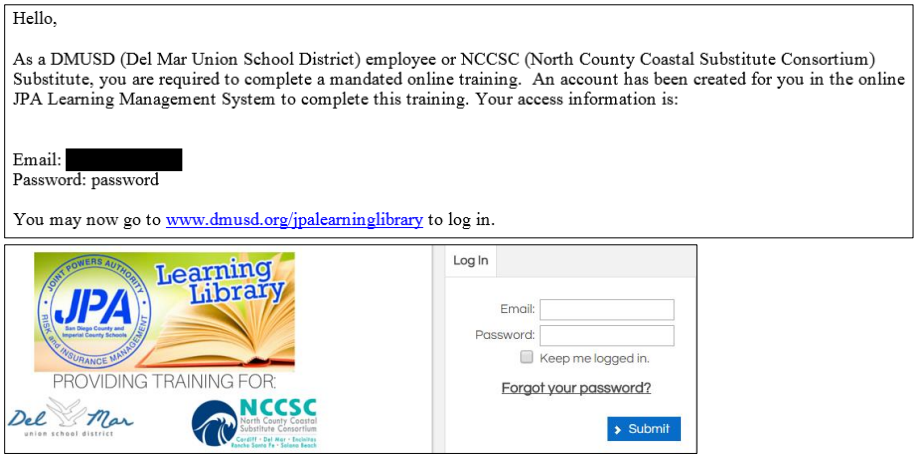
Notice: This form may be reproduced by school districts and offices of county superintendents of schools.

Revised April 1996

California AB1432 Mandatory Reporter & Bloodborne Pathogens Awareness
TRAINING INFORMATION

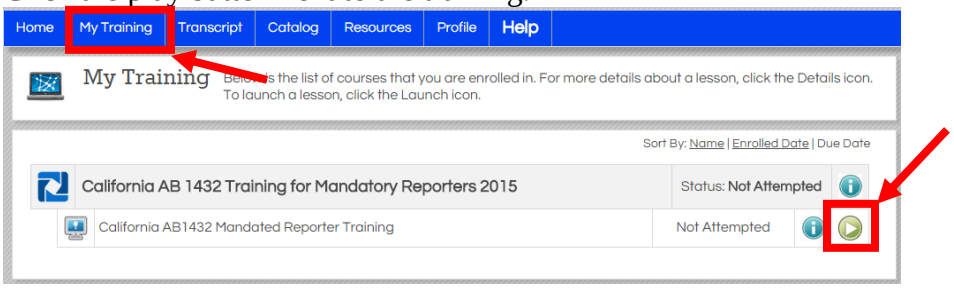
Once your packet has been processed, you will be emailed login information for these trainings. These trainings will need to be completed within the first 6 weeks of your employment, however, it is highly encouraged you complete these trainings ***AS SOON AS POSSIBLE*** upon receiving the email. Please see steps below on how to complete these trainings. If you have any questions, please contact the Substitute Consortium Coordinator at (858) 755-9301 ext. 3678.

- **Log in to get started:**
  - You will automatically receive an email from hr@dmusd.org
  - Email will contain your username, password and a link for the trainings where you can log in.



- **If you do not get the login email, please see login information below:**
  - Website: www.jpalearninglibrary.com
  - Choose Del Mar Union SD from the drop-down menu
  - Email: your personal email (the one you provided in your employment packet)
  - Password: **password** (you will be prompted to change this after your first login)

- **Begin class:**
  - Select "My Training" from the top menu.
  - Click the play button next to the training.



- **At the completion of your training, submit your certificates in PDF form to the NCCSC via <u>email</u>**
  substitute@dmusd.org

- If you can't send your certificates via email, then simply email your coordinator to let them know you completed the training. If you do not notify the coordinator that you have completed the trainings, your substitute account may be suspended.
- Do not submit paper copies of your certificates. We are trying to go GREEN!!

Ed. 08/2015

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2013)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Payroll Office, Cardiff School District, 1888 Montgomery Avenue, Cardiff CA 92007, (760) 632-5890 Ext. 163.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
Cardiff School District	95-6000501
5. Employer address	**6. Employer phone number**
1888 Montgomery Avenue	(760) 632-5890

7. City	8. State	9. ZIP code
Cardiff	CA	92007

10. Who can we contact about employee health coverage at this job?	
Payroll Office	
11. Phone number (if different from above)	**12. Email address**

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees.
  - ☑ Some employees. Eligible employees are:

    Classified - Regular full-time employees of the district that work eight (8) hours per day on an 11 or 12 month pay period.
    Certificated - All certificated employees covered under the bargaining unit agreement as well as the certificated management.

- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:

    Spouse
    Registered domestic partners
    Children up age 26

  - ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about Del Mar Union School District in the event you wish to apply for coverage on the Health Insurance Marketplace. All the information you need from Human Resources is listed in this notice. If you wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, you can contact KeenanDirect at 855.653.3626 or at www.KeenanDirect.com, or contact the Health Insurance Marketplace directly at HealthCare.gov.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace (in California) for 2016 begins October 15, 2015 to December 7, 2015.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer you coverage, or offers medical coverage that is not "Affordable" or does not provide "Minimum Value." If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, then that coverage is not Affordable. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of medical coverage from your employer that is both Affordable and provides Minimum Value, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's medical plan.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered medical coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage, is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

PART B: EXCHANGE APPLICATION INFORMATION

In the event you wish to apply for coverage on the Exchange. All the information you need from Human Resources is listed below. If you wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, you can contact KeenanDirect at 855.653.3626 or at www.KeenanDirect.com.

1. Employer name Del Mar Union School District	2. Employer Identification Number (EIN) 95-6000995	
3. Employer address 11232 El Camino Real	4. Employer phone number (858)755-9301 x3690	
5. City San Diego	6. State CA	7. ZIP code 92130
8. Who can we contact about employee health coverage at this job? Margaret Mendenhall		
9. Phone number (if different from above)	10. Email address mmendenhall@dmusd.org	

Encinitas
UNION SCHOOL DISTRICT

101 S. Rancho Santa Fe Road
Encinitas, CA 92024-4349
Phone: (760) 944-4300
FAX: (760) 634-7786
www.eusd.net

July 1, 2015

For School Year 2015/2016

Dear valued employees,

We would like to inform you of the availability of medical insurance through the "Marketplace" (aka Exchange) available in your state and established pursuant to the national health care legislation (The Affordable Care Act). This Marketplace Notice will inform you of important information pertaining to the existence, contact information for, and services provided to you by the Marketplace. In addition, this Notice will provide important information to you regarding your employer-sponsored plan.

This Notice is available on the web at: www.eusd.net. A paper copy is also available, free of charge by calling 760 944-4300, ext. 1185.

General Information on the Affordable Care Act (ACA)

Health Care Reform encourages each state to set up an Exchange (also known as "Marketplace") where medical insurance can be purchased. If a state chooses not to set up a State Exchange, then the federal government will set up a Federal Exchange in that state.

California has a State Exchange called Covered California. You can find out more information about the plan designs being offered, the availability of tax credits / government's subsidies, and the expansion of Medi-Cal by logging onto www.coveredca.com.

The Affordable Care Act requires that most U.S. citizens and legal residents have qualifying health insurance coverage starting January 1, 2015, or pay a penalty. The Exchange will include four basic levels of coverage: Bronze (lowest level), Silver, Gold, and Platinum (highest level). As the coverage level goes up; Bronze to Platinum; the monthly cost increases, but the services offered require less out-of-pocket for most services. The choice will be up to the participant.

The attached Notice provides information about:

- The Healthcare Exchanges / Marketplace;
- How to request assistance in accessing the State (or Federal) Exchange;
- The availability of premium tax credits (if applicable); and
- The impact to an employee if the decision is made to purchase a health plan through the Exchange.

For Benefit Eligible Employees

- Encinitas Union School District (EUSD) provides medical coverage which meets the requirements of the Affordable Care Act.
  - The medical coverage meets minimum value requirements as well as affordability requirements.
- Because the EUSD medical plans meet Health Care Reform requirements, you and/or your dependents probably will not be eligible for government subsidies / tax credits through the State Exchange. A financial hardship exemption for the individual penalty may be available based on your household income.
- Additional information on the California State Exchange can be found at www.coveredca.com.
  - Open enrollment for the State Exchange is scheduled to start October 1st for a January 1st, 2016 medical coverage start date.
  - An illustration of the plan designs available can be found on the California State Exchange website.

For Non-Benefit Eligible (Part-Time) Employees

- Please see the attached Notice in regards to your options surrounding Health Care coverage available through the Marketplace starting January 1, 2016.
- The California State Exchange will start open enrollment October 1st for a January 1st, 2016 medical coverage start date.
- Depending on your household income, you and/or your family may be eligible for government subsidies / tax credits via the State Exchange. The tax credits help lower the cost of medical coverage for individuals and families who meet certain income requirements and are not offered affordable and minimum value health insurance from an employer, or not eligible for a government program that meets minimum coverage requirements. Additional information can be found: http://www.coveredca.com/individuals_and_families.html#faq-10.

Questions?

Any questions regarding this letter, the Exchange Notice or others regarding Health Care Reform may be directed to our Insurance Advocates, provided by Barney & Barney, LLC.

- **By Phone:** Monday – Friday, 8am – 5pm Pacific
  For English, call: (855) 298-6588
  For Spanish, call: (855) 298-6589
- **By Email:** InsuranceAdvocates@barneyandbarney.com

Sincerely,

Dora Jones

Dora Jones
HR Benefits Specialist
Encinitas Union School District

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2013)

PART A: General Information

When key parts of the health care law took effect in 2014, a new way to buy health insurance was introduced: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2015 for coverage starting as early as January 1, 2016.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace, and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after- tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Dora Jones, HR Benefits Specialist for the Encinitas Union School District. Or, for information about other medical insurance coverage that may be available to you and your family, you may contact Barney & Barney at (855) 298-6588.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Encinitas Union School District		4. Employer Identification Number (EIN) 95-6001089
5. Employer address 101 S Rancho Santa Fe Road		6. Employer phone number 760 944-4300, ext. 1185
7. City Encinitas	8. State CA	9. ZIP Code 92024
10. Who can we contact about employee health coverage at this job? Your Human Resources Department, or for assistance with other types of available health insurance, contact Barney & Barney: (855) 298-65		
11. Phone number (if different from above) Click here to enter text.		12. Email address Dora.jones@eusd.net

Here is some basic information about health coverage offered by this employer:

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

- As your employer, we offer a health plan to:
  ☐ All employees.

  ☒ Some employees. Eligible employees are: Employees working 50% of a work day (i.e. 8 hours/day) in a permanent position with the exception of some special education and teaching positions as outlined in the Memorandum of Understanding.

- With respect to dependents:
  ☒ We do offer coverage. Eligible dependents are: those dependents of benefited eligible employees for which an employee can use the difference of the district offered cafeteria cash plan stipend.

  ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

Beginning in 2014, all United States citizens and legal residents will be required to maintain a minimum level of medical insurance coverage (known as "Minimum Essential Coverage"). The Internal Revenue Service (IRS) will monitor your compliance with this new law through the addition of IRS Tax forms and Schedules filed with your annual income tax return, as well as your employer's tax returns. Those failing to maintain adequate medical insurance coverage will be fined. This fine or "tax penalty" will be payable as an additional tax of up to 1% of your family's household income (this tax penalty will increase annually).

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. On the next page you will find the employer optional information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

All United States citizens and legal residents are required to maintain a minimum level of medical insurance coverage (known as "Minimum Essential Coverage"). The Internal Revenue Service (IRS) will monitor your compliance with this new law through the addition of IRS Tax forms and Schedules filed with your annual income tax return, as well as your employer's tax returns. Those failing to maintain adequate medical insurance coverage will be fined. This fine or "tax penalty" will be payable as an additional tax of up to 1% of your family's household income (this tax penalty will increase annually).

If you are not eligible for your employer's medical insurance, or it does not meet the minimum value standard (as the above checkbox would indicate), it is not too late to avoid a tax penalty. You have the option of speaking with a Barney & Barney, a Marsh & McLennan Agency LLC Company Health Insurance Advocate for assistance in obtaining insurance coverage for you or your family, including coverage that may be available at a discount, or in some cases free, through the public State Exchange, such as "Covered California" for California residents. Note: Each State has its own "Exchange Marketplace." An Exchange Marketplace is an additional place to shop for and buy health insurance from a variety of insurance providers. Some individuals and families may qualify for and receive tax credits or assistance in paying for health insurance when purchasing medical insurance through the Exchange Marketplace.

If you would like to review your options directly with your State's Exchange, please contact your State's Exchange directly. If you would like assistance in determining what type of individual or family plan is best for you and your family, or need assistance in being directed to your State's Exchange, feel free to contact a Barney & Barney, a Marsh & McLennan Agency LLC Company Insurance Advocate:

Monday through Friday 8:00am – 5:00pm PST

By Phone: Monday – Friday, 8am – 5pm Pacific

- For English, call: (855) 298-6588
- For Spanish, call: (855) 298-6589

By Email: InsuranceAdvocates@barneyandbarney.com

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but helps employees understand their coverage choices.

Questions 13 – 16 are left blank intentionally. You can get assistance completing these questions from your Benefits Department.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee being eligible in the next 3 months?

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? Click here to enter a date. (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $Click here to enter text.

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan?

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Year

Date of change (mm/did/yyyy):

If you are not eligible for your employer's medical insurance, or it does not meet the minimum value standard (as the above checkbox would indicate), it is not too late to avoid a tax penalty. You have the option of speaking with a Barney & Barney Health Insurance Advocate for assistance in obtaining insurance coverage for you or your family, including coverage that may be available at a discount, or in some cases free, through the public State Exchange, such as "Covered California" for California residents. Note: Each State has its own "Exchange Marketplace." An Exchange Marketplace is an additional place to shop for and buy health insurance from a variety of insurance providers. Some individuals and families may qualify for and receive tax credits or assistance in paying for health insurance when purchasing medical insurance through the Exchange Marketplace.

If you would like to review your options directly with your State's Exchange, please contact your State's Exchange directly. If you would like assistance in determining what type of individual or family plan is best for you and your family, or need assistance in being directed to your State's Exchange, feel free to contact a Barney & Barney Insurance Advocate:

By Phone: Monday – Friday, 8am – 5pm Pacific

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- For Spanish, call: (855) 298-6589

By Email: InsuranceAdvocates@barneyandbarney.com

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORAMTION

This notice provides you with information about Rancho Santa Fe School District in the event you wish to apply for coverage on the Health Insurance Marketplace. This notice provides basic information about the new Marketplace.

What is the Heath Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Can I Save Money on my Health Insurance Premium in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or the coverage your employer provides does not meet the "minimum value" standards set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer- offered coverage. Also, this employer contribution- as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after tax basis.

How Can I Get More Information?

The Marketplace can help you evaluate our coverage options, including your eligibility through the Marketplace and its cost. Please visit HealthCare.org for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY OUR EMPLOYER

If you wish to apply for coverage through the Marketplace, all the information you need from Human Resources is listed below.

1. Employer Name: Rancho Santa Fe School District		**2. Employer Identification Number (EIN)**
3. Employer Address: 5927 La Granada		**4. Employer Phone Number:** 858-756-1141 x. 117
5. City: Rancho Santa Fe	**6. State:** CA	**7. Zip Code:** 92067
8. Who can we contact about employee health coverage at this job? Nicole Graciano		
9. Phone Number (if different from above)		**10. Email Address:** ngraciano@rsf.k12.ca.us

HEALTH INSURANCE MARKETPLACE COVERAGE LETTER

AWAITING FROM **RANCHO SANTA FE**

Making Health Care Better for Everyone

AFFORDABLE CARE ACT: WHAT YOU NEED TO KNOW

Dear New Employee:

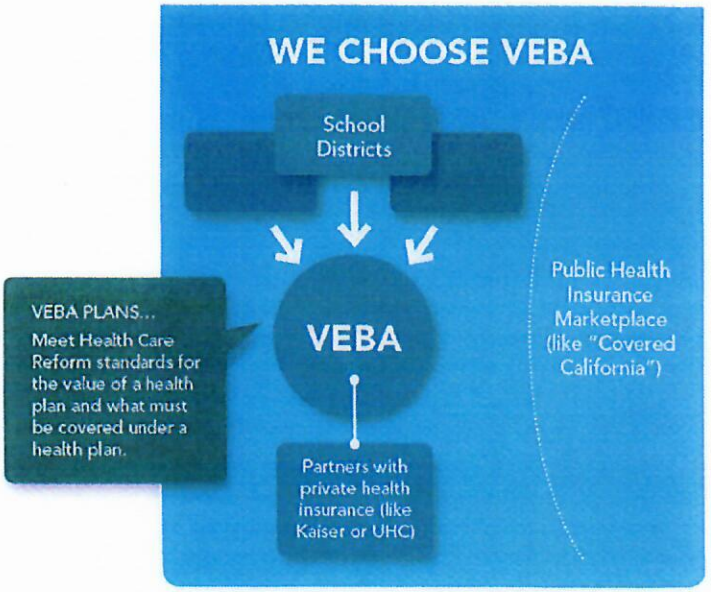
You've probably heard about the Affordable Care Act, also called the Health Care Reform law. This letter describes what the Affordable Care Act means to you as a school district employee. Effective March 31, 2014, the law requires most Americans to be covered under a health plan — whether they get it from an employer, a private insurance company or from the government. This is called the "Individual Mandate." If you do not have health insurance as of this date, you may have to pay a tax penalty.

The good news is, if you are eligible for benefits through your school district, **your school district benefits through VEBA meet the Individual Mandate requirement.** To find out if you are eligible for benefits, contact your school district's benefits department.

You've probably also heard a lot about "exchanges" or "marketplaces." In California, the public, state-sponsored Health Insurance Marketplace is called Covered California™. This marketplace is intended to help people without coverage find a health plan. But, if you're benefits-eligible, you have coverage available through your school district.

Although Covered California is available to you as an alternative source for health care coverage, for now, we believe the best choice is to offer comprehensive health plan options at the most cost-effective price, directly through VEBA, if you are benefits-eligible with your school district.

We will monitor the changes related to the Affordable Care Act over the coming months and years and continue to use the collective bargaining process for represented employees, as the elements of the law become clearer.



What You Need To Do

The Affordable Care Act makes it clear: it's up to you to make sure you have health insurance beginning as of March 31, 2014. If eligible, be sure to enroll in the district health plan that works best for you and your family — *so that you're covered.* If you are not eligible, you may be able to enroll in coverage through your spouse's/domestic partner's employer, Covered California (www.coveredca.com), Medicare (if eligible) or Medicaid benefits, if you qualify. (Find out if you are eligible for Medicaid by contacting Medicaid in your state (Medi-Cal in the State of California). Contact information can be found at www.medicaid.gov.)

If you enroll in coverage elsewhere, we encourage you to review your coverage with your tax planner to ensure your coverage meets the Affordable Care Act requirements.

More information about the Affordable Care Act can be found at www.healthcare.gov, the website sponsored by the Department of Health and Human Services.

THIS POSTER MUST BE DISPLAYED WHERE EMPLOYEES CAN EASILY READ IT

(Poster may be printed on 8 ½" x 11" letter size paper)

HEALTHY WORKPLACES/HEALTHY FAMILIES ACT OF 2014
PAID SICK LEAVE

Entitlement:

- An employee who, on or after July 1, 2015, works in California for 30 or more days within a year from the beginning of employment is entitled to paid sick leave.
- Paid sick leave accrues at the rate of one hour per every 30 hours worked, paid at the employee's regular wage rate. Accrual shall begin on the first day of employment or July 1, 2015, whichever is later.
- Accrued paid sick leave shall carry over to the following year of employment and may be capped at 48 hours or 6 days. However, subject to specified conditions, if an employer has a paid sick leave, paid leave or paid time off policy (PTO) that provides no less than 24 hours or three days of paid leave or paid time off, no accrual or carry over is required if the full amount of leave is received at the beginning of each year in accordance with the policy.

Usage:

- An employee may use accrued paid sick days beginning on the 90th day of employment.
- An employer shall provide paid sick days upon the oral or written request of an employee for themselves or a family member for the diagnosis, care or treatment of an existing health condition or preventive care, or specified purposes for an employee who is a victim of domestic violence, sexual assault, or stalking.
- An employer may limit the use of paid sick days to 24 hours or three days in each year of employment.

Retaliation or discrimination against an employee who requests paid sick days or uses paid sick days or both is prohibited. An employee can file a complaint with the Labor Commissioner against an employer who retaliates or discriminates against the employee.

For additional information you may contact your employer or the local office of the Labor Commissioner. Locate the office by looking at the list of offices on our website http://www.dir.ca.gov/dlse/DistrictOffices.htm using the alphabetical listing of cities, locations, and communities. Staff is available in person and by telephone.