Evergreen Home Health

GROWING STRONGER EVERY DAY, WITH EVERGREEN HOME HEALTH.

Application For Employment

We are an Equal Opportunity Employer and committed to excellence through diversity.

Please print or type. The application must be fully completed to be considered. Please complete each section, even if you attach a resume.

Personal Information

Name: Alexandria A Abraham

Address	City	State	Zip
2214 Hickorywood dr	Gaylord	MI	49735

Phone number: (989)350-8228

Email address: alexis.abraham1142@kirtland.edu

Are you legally eligible to work in the US? Yes (●) No ( )

Please list any licenses and/or certifications you may hold (RN, CNA, etc.): RN, BSN

Are you able to perform the essential functions of the job you are applying for with or without reasonable accommodation? Yes (●) No ( )

If selected for employment, are you willing to submit to a background check? Yes (●) No ( )

Have you ever been convicted of a felony offense in any state? ( ) YES (●) NO

Emergency Contact Information

Emergency Contact Name: Moses Abraham Phone #: (989)858-2599 Relationship: Husband

Position

Position you are applying for	Available start date	Desired pay
Registered Nurse	10/13/25	

Employment desired: ( ) Full time (●) Part time ( ) Contingent

Education

School name	Location	Years attended	Degree received	Major
Kirtland Community College	Grayling	2019-2020	Associates Degree	Nursing
Chamberlain University	Chicago	2021-2022	Bachelors Degree	Nursing
			Select...	

Employment History

Employer (1)	Job title		Dates employed
Sonshine Barn	Wedding Planner		05/17 TO 10/25
Work phone	**May we contact?**	**Supervisor Name:**	**Reason for Leaving**
(989)350-6990	YES (required)	Sarah	Currently Employ
Address	**City**	**State**	**Zip**
2838 Wilkinson Rd	Gaylord	MI	49735

Employer (2) Munson OMH	Job title Registered Nurse		Dates employed 04/21 TO 10/25
Work phone (989)348-0415	May we contact? YES (required)	Supervisor Name: Jason	Reason for Leaving Currently Employ
Address 825 N center ave	City Gaylord	State MI	Zip 49735
Employer (3) OPTIONAL TO COMPLETE	Job title		Dates employed TO
Work phone	May we contact?	Supervisor Name:	Reason for Leaving Select...
Address	City	State MI	Zip

Applicant Certification Statement

I certify that all information provided in this application, as well as any supporting documents, is true, complete, and accurate to the best of my knowledge. I understand that any misrepresentation, falsification, or omission of information may result in disqualification from further consideration for employment or, if employed, immediate termination.

I authorize Evergreen HC Group Inc to verify the information provided, including contacting references and previous employers, and conducting background checks as necessary. I understand that any offer of employment is contingent upon the successful completion of these verifications.

I understand that if hired, my employment with Evergreen HC Group Inc will be at-will, meaning that either I or the company may terminate the employment relationship at any time, with or without cause or notice, subject to applicable laws. I acknowledge that no company policy, statement, or representative can alter the at-will nature of employment except through a formal written agreement signed by an authorized company representative.

I acknowledge that this application is not a contract of employment, nor does it guarantee employment. If hired, I agree to abide by all company policies, procedures, and expectations.

By signing below, I acknowledge that I have read, understand, and agree to the above statements.

Name (please print) Alexis Abraham	Signature  Alexis Abraham (Oct 2, 2025 08:54:50 EDT)
Date Oct 2, 2025	

Employment Verification and Reference Form

Applicant Information

Applicant Name: Alexis Abraham

I authorize the Agency to obtain employment-related information necessary for making a hiring decision. I waive any restrictions preventing the release of this information and agree to provide any additional details required beyond what is included in my employment application and this form.

Applicant Signature: Alexis Abraham
Alexis Abraham (Oct 2, 2025 08:54:50 EDT)

Date: Oct 2, 2025

Section 1: Employment History (To Be Completed by Applicant)

Company Name:	Sonshine Barn				
Supervisor Name / Title:	Sarah				
Company Address:	2838 Wilkinson Rd	Gaylord	MI	49735	
Phone:	(989)350-6990				
Position Held:	Wedding Planner				
Dates of Employment (MM/YY):	From:	05/17	To:	10/25	
Full Name(s) Used During Employment:	Alexis Abraham	OTHERS:			

Section 2: Employment Verification (To Be Completed by Former Employer)

Instructions: Please review the applicant's information for accuracy, complete this section, and return the form to the Agency using the contact details provided in the cover letter. Verbal verification of employment or references may also be provided by calling the Agency. Section 3 is optional and allows for additional reference information.

Verification Options

❒ The information provided above is accurate to the best of my knowledge, and I confirm the applicant held the position listed for the dates indicated.

❒ Unable to verify this employment / no record of employment exists.

❒ The applicant was employed by our organization, but the information above is inaccurate.

Details:

Signature and Title: _____ **Date**: _____

Section 3: Optional Reference (To Be Completed by Former Employer)

Employment Status:	❒ Resigned ❒ Laid-Off ❒ Terminated for Cause
Reason for Termination/Resignation:	
Eligible for Rehire:	❒ Yes ❒ No ❒ Unsure
Recommended for Hire:	❒ Yes ❒ No ❒ Unsure
Record of Disciplinary Action:	❒ Yes ❒ No ❒ Unsure

Performance Ratings

Category	**Rating**
Teamwork	❒ Unsatisfactory ❒ Below Average ❒ Average ❒ Above Average ❒ Excellent
Dependability	❒ Unsatisfactory ❒ Below Average ❒ Average ❒ Above Average ❒ Excellent
Quality	❒ Unsatisfactory ❒ Below Average ❒ Average ❒ Above Average ❒ Excellent
Customer Service	❒ Unsatisfactory ❒ Below Average ❒ Average ❒ Above Average ❒ Excellent
Overall Performance	❒ Unsatisfactory ❒ Below Average ❒ Average ❒ Above Average ❒ Excellent

Additional Comments:

Section 4: Office Use Only

Verification Attempts (Date/Method):

1. _____

2. _____

3. _____

Verification Completed By:

❒ Previous Employer

❒ Agency (Verbal/Phone)

❒ Database

Date Verification Received: _____

Agency Representative Signature/Title:

_____

Employment Verification and Reference Form

Applicant Information

Applicant Name: Alexis Abraham

I authorize the Agency to obtain employment-related information necessary for making a hiring decision. I waive any restrictions preventing the release of this information and agree to provide any additional details required beyond what is included in my employment application and this form.

Applicant Signature: Alexis Abraham (Oct 2, 2025 08:54:50 EDT) **Date:** Oct 2, 2025

Section 1: Employment History (To Be Completed by Applicant)

Company Name:	Munson OMH				
Supervisor Name / Title:	Jason				
Company Address:	825 N center ave		Gaylord	MI	49735
Phone:	(989)348-0415				
Position Held:	Registered Nurse				
Dates of Employment (MM/YY):	From:	04/21	To:	10/25	
Full Name(s) Used During Employment:	Alexis Abraham	OTHERS:			

Section 2: Employment Verification (To Be Completed by Former Employer)

Instructions: Please review the applicant's information for accuracy, complete this section, and return the form to the Agency using the contact details provided in the cover letter. Verbal verification of employment or references may also be provided by calling the Agency. Section 3 is optional and allows for additional reference information.

Verification Options

❒ The information provided above is accurate to the best of my knowledge, and I confirm the applicant held the position listed for the dates indicated.

❒ Unable to verify this employment / no record of employment exists.

❒ The applicant was employed by our organization, but the information above is inaccurate.

Details:

Signature and Title: _____ **Date**: _____

Section 3: Optional Reference (To Be Completed by Former Employer)

Employment Status:	❒ Resigned ❒ Laid-Off ❒ Terminated for Cause
Reason for Termination/Resignation:	
Eligible for Rehire:	❒ Yes ❒ No ❒ Unsure
Recommended for Hire:	❒ Yes ❒ No ❒ Unsure
Record of Disciplinary Action:	❒ Yes ❒ No ❒ Unsure

Performance Ratings

Category	**Rating**
Teamwork	❒ Unsatisfactory ❒ Below Average ❒ Average ❒ Above Average ❒ Excellent
Dependability	❒ Unsatisfactory ❒ Below Average ❒ Average ❒ Above Average ❒ Excellent
Quality	❒ Unsatisfactory ❒ Below Average ❒ Average ❒ Above Average ❒ Excellent
Customer Service	❒ Unsatisfactory ❒ Below Average ❒ Average ❒ Above Average ❒ Excellent
Overall Performance	❒ Unsatisfactory ❒ Below Average ❒ Average ❒ Above Average ❒ Excellent

Additional Comments:

Section 4: Office Use Only

Verification Attempts (Date/Method):

1. _____

2. _____

3. _____

Verification Completed By:

❒ Previous Employer

❒ Agency (Verbal/Phone)

❒ Database

Date Verification Received: _____

Agency Representative Signature/Title:

_____

EMPLOYEE DIRECT DEPOSIT AUTHORIZATION FORM

Direct Deposit Authorization

I authorize **Evergreen HC Group Inc.** to deposit my paycheck directly into the bank account(s) specified below. I understand that:

- Funds will be deposited on each scheduled payday.
- **If my banking information changes, I must notify Evergreen HC Group Inc. immediately by submitting a new authorization form**.
- This authorization remains in effect until I provide written notice to cancel or change my direct deposit setup.

Primary Account (Account #1) – Required

Bank Name: Horizon Bank

Routing Number: 071201320

Account Number: 11702818

Account Type: ◉ Checking ○ Savings

◉ **Deposit my entire paycheck into this account**

○ **Deposit a specific percentage: _____%**

○ **Deposit a specific amount: $_____**

Secondary Account (Account #2) – Optional

Bank Name: _____

Routing Number: _____

Account Number: _____

Account Type: ○ Checking ○ Savings

○ **Deposit the remaining balance after primary account allocation**

○ **Deposit a specific percentage: _____%**

○ **Deposit a specific amount: $_____**

Authorization and Signature

By signing below, I authorize Evergreen HC Group Inc. to initiate deposits (and, if necessary, corrections to deposits made in error) to the accounts listed above. I understand that payroll processing times may vary and that I am responsible for ensuring my bank account details are accurate.

Employee Signature: Alexis Abraham
Alexis Abraham (Oct 2, 2025 08:54:50 EDT)

Date: Oct 2, 2025

Evergreen Home Health

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Employee Availability Form

Full Name: Alexis Abraham

Email address: alexis.abraham1142@kirtland.edu

Phone number: (989)350-8228

Desired Hours:

Full Time (30-40+hrs)	○
Part Time (10-29hrs)	◉

Availability (Choose yes if you are available or no if you are not for each time slot below. Add additional details in next section if available for only part of selected shift, etc.)

Day	Morning Hours 08:00 AM - 12:00 PM		Mid-day Hours 12:00PM - 05:00PM		Evening Hours 05:00PM - 08:00PM		On-Call Availability	
Monday	Yes ◉	No ○	Yes ◉	No ○	Yes ○	No ◉	Yes ◉	No ○
Tuesday	Yes ○	No ◉	Yes ○	No ◉	Yes ○	No ◉	Yes ○	No ◉
Wednesday	Yes ◉	No ○	Yes ◉	No ○	Yes ○	No ◉	Yes ◉	No ○
Thursday	Yes ○	No ◉	Yes ○	No ◉	Yes ○	No ◉	Yes ○	No ◉
Friday	Yes ◉	No ○	Yes ◉	No ○	Yes ○	No ◉	Yes ◉	No ○
Saturday	Yes ○	No ◉	Yes ○	No ◉	Yes ○	No ◉	Yes ○	No ◉
Sunday	Yes ○	No ◉	Yes ○	No ◉	Yes ○	No ◉	Yes ○	No ◉
Saturday – Every Other	Yes ○	No ◉	Yes ○	No ◉	Yes ○	No ◉	Yes ◉	No ○
Sunday – Every Other	Yes ○	No ◉	Yes ○	No ◉	Yes ○	No ◉	Yes ◉	No ○

What distance are you willing to travel to care for a patient:

0-30 mile radius	○
30-45 mile radius	○
45-60 mile radius	◉

Evergreen Home Health

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Shift/Day preferences: Do you have any preferences for specific days or shifts?

I am available Monday, Wednesday, and Friday until January 19th. Starting January 19th I am available Monday-Thursday. I am able to pick up some outside these hours with 24 hours notice to find childcare. I am willing to be on a weekend OC rotation.

*Note: We will do our best to accommodate these depending on workload, deadlines, and other employee availability. We can't guarantee all preferences will be reflected in the final schedule.

Additional Comments:

Acknowledgement:

I, Alexis Abraham (Print Name), confirm that I have provided accurate information about my work availability on this form.

I understand that it is my responsibility to update the company about any changes to my availability. I also confirm that while my preferences will be considered, my schedule is not always guaranteed to reflect them.

Employee Signature **Date**

Alexis Abraham

Alexis Abraham (Oct 2, 2025 08:54:50 EDT)

10/02/2025

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

MICHIGAN WORKFORCE BACKGROUND CHECK CONSENT AND DISCLOSURE

MCL 333.20173a, MCL 330.1134a, and MCL 400.734b require that a heath facility/agency that is a:

- Nursing Home
- Hospice
- Home for the Aged
- Adult Foster Care Facility (AFC)
- County Medical Care Facility
- Hospital that provides Swing Bed Services
- Home Health Agency
- Psychiatric Hospital/Inpatient Unit

Shall not employ, independently contract with, or grant clinical privileges to an individual who regularly has direct access to or provides direct services to patients or residents in the health facility/agency or AFC until the health facility/agency or AFC conducts a fingerprint-based criminal history check.

An individual who applies for employment either as an employee or as an independent contractor or for clinical privileges with a health care facility/agency or AFC and has received a good faith offer of employment, an independent contract, or clinical privileges shall give written consent at the time of application for the health care facility/agency or AFC to conduct a criminal history check, including a state and Federal Bureau of Investigation (FBI) fingerprint-based check, and shall give a written statement disclosing that he or she has not been convicted of a crime that would prohibit employment.

Note: Throughout this form:
- "Employee" includes persons independently contracted with and/or those granted clinical privileges.
- Clinical privileges do not apply to adult foster care facilities.

Health Facility or Agency

Licensee Name: EVERGREEN HOME HEALTH **Date:** Oct 2, 2025

Employment Applicant Name: Alexis Abraham

Facility Name/License Number: IQ00000001285673

The health facility/agency or AFC:

a. May not knowingly employ a worker, having direct access to patients or residents, who has been convicted of a disqualifying crime or has been the subject of a state or federal agency substantiated finding of patient or resident neglect, abuse, or misappropriation of property. "Direct access" means regular access to a patient or resident, or to a patient's or resident's property, financial information, medical records, treatment information, or any other identifying information.
b. May terminate the background check or decide not to hire the individual at any stage of the process.
c. Must ensure that any background check information provided will only be used for the purpose of determining an individual's suitability for employment in a covered health care facility/agency or AFC.
d. Must retain verification of compliance with background check requirements.
e. Will make the final employment decision.

*This does not include a finding of abuse, neglect, or misappropriation (financial exploitation) substantiated under the Michigan Mental Health Code or Adult Protective Services Act.

Part 1 – Consent to Conduct Background and Criminal Record Checks

As a condition of being considered for employment:

a. I hereby consent to and authorize the health facility/agency or AFC to conduct a background check that includes a search of state and federal abuse and neglect registries and databases, in addition to a fingerprint-based search of state and federal criminal history records. I understand that this consent extends to the release and sharing of such information with the Michigan Departments of Licensing and Regulatory Affairs and State Police.

b. I hereby authorize the release of any relevant information to the health facility/agency or AFC to be used to conduct the background check as required under MCL 333.20173a, MCL 330.1134a, and MCL 400.734b.

c. I understand, except for a knowing or intentional release of false information, the health facility/agency or AFC has no liability in connection with a background check conducted under MCL 333.20173a, MCL 330.1134a, and MCL 400.734b or the release of criminal history record information for the purposes of making an employment decision.

d. I understand that the health facility/agency or AFC will make the final employment determination. I also understand that the health facility/agency or AFC may terminate the background check or decide not to hire me at any stage of the process.

e. I understand that the health facility/agency or AFC, in denying employment to an applicant, and reasonably relying on information obtained through a background check, is provided immunity from any action brought by an applicant due to the employment decision.

f. I agree to provide the information necessary to conduct a criminal background check.

g. Privacy Act Statement:

    a. Authority: Acquisition, preservation, and exchange of fingerprints and associated information by the Federal Bureau of Investigation (FBI) is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

    b. Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

c. Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine Uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

h. Procedure to Obtain a Change, Correction or Update of Identification Records:
If, after reviewing his/her identification record, the subject thereof believes that it is incorrect or incomplete in any respect and wishes changes, corrections, or updating of the alleged deficiency; he/she should make application directly to the agency which contributed the questioned information. The subject of a record may also direct his/her challenge as to the accuracy or completeness of any entry on his/her record to the FBI, Criminal Justice Information Services (CJIS) Division, ATTN: SCU, Mod. D2, 1000 Custer Hollow Road, Clarksburg, WV 26306. The FBI will then forward the challenge to the agency which submitted the data requesting that agency to verify or correct the challenged entry. Upon the receipt of an official communication directly from the agency which contributed the original information, the FBI CJIS Division will make any changes necessary in accordance with the information supplied by that agency. (28 CFR § 16.34)

i. Consent:
I understand that my personal information and biometric data being submitted by Live Scan, will be used to search against identification records from both the Michigan State Police (MSP) and the FBI for the purpose listed above. I hereby authorize the release of my personal information for such purposes and release of any records found to the authorized requesting agency listed above.

Alexis Abraham
Alexis Abraham (Oct 2, 2025 08:54:50 EDT)

Signature of Applicant

Oct 2, 2025

Date

Part 2 – This employment applicant information is required to process a complete and accurate criminal record check.

EMPLOYEE PERSONAL INFORMATION

First Name: Alexandria

Middle Name: Ann

Last Name: Abraham Suffix: _____

OTHER NAME(S) USED (MAIDEN NAME, ALIAS)

Enter additional names used here (first and last):

N/a

First Name: Alexandria

Middle Name: Ann

Last Name: Freeman Suffix: _____

(Please use back of form or attach additional sheets if needed to report all other/alias names used)

Date of Birth: 06/08/1992 Social Security Number: 367-15-9063

Country of Citizenship: USA

Place of Birth (City, State/Province): Saginaw, MI

Height: 5ft 5in Weight: 150 Hair Color: Brown Eye Color: Brown Gender: ◉ Female ○ Male ○ Unknown

Race: ○ Asian ○ Black ○ Hispanic ○ Native American ○ Pacific Islander ◉ White ○ All

ADDRESS

Street Address: 2214 Hickorywood dr

City: Gaylord State: MI Zip Code: 49735 County: Otsego

Phone Number: (989)350-8228 Email Address: alexis.abraham1142@kirtland.edu

Driver's License or State/Canadian ID Number: MI F655044067430

State/Prov. License/ID Number

RESIDENCY

Has this employment applicant resided in Michigan continuously for the past 12 months? ◉ YES ○ NO

Job Title: Registered Nurse Conditional Hire Date: Nov 6, 2025

PROFESSIONAL LICENSE(S)/CERTIFICATION(S)

1. License/Certification Number: 4704370573
2. License/Certification Number: _____
3. License/Certification Number: _____

Part 3 – Employment Applicant Disclosure Statements

MCL 333.20173a, MCL 330.1134a, and MCL 400.734b, subsections (1)(a) through (g) describe crimes for which a conviction during the applicable time period will disqualify a person from being employed by, independently contracting with, or being granted clinical privileges in a covered health care facility/agency or AFC.

The above laws define "conviction" as, "… a final conviction, the payment of a fine, a plea of guilty or nolo contendere (no contest) if accepted by the court, or a finding of guilt for a criminal law violation or a juvenile adjudication or disposition by the juvenile division of probate court or family division of circuit court for a violation that if committed by an adult would be a crime." For relevant crimes described under 42-USC 1320a-7(a), convicted means that term as defined in 42-USC 1320a-7. These definitions may include cases that resulted in an alternative sentencing agreement, including deferred or delayed sentences, and for relevant crimes under 42-USC 1320a-(7)(a), convictions which may have been expunged or set aside.

I hereby certify that:

a. I have not been convicted of 1 or more of the crimes described in subsection (1)(a) through (g) of MCL 333.20173a, MCL 330.1134a, or MCL 400.734b within the applicable time period described in each subdivision. Initial AA Date Oct 2, 2025

b. I have never been found Not Guilty by Reason of Insanity. Initial AA Date Oct 2, 2025

c. I have never been the subject of a substantiated finding of neglect, abuse, or misappropriation of property resulting from an investigation conducted in accordance with 42 USC 1395i or 1396r. Initial AA Date Oct 2, 2025

If you are not able to certify a, b, or c above, please explain below:

Offense/Finding	Date	City, State	Sentence	Discharge Date

I certify that the above statements are correct and complete to the best of my knowledge:

Alexis Abraham
Alexis Abraham (Oct 2, 2025 08:54:50 EDT)

Signature of Applicant

Oct 2, 2025

Date

Part 4 – Conditional Employment

If the health facility/agency or AFC determines it necessary to employ me pending the results of the state and federal criminal history background check, I understand the following:

a. If the background check reveals disqualifying information my employment will be terminated for good cause, unless and until I successfully prove that the disqualifying information is inaccurate, expunged, or set aside.
b. If I knowingly provided false information regarding my identity, criminal convictions, or substantiated findings of patient or resident neglect, abuse, or misappropriation of property, I may be guilty of a misdemeanor punishable by imprisonment for not more than 93 days and/or a fine of not more than $500.00.
c. I understand that as a condition of continued employment, I am required to report in writing to the health facility/agency or AFC immediately upon being arraigned on a felony charge or convicted of one of more of the criminal offenses as described in MCL 333.20173a, MCL 330.1134a, and MCL 400.734b, or upon becoming the subject of an order or dispositional finding of "Not Guilty by Reason of Insanity," or upon being the subject of a state or federal agency substantiated finding of patient or resident neglect, abuse, or misappropriation of property. Reporting of an arraignment is not cause for termination or denial of employment.

Alexis Abraham
Alexis Abraham (Oct 2, 2025 08:54:50 EDT)

Signature of Applicant

Oct 2, 2025

Date

Part 5 – Applicant Rights

1. I understand that upon my request, the health facility/agency or AFC can provide a copy of any disqualifying record information found on any of the relevant registries or databases.

2. I understand that if I believe the results of any disqualifying information found of any relevant registry is inaccurate, it is my responsibility to contact the agency that maintains the registry to correct the registry information.

3. I understand that if I believe the results of the criminal history fingerprint record are inaccurate, or if the conviction contained in the criminal history record is one that may be expunged or set aside, I may file an appeal with the Department of Licensing and Regulatory Affairs.

4. As an applicant who is the subject of a national fingerprint-based criminal history record check for a noncriminal justice purpose (such as an application for employment or a license, an immigration or naturalization matter, security clearance, or adoption), you have certain rights which are discussed below. All notices must be provided to you in writing. These obligations are pursuant to the Privacy Act of 1974, Title 5, United States Code (U.S.C.) Section 552a, and Title 28 Code of Federal Regulations (CFR), 50.12, among other authorities.
   - You must be provided an adequate written FBI Privacy Act Statement (dated 2013 or later) when you submit your fingerprints and associated personal information. This Privacy Act Statement must explain the authority for collecting your fingerprints and associated information and whether your fingerprints and associated information will be searched, shared, or retained.
   - You must be advised in writing of the procedures for obtaining a change, correction, or update of your FBI criminal history record as set forth at 28 CFR 16.34.
   - You must be provided the opportunity to complete or challenge the accuracy of the information in your FBI criminal history record (if you have such a record).
   - If you have a criminal history record, you should be afforded a reasonable amount of time to correct or complete the record (or decline to do so) before the officials deny you the employment, license, or other benefit based on information in the FBI criminal history record.

- If agency policy permits, the officials may provide you with a copy of your FBI criminal history record for review and possible challenge. If agency policy does not permit it to provide you a copy of the record, you may obtain a copy of the record by submitting fingerprints and a fee to the FBI. Information regarding this process may be obtained at https:www.fbi.gov/services/cjis/identity-history-summary-checks and https:www.edo.cjis.gov.
- If you decide to challenge the accuracy or completeness of your FBI criminal history record, you should send your challenge to the agency that contributed the questioned information to the FBI. Alternatively, you may send your challenge directly to the FBI by submitting a request via https:www.edo.cjis.gov. The FBI will then forward your challenge to the agency that contributed the questioned information and request the agency to verify or correct the challenged entry. Upon receipt of an official communication from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency. (See 28 CFR 16.30 through 16.34.)
- You have the right to expect that officials receiving the results of the criminal history record check will use it only for authorized purposes and will not retain or disseminate it in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council.

Alexis Abraham
Alexis Abraham (Oct 2, 2025 08:54:50 EDT)

Signature of Applicant

Oct 2, 2025

Date

Part 6- Disclaimer

The state of Michigan is not responsible for any additional information, requirements, or use of any substitute forms that the above-named health facility/agency or AFC provides to the applicant.

THIS FORM MUST BE MAINTAINED IN THE APPLICANT FILE AND SHALL BE MADE AVAILABLE TO THE DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS UPON REQUEST.

If you are concerned about maintaining personal information in the file, you may only black out the following information as all additional information is required by Michigan State Police:

Social Security Number
Address
Driver's License Number
Telephone Number
Email Address
Professional License/Certification Number(s)

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

2025

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Alexandria A	Abraham	367-15-9063

Address: 2214 Hickorywood dr

City or town, state, and ZIP code: Gaylord MI 49735

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*.

(c)
- ☐ **Single** or **Married filing separately**
- ◉ **Married filing jointly** or **Qualifying surviving spouse**
- ☐ **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.)

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if: you are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

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, and when to use the estimator at *www.irs.gov/W4App*.

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 the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **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 generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

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 Dependent and Other Credits

If your total 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 $ 8,000

Multiply the number of other dependents by $500 . . . . . $ 0

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $ 8,000

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)** $ 0

(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)** $ 0

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $ 0

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.

Alexis Abraham
Alexis Abraham (Oct 2, 2025 08:54:50 EDT)

Employee's signature (This form is not valid unless you sign it.) — **Date**: Oct 2, 2025

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)
Evergreen HC Group Inc 403 W Main Street Ste A1 Gaylord, MI 49735	Nov 6, 2025	82-4026167

General Instructions

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

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, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 **and** you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), 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 2025 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 17, 2026.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

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

1. Are submitting this form after the beginning of the year;

2. Expect to work only part of the year;

3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;

4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

5. Prefer the most accurate withholding for multiple job situations.

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

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. Submit a separate Form W-4 for each job.

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

Instead, if you (and your spouse) have a total of only two jobs, you may 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 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. This step 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. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. 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 2025 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. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

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 2025 itemized deductions (from Schedule A (Form 1040)). 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:
- $30,000 if you're married filing jointly or a qualifying surviving spouse
- $22,500 if you're head of household
- $15,000 if you're single or married filing separately

. . . . . **2** $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. 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)). 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 territories 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 Surviving Spouse

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	$0	$700	$850	$910	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	700	1,700	1,910	2,110	2,220	2,220	2,220	2,220	2,220	2,220	3,220
$20,000 - 29,999	700	1,700	2,760	3,110	3,310	3,420	3,420	3,420	3,420	3,420	4,420	5,420
$30,000 - 39,999	850	1,910	3,110	3,460	3,660	3,770	3,770	3,770	3,770	4,770	5,770	6,770
$40,000 - 49,999	910	2,110	3,310	3,660	3,860	3,970	3,970	3,970	4,970	5,970	6,970	7,970
$50,000 - 59,999	1,020	2,220	3,420	3,770	3,970	4,080	4,080	5,080	6,080	7,080	8,080	9,080
$60,000 - 69,999	1,020	2,220	3,420	3,770	3,970	4,080	5,080	6,080	7,080	8,080	9,080	10,080
$70,000 - 79,999	1,020	2,220	3,420	3,770	3,970	5,080	6,080	7,080	8,080	9,080	10,080	11,080
$80,000 - 99,999	1,020	2,220	3,420	4,620	5,820	6,930	7,930	8,930	9,930	10,930	11,930	12,930
$100,000 - 149,999	1,870	4,070	6,270	7,620	8,820	9,930	10,930	11,930	12,930	14,010	15,210	16,410
$150,000 - 239,999	1,870	4,240	6,640	8,190	9,590	10,890	12,090	13,290	14,490	15,690	16,890	18,090
$240,000 - 259,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$260,000 - 279,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$280,000 - 299,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$300,000 - 319,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,170	19,170
$320,000 - 364,999	2,040	4,440	6,840	8,390	9,790	11,100	12,470	14,470	16,470	18,470	20,470	22,470
$365,000 - 524,999	2,790	6,290	9,790	12,440	14,940	17,350	19,650	21,950	24,250	26,550	28,850	31,150
$525,000 and over	3,140	6,840	10,540	13,390	16,090	18,700	21,200	23,700	26,200	28,700	31,200	33,700

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	$200	$850	$1,020	$1,020	$1,020	$1,370	$1,870	$1,870	$1,870	$1,870	$1,870	$2,040
$10,000 - 19,999	850	1,700	1,870	1,870	2,220	3,220	3,720	3,720	3,720	3,720	3,890	4,090
$20,000 - 29,999	1,020	1,870	2,040	2,390	3,390	4,390	4,890	4,890	4,890	5,060	5,260	5,460
$30,000 - 39,999	1,020	1,870	2,390	3,390	4,390	5,390	5,890	5,890	6,060	6,260	6,460	6,660
$40,000 - 59,999	1,220	3,070	4,240	5,240	6,240	7,240	7,880	8,080	8,280	8,480	8,680	8,880
$60,000 - 79,999	1,870	3,720	4,890	5,890	7,030	8,230	8,930	9,130	9,330	9,530	9,730	9,930
$80,000 - 99,999	1,870	3,720	5,030	6,230	7,430	8,630	9,330	9,530	9,730	9,930	10,130	10,580
$100,000 - 124,999	2,040	4,090	5,460	6,660	7,860	9,060	9,760	9,960	10,160	10,950	11,950	12,950
$125,000 - 149,999	2,040	4,090	5,460	6,660	7,860	9,060	9,950	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,090	5,460	6,660	8,450	10,450	11,950	12,950	13,950	15,080	16,380	17,680
$175,000 - 199,999	2,040	4,290	6,450	8,450	10,450	12,450	13,950	15,230	16,530	17,830	19,130	20,430
$200,000 - 249,999	2,720	5,570	7,900	10,200	12,500	14,800	16,600	17,900	19,200	20,500	21,800	23,100
$250,000 - 399,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$400,000 - 449,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$450,000 and over	3,140	6,490	9,160	11,660	14,160	16,660	18,660	20,160	21,660	23,160	24,660	26,160

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	$450	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,870	$1,870	$1,870	$1,890
$10,000 - 19,999	450	1,450	2,000	2,200	2,220	2,220	2,220	3,180	4,070	4,070	4,090	4,290
$20,000 - 29,999	850	2,000	2,600	2,800	2,820	2,820	3,780	4,780	5,670	5,690	5,890	6,090
$30,000 - 39,999	1,000	2,200	2,800	3,000	3,020	3,980	4,980	5,980	6,890	7,090	7,290	7,490
$40,000 - 59,999	1,020	2,220	2,820	3,830	4,850	5,850	6,850	8,050	9,130	9,330	9,530	9,730
$60,000 - 79,999	1,020	3,030	4,630	5,830	6,850	8,050	9,250	10,450	11,530	11,730	11,930	12,130
$80,000 - 99,999	1,870	4,070	5,670	7,060	8,280	9,480	10,680	11,880	12,970	13,170	13,370	13,570
$100,000 - 124,999	1,950	4,350	6,150	7,550	8,770	9,970	11,170	12,370	13,450	13,650	14,650	15,650
$125,000 - 149,999	2,040	4,440	6,240	7,640	8,860	10,060	11,260	12,860	14,740	15,740	16,740	17,740
$150,000 - 174,999	2,040	4,440	6,240	7,640	8,860	10,860	12,860	14,860	16,740	17,740	18,940	20,240
$175,000 - 199,999	2,040	4,440	6,640	8,840	10,860	12,860	14,860	16,910	19,090	20,390	21,690	22,990
$200,000 - 249,999	2,720	5,920	8,520	10,960	13,280	15,580	17,880	20,180	22,360	23,660	24,960	26,260
$250,000 - 449,999	2,970	6,470	9,370	11,870	14,190	16,490	18,790	21,090	23,280	24,580	25,880	27,180
$450,000 and over	3,140	6,840	9,940	12,640	15,160	17,660	20,160	22,660	25,050	26,550	28,050	29,550

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS Form I-9
OMB No.1615-0047
Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)
Abraham	Alexandria	A	Freeman

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code
2214 Hickorywood dr		Gaylord	MI	49735

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number
06/08/1992	367-15-9063	alexis.abraham1142@kirtland.edu	(989)350-8228

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- (●) 1. A citizen of the United States
- ( ) 2. A noncitizen national of the United States (See Instructions.)
- ( ) 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ( ) 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

Signature of Employee	Today's Date (mm/dd/yyyy)
Alexis Abraham (Oct 2, 2025 08:54:50 EDT)	Oct 2, 2025

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1			Drivers License		Social Security Card
Issuing Authority			State of Michigan		U.S. Social Security Administration
Document Number (if any)			F 655 044 067 430		367159063
Expiration Date (if any)			06/08/2029		N/A
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

( ) Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears 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.

First Day of Employment (mm/dd/yyyy): Nov 6, 2025

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
Churches, Christopher Agency Administrator	Christopher Churches (Nov 6, 2025 13:24:33 EST)	Nov 6, 2025

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
Evergreen HC Group Inc	403 W Main Street Suite A Gaylord, MI 49735

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

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 an individual temporarily authorized to work for a specific employer because of his or her status or parole: **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 individual's status or parole 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 For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
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				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	**OR**	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

Supplement A, Preparer and/or Translator Certification for Section 1

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS Form I-9 Supplement A
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

Supplement B,
Reverification and Rehire (formerly Section 3)

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

Check here if you used an alternative procedure authorized by DHS to examine documents.

MI-W4

(Rev. 12-20)

EMPLOYEE'S MICHIGAN WITHHOLDING EXEMPTION CERTIFICATE
STATE OF MICHIGAN - DEPARTMENT OF TREASURY

This certificate is for Michigan income tax withholding purposes only. ***Read instructions on page 2 before completing this form.***

Issued under P.A. 281 of 1967.

1. Full Social Security Number	2. Date of Birth
367-15-9063	06/08/1992

3. Name (First, Middle Initial, Last)	4. Driver's License Number or State ID
Alexandria A Abraham	F655044067430

Home Address (No., Street, P.O. Box or Rural Route)	5. Are you a new employee?	(mm/dd/yyyy)
2214 Hickorywood dr	[X] Yes If Yes, enter date of hire.....	10/02/2025
	[ ] No	

City or Town	State	ZIP Code
Gaylord	MI	49735

6. Enter the number of personal and dependent exemptions (see instructions) ..... ▸ 6. 0

7. Additional amount you want deducted from each pay (if employer agrees) ..... 7. $ 0 .00

8. I claim exemption from withholding because (see instructions):

a. [ ] A Michigan income tax liability is not expected this year.

b. [ ] Wages are exempt from withholding. Explain: _____

c. [ ] Permanent home (domicile) is located in the following Renaissance Zone: _____

EMPLOYEE: If you fail or refuse to file this form, your employer must withhold Michigan income tax from your wages without allowance for any exemptions. Keep a copy of this form for your records. See additional instructions on page 2.

Under penalty of perjury, I certify that the number of withholding exemptions claimed on this certificate does not exceed the number I am allowed to claim. If claiming exemption from withholding, I certify that I do not anticipate a Michigan income tax liability this year.

9. Employee's Signature	Date
Alexis Abraham Alexis Abraham (Oct 2, 2025 08:54:50 EDT)	Oct 2, 2025

EMPLOYER: Complete the below section.

10. Employer's Name	11. Federal Employer Identification Number		
Evergreen HC Group Inc	82-4026167		
Address (No., Street, P.O. Box or Rural Route)	City or Town	State	ZIP Code
403 W Main St Suite A1	Gaylord	MI	49735
Name of Contact Person	Contact Phone Number		
Christopher Churches	989-370-3474		

INSTRUCTIONS TO EMPLOYER: Keep a copy of this certificate with your records. All new hires must be reported to the State of Michigan. See **www.mi-newhire.com** for information.

In addition, a copy of this form must be sent to the Michigan Department of Treasury if the employee claims 10 or more exemptions or claims they are exempt from withholding. Send a copy to:

Michigan Department of Treasury
Tax Technical Section
P.O. Box 30477
Lansing, MI 48909

INSTRUCTIONS TO *EMPLOYEE'S MICHIGAN WITHHOLDING EXEMPTION CERTIFICATE* (Form MI-W4)

You must submit a Michigan withholding exemption certificate (form MI-W4) to your employer on or before the date that employment begins. If you fail or refuse to submit this certificate, your employer must withhold tax from your compensation without allowance for any exemptions. Your employer is required to notify the Michigan Department of Treasury if you have claimed 10 or more personal or dependency exemptions or claimed that you are exempt from withholding.

You MUST provide a new MI-W4 to your employer within 10 days if your residency status changes or if your exemptions decrease because: a) your spouse, for whom you have been claiming an exemption, is divorced or legally separated from you or claims his/her own exemption(s) on a separate certificate, or b) a dependent no longer qualifies under the Internal Revenue Code.

Line 5: If you check "Yes," enter your date of hire.

Line 6: Personal and dependency exemptions. The number of exemptions claimed here may not exceed the number of exemptions you are entitled to claim on a *Michigan Individual Income Tax Return* (Form MI-1040). Dependents include qualifying children and qualifying relatives under the Internal Revenue Code, even if your AGI exceeds the limits to claim federal tax credits for them.

Do not claim the same exemptions more than once or tax will be under-withheld. Specifically, **do not claim:**

- Your personal exemption if someone else will claim you as their dependent.
- Your personal exemption with more than one employer at a time.
- Your spouse's personal exemption if they claim it with their employer.
- Your dependency exemptions if someone else (for example, your spouse) is claiming them with their employer.

Line 7: You may designate additional withholding if you expect to owe more than the amount withheld.

Line 8a: You may claim exemption from Michigan income tax withholding if all of the following conditions are met:

i) Your employment is intermittent, temporary, or less than full time;

ii) Your personal and dependency exemptions exceed your annual taxable compensation;

iii) You claimed exemption from federal withholding; and

iv) You did not incur a Michigan income tax liability for the previous year.

Line 8b: Reasons wages might be exempt from withholding include:

- You are a nonresident spouse of military personnel stationed in Michigan.
- You are a resident of one of the following reciprocal states while working in Michigan: Illinois, Indiana, Kentucky, Minnesota, Ohio, or Wisconsin.
- You are an enrolled member of a federally-recognized tribe that does not have a tax agreement with the state of Michigan, you reside within that tribe's Indian Country (as defined in 18 USC 1151), and compensation from this job will be earned within that Indian Country.

Line 8c: For questions about Renaissance Zones, contact your local assessor's office.

Approved By: Governing Body/Owner	**Policy Name:** EH047 – Employee Owned Vehicle Use Policy
Date Effective: 01/01/2025	**Date(s) Revised:**

Policy

EVERGREEN HOME HEALTH permits eligible employees to use their personal vehicles as part of their designated duties. This policy ensures that all vehicles used are legally registered, properly insured, and maintained in a safe and operational condition. Employees must comply with all applicable laws and regulations, as well as provide proof of valid insurance coverage that includes protection for both the employee and any patients being transported.

Procedures

I. EMPLOYEE ELIGIBILITY AND REQUIREMENTS

1. Authorization: Employees must receive written authorization from Evergreen Home Health to use their personal vehicle for purposes related to their employment.
2. Vehicle Requirements:
    a. The vehicle must be legally registered, licensed, and inspected (if required by state law).
    b. The vehicle must be in safe and operational condition.
3. License & Insurance Requirements:
    a. Employees must maintain valid auto insurance that meets or exceeds state minimum requirements.
    b. Employees must maintain a valid Driver's License.
    c. The insurance policy must cover the employee and any patients being transported (if applicable).
    d. Employees must provide proof of insurance, including the policy number and insurance company contact information.
4. Motor Vehicle Record (MVR) Checks:
    a. Employees must consent to and pass a Motor Vehicle Record (MVR) check as a condition of using their personal vehicle for patient transportation.
    b. The MVR check will be conducted at the time of hire and periodically thereafter, as determined by Evergreen Home Health.
    c. Employees must maintain a clean driving record, free of major violations (e.g., DUIs, reckless driving, or excessive speeding tickets) to remain eligible for vehicle use under this policy.

II. APPROVAL PROCESS

1. Authorization: Employees must obtain written approval from an Evergreen Home Health Administrator before using their personal vehicle for patient transportation.

2. Documentation: Employees must submit the completed Employee Certification Form, including vehicle and insurance details, to the Administrator for review and approval.
3. Recordkeeping: Approved forms will be kept on file by Evergreen Home Health for compliance and verification purposes.

III. RESPONSIBILITIES

1. Employee Responsibilities:
    a. Ensure the vehicle is safe, operational, and properly maintained.
    b. Maintain valid auto insurance and provide updated proof of insurance as required.
    c. Maintain a valid Driver's License.
    d. Comply with all traffic laws and regulations while transporting patients.
    e. Report any accidents or incidents involving the vehicle immediately to Evergreen Home Health.
2. Employer Responsibilities:
    a. Review and approve employee requests to use personal vehicles for patient transportation.
    b. Maintain records of approved vehicles and insurance documentation.
    c. Provide guidance and support to employees regarding this policy.

SEE EMPLOYEE CERTIFICATION STATEMENT BELOW

Employee Certification Form

I, Alexis Abraham (please print full name), certify that the vehicle described below is legally registered, properly licensed, and maintained in a safe and operational condition. I further certify that I currently carry, and will continue to maintain, a valid driver's license and auto insurance that meets all state requirements, providing coverage for myself and any patients I transport in the course of my duties with Evergreen HC Group Inc. throughout my employment.

I authorize Evergreen HC Group Inc. to conduct Motor Vehicle Record (MVR) checks as necessary to ensure my continued eligibility for vehicle use authorization.

Vehicle Information	
License Plate Number	DVF7743
State Registered	Michigan
Make/Model	Kia Carnival
Color	Silver

Insurance Information	
Insurance Company	State Farm
Policy Number	6518286-E10-22G
Insurance Company Phone #	(989)732-9081

Vehicle Owner Information	
Signature of Vehicle Owner	Alexis Abraham Alexis Abraham (Oct 2, 2025 08:54:50 EDT)
Address of Vehicle Owner	2214 Hickorywood Dr
Phone Number of Vehicle Owner	(989)350-8228

By signing below, I acknowledge that I have read, understood, and agree to comply with Evergreen Home Health's Employee Vehicle Use Policy EH047.

Christopher Churches Christopher Churches (Nov 6, 2025 13:24:33 EST)	Nov 6, 2025	Alexis Abraham Alexis Abraham (Oct 2, 2025 08:54:50 EDT)	Oct 2, 2025
Agency Approval Signature	*Date*	*Employee Signature*	*Date*

Christopher Churches	Administrator
Agency Representative Name	*Title*

Evergreen Home Health

GROWING STRONGER EVERY DAY, WITH EVERGREEN HOME HEALTH.

Evergreen Home Health Training Plan / Calendar

Training Requirements:

• Non-direct care (agency administrative, companion or homemaker) personnel will have a minimum of 8 hours of in-services / continuing education per year.

• Direct care personnel must have a minimum of 12 hours of in-services/continuing education per year. Aide in-service training may be conducted while the aide is providing care to a client.

New Hire Employee Training - Clinician (Skilled Nurse, Therapy) / Administrative		
Course (Due within 30 days of Hire)	**Source**	**Credits**
About Advance Directives	Relias	0.5
Hand Hygiene Basics	Relias	0.25
HIPAA: Basics	Relias	0.5
Infection Control in Home Care	Relias	0.75
Workplace Emergencies and Natural Disasters: An Overview	Relias	0.5
Protecting Patient Rights in Home Health	Relias	0.5
Preventing, Recognizing, and Reporting Abuse	Relias	0.5
Home Health Care OASIS-E	Relias	0.5
Cultural Diversity for Home-Based Providers	Relias	0.75
Maintaining Professional Boundaries	Relias	0.5
Ethics and Corporate Compliance	Relias	0.5
Effective Healthcare Communications Skills	Relias	1
	TOTAL:	**6.75**

New Hire Employee Training - Home Health Aide		
Course (Due within 30 days of Hire)	**Source**	**Credits**
About Advance Directives	Relias	0.5
Hand Hygiene Basics	Relias	0.25
HIPAA: Basics	Relias	0.5
Infection Control in Home Care	Relias	0.75
Workplace Emergencies and Natural Disasters: An Overview	Relias	0.5
Protecting Patient Rights in Home Health	Relias	0.5
Preventing, Recognizing, and Reporting Abuse	Relias	0.5
Assisting with ADLs Self-Paced	Relias	2
Cultural Diversity for Home-Based Providers	Relias	0.75
Home Health Care OASIS-E	Relias	0.5
Maintaining Professional Boundaries	Relias	0.07
Ethics and Corporate Compliance	Relias	0.5
Basic Principles of Communication	Relias	0.07
	TOTAL:	**7.39**

Administrative Staff Annual Training

Jan-Jun Administrative Employee Training (Due by June 30th each year)

Course	Source	Credits
About Advance Directives	Relias	0.5
Hand Hygiene Basics	Relias	0.25
HIPAA: Basics	Relias	0.5
Infection Control in Home Care	Relias	0.75
Workplace Emergencies and Natural Disasters: An Overview	Relias	0.5
Protecting Patient Rights in Home Health	Relias	0.5
Preventing, Recognizing, and Reporting Abuse	Relias	0.5
Workplace Safety: The Basics	Relias	0.25
	TOTAL JAN-JUN:	**3.75**

Jul-Dec Administrative Employee Training (Due by December 31st each year)

Course	Source	Credits
Effective Healthcare Communication Skills	Relias	1
Home Health PDGM and the OASIS	Relias	1
Home Health and Corporate Compliance	Relias	0.75
Maintaining Professional Boundaries	Relias	0.5
Sexual Harassment: What Employees Need to Know	Relias	0.5
Ethics and Corporate Compliance	Relias	0.5
	TOTAL JUL-DEC:	**4.25**
	TOTAL YEARLY TRAINING:	**8**

Home Health Aide Training

Jan-Jun Yearly HHA Training (Due by June 30th each year)

Course	Source	Credits
About Advance Directives	Relias	0.5
Assisting with ADLs Self-Paced	Relias	2
Hand Hygiene Basics	Relias	0.25
HIPAA: Basics	Relias	0.5
Ethics and Corporate Compliance	Relias	0.5
Infection Control in Home Care	Relias	0.75
Workplace Emergencies and Natural Disasters: An Overview	Relias	0.5
Protecting Patient Rights in Home Health	Relias	0.5
Preventing, Recognizing, and Reporting Abuse	Relias	0.5
	TOTAL JAN-JUN:	**6**

Jul-Dec Yearly HHA Training* (Due by December 31st each year)

Course	Source	Credits
An Overview of Quality Dementia Care	Relias	1
Assisting with IADLS	Relias	1
Assisting with Personal Care	Relias	1
Assisting with Transfers and Ambulation	Relias	0.13
Assisting with the Self- Administration of Medications for Home Care Staff	Relias	0.5
Bathing the Difficult Patient	Relias	0.5
Assisting with Proper Positioning	Relias	1
Using Mechanical Lifts Safely	Relias	1
	TOTAL JUL-DEC:	**6.13**
	TOTAL YEARLY TRAINING:	**12.13**

*HHAs may choose other Basic Care Skills Courses on Relias if approved by Administration

Clinician (Skilled Nurse, PT, PTA, COTA, MSW, ST) Annual Training		
Jan-Jun Yearly Clinician Training (Due by June 30th each year)		
Course	**Source**	**Credits**
About Advance Directives	Relias	0.5
Hand Hygiene Basics	Relias	0.25
HIPAA: Basics	Relias	0.5
Infection Control in Home Care	Relias	0.75
Workplace Emergencies and Natural Disasters: An Overview	Relias	0.5
Protecting Patient Rights in Home Health	Relias	0.5
Preventing, Recognizing, and Reporting Abuse	Relias	0.5
Domestic Violence Awareness for Healthcare Personnel	Relias	2
Ethics and Corporate Compliance	Relias	0.5
	TOTAL JAN-JUN:	**6**
Jul-Dec Yearly Clinician Training* (Due by December 31st each year)		
Course	**Source**	**Credits**
Effective Healthcare Communications Skills	Relias	1
Reconciling Medications in the Home Setting	Relias	1
Home Health OASIS Overview	Relias	0.5
Implicit Bias in Healthcare	Relias	1.5
Developing an Individualized Patient-Centered Care Plan	Relias	1
Care Transitions in Home Health	Relias	1
	TOTAL JUL-DEC:	**6**
	TOTAL YEARLY TRAINING:	**12**
*Clinicians may choose other accrediting body approved courses on Relias if approved by Administration		
*Clinicans may count other completed CEU's toward annual training requirements		

Employee Training Plan Acknowledgment and Certification

I acknowledge that I have reviewed the Evergreen Home Health Training Plan and understand the training requirements for my role.

I understand that:

- **Direct care personnel** (including clinicians and home health aides) are required to complete a **minimum of 12 hours** of in-service or continuing education annually.
- **Non-direct care personnel** (such as administrative, companion, or homemaker staff) are required to complete a **minimum of 8 hours** of in-service or continuing education annually.
- Specific courses and credit hours have been assigned based on my position, and these trainings are to be completed through Relias unless otherwise approved by administration.
- Completion of required training is a condition of continued employment and essential to maintaining compliance with agency policies and regulatory standards. AA

By signing below, I certify that I understand the training expectations for my position and agree to complete the required courses within the designated timeframes.

Employee Name (Printed): Alexis Abraham

Employee Signature: Alexis Abraham
Alexis Abraham (Oct 2, 2025 08:54:50 EDT)

Date: Oct 2, 2025

Documentation Requirements

We need a copy of the following documents on file before you are able to start:

- Social Security Card or Birth Certificate
- Valid Driver's License
- Valid Automobile Insurance
- Current Licensure (RN, LPN, CNA, etc.)

Please bring these with you to your in-person orientation OR email a clear photo encompassing the entire document to homehealth@evergreenhcgroup.com

Alexis Abraham
Alexis Abraham (Oct 2, 2025 08:54:50 EDT)

Oct 2, 2025