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## INTEROFFICE MEMORANDUM

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**TO:** NEW EMPLOYEES  
**FROM:** LINDA ELDRIDGE, PAYROLL COORDINATOR  
**SUBJECT:** PAYROLL PAPERWORK

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Please review and complete the attached packet of paperwork. **Please** make sure you review both sides of each page and sign where indicated. No pay can be processed prior to receipt of **all completed** payroll paperwork including physical/TB forms. A letter stating acceptability of a "low risk" statement in lieu of TB testing and immunization requirements has been provided should you need one for your medical provider.

On Form I9, complete the appropriate sections and **provide the acceptable documents** as listed on the back for review to any building secretary or the payroll office for verification. Further instructions for the I9, if desired, are available upon request.

All District policies are located on our website at: [www.freedomareaschools.org](http://www.freedomareaschools.org)

If you have any questions, please call me at 724-775-7644 Ext. 126, or email me at [l Eldridge@freedomarea.org](mailto:l Eldridge@freedomarea.org).

Thank you.

## Required Hiring Information

There are mandatory clearances/forms that must be obtained prior to working in the Freedom Area School District.

### **Act 34-PA Criminal Record History - \$22.00 (subject to change)(free for volunteer)**

This clearance can be obtained online if you go to. You may <https://epatch.pa.gov/home> apply online or download the form for submission. The PATCH unit will no longer mail out any PATCH check that is requested on the EPATCH web site. It will be the responsibility of the requestor to print out the No Record or Record response. PATCH Helpdesk 1-888-QUERY-PA (1-888-783-7972) *Volunteers: Please indicate "VOLUNTEER" in the Reason for Request section.*

### **Act 151 PA Child Abuse History - \$13 (subject to change) (free for volunteer)**

This clearance can be obtained online at [www.compass.state.pa.us/CWIS](http://www.compass.state.pa.us/CWIS) . You may apply online or download the form for submission. *Volunteers: Please indicate "SCHOOL" in the Purpose of Clearance section.*

### **Act 114 FBI Federal Criminal History (Fingerprints) - \$25.25(subject to change)**

The fingerprint-based background check is a multiple-step process, as follows:

Step One: Register online at [www.uenroll.identogo.com](http://www.uenroll.identogo.com) or by calling 1-844-321-2101. **Code: 1KG6XN**

Step Two: Go to an approved fingerprint site to be fingerprinted. A complete list of approved locations can be found at [www.uenroll.identogo.com](http://www.uenroll.identogo.com).

Step Three: Once you have been fingerprinted, provide the UEID number to the FASD via e-mail at [leldridge@freedomarea.org](mailto:leldridge@freedomarea.org) .

When registering, you will need to provide the code **1KG6XN** . When asked which state, select Pennsylvania, when asked to choose an agency – select PDE, and when asked to pick reason – select PDE-School District. (It is important to pick the correct options in order for the School District to obtain your results).

## **Act 126**

**Act 126 consists of completing mandated Act 126 Child Abuse Recognition and Reporting, as well as completing the Professional Ethics and the Educator Discipline Act.**

You must submit **BOTH** certificates (one from each training. Instructions for both are below:

The **Child Abuse Recognition & Reporting training** can be completed at [www.reportabusepa.pitt.edu](http://www.reportabusepa.pitt.edu).

**AND**

**The Professional Ethics & the Educator Discipline Act training** can be completed at [pdesas.org](http://pdesas.org). You must create an account first before you can access the courses, go to [http://pdesas.org/](http://pdesas.org) to create a new account if you don't already have one. Once you have an id and password, then go to <http://pdc.pdesas.org/> and log in. Once logged in, near the top of screen, click on menu and pick course catalog, then when that screen opens, half-way down, on drop-down menu pick Act 126 and then pick appropriate option.

### **Act 71-Suicide Prevention Training-Free (Educators working with grades 6-12 only)**

Training can be completed online at <http://pspalearning.com> , choose "Suicide Prevention for Educators" , register and proceed with the course.

### **Act 24 Arrest and Conviction Report-Free-EMPLOYEES ONLY**

This form is available on the District website at [www.freedomareaschools.org](http://www.freedomareaschools.org). It is in the *Employee Only* and *Employment* sections.

### **Act 168 of 2014-Sexual Misconduct/Abuse Disclosure Release-Free THIS IS FOR NEW HIRES ONLY**

This form must be completed for your current employer **AND** for any other place of employment where you had direct contact with children. It is available on the District website at [www.freedomareaschools.org](http://www.freedomareaschools.org) in the *Employee Only* and *Employment* sections. Please complete the information and submit to Payroll. They will forward to employers for completion.

# FREEDOM AREA SCHOOL DISTRICT PERSONNEL GENERAL INFORMATION FORM

Full Name \_\_\_\_\_

Address \_\_\_\_\_

E-Mail \_\_\_\_\_

Telephone Home \_\_\_\_\_

SS# \_\_\_\_\_

Cell \_\_\_\_\_

D/O/B \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you worked in another public school district, area vocational technical school or intermediate unit (PA Only) prior to July 1, 1994?

\_\_\_\_\_ YES

\_\_\_\_\_ NO

Are you presently a member of the Public School Employees Retirement System? (PSERS)

\_\_\_\_\_ NO

If YES, what district(s) did you work for? \_\_\_\_\_

\_\_\_\_\_ YES

What is your Class & Rate? \_\_\_\_\_

Have you paid the annual Local Services Tax (LST) for the current year? *circle one* YES NO

*If YES you must provide proof of payment, or the district is required to deduct this tax from your earnings*

LST Exemption Form is included in packet-complete if you have already paid it or will not earn at least \$12,000

FASD is required by law to withhold retirement from all salaried part-time employees when they start.

Once PT hrly/daily employees reach 500 hrs/80 days FASD must begin withholding retirement.

Part-time employees who have an IRA and can provide proof of such may request to waive membership in

The Public School Employees Retirement System (PSERS) within 90 days of qualification.

If you wish to waive membership, please contact payroll office for more information.

I authorize the receipt of employer communications via electronic delivery (e-mail): *circle one* YES NO

Employee Signature\* \_\_\_\_\_

\_\_\_\_\_ Date

*\*Signature acknowledges receipt and understanding of all packet info and Board policies.*

*All Policies are available at [www.freedomareaschools.org](http://www.freedomareaschools.org) in the "Employee Only" Section. Paper copies available upon request.*

# EMERGENCY CONTACT INFORMATION

Please complete and submit to payroll office

EMPLOYEE NAME: \_\_\_\_\_

First Emergency Contact Name: \_\_\_\_\_

First Emergency Contact Number(s):

\_\_\_\_\_  
\_\_\_\_\_

Second Emergency Contact Name: \_\_\_\_\_

Second Emergency Contact Number(s):

\_\_\_\_\_  
\_\_\_\_\_

Please provide a name and contact info for person(s) permitted to collect any  
outstanding funds should it be required.

Beneficiary: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

NOTES:

\_\_\_\_\_  
\_\_\_\_\_



# **FREEDOM AREA SCHOOL DISTRICT**

## **Direct Deposit Sign-Up Form**

Required  
Account Information

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Bank \_\_\_\_\_

Account Type: Checking \_\_\_\_\_ Savings \_\_\_\_\_

Routing # \_\_\_\_\_ Acct.# \_\_\_\_\_

### **Attach a voided check and return to the Payroll Department**

I hereby authorize my employer (hereinafter "Company") to deposit any amounts owed me by initiating credit entries to my account at the financial institution (hereinafter "Bank") indicated on this form. Further, I authorize Bank to accept and to credit any credit entries indicated by Company to my account. In event that Company deposits funds erroneously into my account, I authorize Company to debit my account for an amount not to exceed the original amount of the erroneous credit.

This authorization is to remain in full force and effect until Company and Bank have received written notice from me of its termination in such time and in such manner as to afford Company and Bank Reasonable opportunity to act on it.

Employee Signature \_\_\_\_\_

Date \_\_\_\_\_

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

**2024**

<b>Step 1:</b> <b>Enter Personal Information</b>	(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 <a href="http://www.ssa.gov">www.ssa.gov</a> .
	City or town, state, and ZIP code		
	(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

Complete Steps 2-4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App).

<b>Step 2:</b> <b>Multiple Jobs or Spouse Works</b>	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 <a href="http://www.irs.gov/W4App">www.irs.gov/W4App</a> for 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 . . . . . <input type="checkbox"/>
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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.)

<b>Step 3:</b> <b>Claim Dependent and Other Credits</b>	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 \$ _____ Multiply the number of other dependents by \$500 . . . . . \$ _____ 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 . . . . .	<b>3</b>	\$
<b>Step 4 (optional):</b> <b>Other Adjustments</b>	(a) <b>Other income (not from jobs).</b> 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 . . . . .	<b>4(a)</b>	\$
	(b) <b>Deductions.</b> 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 . . . . .	<b>4(b)</b>	\$
	(c) <b>Extra withholding.</b> Enter any additional tax you want withheld each pay period . . . . .	<b>4(c)</b>	\$

<b>Step 5:</b> <b>Sign Here</b>	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
<b>Employers Only</b>	Employer's name and address	First date of employment	Employer identification number (EIN)

## General Instructions

Section references are to the Internal Revenue Code.

### 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](http://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 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 and you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 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 2024 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 15, 2025.

**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](http://www.irs.gov/W4App) if you:

1. Expect to work only part of the year;
2. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or
3. 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](http://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.

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 2024 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](http://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 2024 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: 

• \$29,200 if you're married filing jointly or a qualifying surviving spouse	}	. . . . .	<b>2</b>	\$ _____
• \$21,900 if you're head of household				
• \$14,600 if you're single or married filing separately				

 . . . . .
- 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	\$780	\$850	\$940	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,370
\$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
\$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
\$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
\$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
\$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
\$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
\$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
\$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
\$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
\$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
\$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
\$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
\$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
\$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
\$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
\$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
\$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

**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	\$240	\$870	\$1,020	\$1,020	\$1,020	\$1,540	\$1,870	\$1,870	\$1,870	\$1,870	\$1,910	\$2,040
\$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
\$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
\$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
\$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
\$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
\$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
\$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
\$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
\$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
\$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
\$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
\$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
\$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
\$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

**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	\$510	\$850	\$1,020	\$1,020	\$1,020	\$1,020	\$1,220	\$1,870	\$1,870	\$1,870	\$1,960
\$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
\$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
\$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
\$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
\$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
\$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
\$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
\$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
\$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
\$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
\$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
\$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
\$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230



## 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
<ol style="list-style-type: none"> <li>U.S. Passport or U.S. Passport Card</li> <li>Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</li> <li>Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</li> <li>Employment Authorization Document that contains a photograph (Form I-766)</li> <li>For an individual temporarily authorized to work for a specific employer because of his or her status or parole: <ol style="list-style-type: none"> <li>Foreign passport; and</li> <li>Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> <li>The same name as the passport; and</li> <li>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.</li> </ol> </li> </ol> </li> <li>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</li> </ol>		<ol style="list-style-type: none"> <li>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</li> <li>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</li> <li>School ID card with a photograph</li> <li>Voter's registration card</li> <li>U.S. Military card or draft record</li> <li>Military dependent's ID card</li> <li>U.S. Coast Guard Merchant Mariner Card</li> <li>Native American tribal document</li> <li>Driver's license issued by a Canadian government authority</li> <li><b>For persons under age 18 who are unable to present a document listed above:</b></li> <li>School record or report card</li> <li>Clinic, doctor, or hospital record</li> <li>Day-care or nursery school record</li> </ol>		<ol style="list-style-type: none"> <li>A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> <li>NOT VALID FOR EMPLOYMENT</li> <li>VALID FOR WORK ONLY WITH INS AUTHORIZATION</li> <li>VALID FOR WORK ONLY WITH DHS AUTHORIZATION</li> </ol> </li> <li>Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)</li> <li>Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal</li> <li>Native American tribal document</li> <li>U.S. Citizen ID Card (Form I-197)</li> <li>Identification Card for Use of Resident Citizen in the United States (Form I-179)</li> <li>Employment authorization document issued by the Department of Homeland Security  For examples, see <a href="#">Section 7</a> and <a href="#">Section 13</a> of the M-274 on <a href="https://uscis.gov/i-9-central">uscis.gov/i-9-central</a>.  The Form I-766, Employment Authorization Document, is a List A, <b>Item Number 4.</b> document, not a List C document.</li> </ol>
<p style="text-align: center;"><b>Acceptable Receipts</b></p> <p style="text-align: center;">May be presented in lieu of a document listed above for a temporary period.</p> <p style="text-align: center;">For receipt validity dates, see the M-274.</p>				
<ul style="list-style-type: none"> <li>Receipt for a replacement of a lost, stolen, or damaged List A document.</li> <li>Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual.</li> <li>Form I-94 with "RE" notation or refugee stamp issued to a refugee.</li> </ul>	OR	<ul style="list-style-type: none"> <li>Receipt for a replacement of a lost, stolen, or damaged List B document.</li> </ul>		<ul style="list-style-type: none"> <li>Receipt for a replacement of a lost, stolen, or damaged List C document.</li> </ul>

\*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.





# 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)							
Address (Street Number and Name)			Apt. Number (if any)	City or Town		State ZIP Code						
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		Employee's Email Address			Employee's Telephone Number						
<p>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.</p> <p>Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):</p> <p><input type="checkbox"/> 1. A citizen of the United States</p> <p><input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)</p> <p><input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)</p> <p><input type="checkbox"/> 4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any)</p> <p>If you check Item Number 4., enter one of these:</p> <table border="1"><tr><td>USCIS A-Number</td><td>OR</td><td>Form I-94 Admission Number</td><td>OR</td><td>Foreign Passport Number and Country of Issuance</td></tr></table>							USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance	
							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)					
							If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the <a href="#">Preparer and/or Translator Certification</a> on Page 3.					
<b>Section 2. Employer Review and Verification:</b> 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					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)	<b>Additional Information</b>				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)	<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
<b>Certification:</b> 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.					
Last Name, First Name and Title of Employer or Authorized Representative			Signature of Employer or Authorized Representative		First Day of Employment (mm/dd/yyyy):
Employer's Business or Organization Name			Employer's Business or Organization Address, City or Town, State, ZIP Code		

For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 4.

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# RESIDENCY CERTIFICATION FORM

## Local Earned Income Tax Withholding

### TO EMPLOYERS/TAXPAYERS:

This form is to be used by employers and taxpayers to report essential information for the collection and distribution of Local Earned Income Taxes to the local EIT collector. This form must be used by employers when a new employee is hired or when a current employee notifies employer of a name or address change. Use the Address Search Application at [dced.pa.gov/Act32](http://dced.pa.gov/Act32) to determine PSD codes, EIT rates, and tax collector contact information.

### EMPLOYEE INFORMATION - RESIDENCE LOCATION

NAME (Last Name, First Name, Middle Initial)			SOCIAL SECURITY NUMBER <div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto;"></div>		
STREET ADDRESS (No PO Box, RD or RR)					
ADDRESS LINE 2					
CITY		STATE	ZIP CODE	DAYTIME PHONE NUMBER	
MUNICIPALITY (City, Borough or Township)					
COUNTY		RESIDENT PSD CODE <div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto;"></div>		TOTAL RESIDENT EIT RATE	

### EMPLOYER INFORMATION - EMPLOYMENT LOCATION

EMPLOYER BUSINESS NAME (Use Federal ID Name)			EMPLOYER FEIN <div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto;"></div>		
FREEDOM AREA SCHOOL DISTRICT			2 5 1 1 4 1 8 4 9		
STREET ADDRESS WHERE ABOVE EMPLOYEE REPORTS TO WORK (No PO Box, RD or RR)					
1702 SCHOOL ST					
ADDRESS LINE 2					
CITY		STATE	ZIP CODE	PHONE NUMBER	
FREEDOM		PA	15042	724-775-7644	
MUNICIPALITY (City, Borough or Township)					
FREEDOM AND NEW SEWICKLEY			PSD NEW SEWICKLEY 040703		
COUNTY		WORK LOCATION PSD CODE <div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto;"></div>		WORK LOCATION NON-RESIDENT EIT RATE	
BEAVER		0 4 0 7 0 2		1%	

### CERTIFICATION

Under penalties of perjury, I (we) declare that I (we) have examined this information, including all accompanying schedules and statements and to the best of my (our) belief, they are true, correct and complete.	
SIGNATURE OF EMPLOYEE	DATE (MM/DD/YYYY)
PHONE NUMBER	EMAIL ADDRESS

For information on obtaining the appropriate MUNICIPALITY (City, Borough, Township), PSD CODES, and EIT (Earned Income Tax) RATES, please refer to the Pennsylvania Department of Community & Economic Development website:

[dced.pa.gov/Act32](http://dced.pa.gov/Act32)

## NEW HIRE REQUIRED NOTICES LISTING

### New Employees

Payroll Packet-Includes WC & 403B Information

Marketplace Exchange (when applicable)

Fringe Benefit Enrollment/Information (when applicable)

### **On Website in Employees Only Section:**

All Board Policies-Including Employee Conduct/Disciplinary Procedures

FMLA

HIPAA Notice of Privacy Practices

Women's Health & Cancer Rights

Newborns and Mothers Health Protection Act

Notice of Credible Coverage

Health Parity

CHIP Notice

HIPAA Notice of Special Enrollment Rights

I acknowledge receipt and understanding of all payroll/informational paperwork and am aware of all Board policies, particularly Policy 815-Acceptable Use of Technology, and Policy 317-Conduct/Disciplinary Procedures. All policies are located online at [www.freedomareaschools.org](http://www.freedomareaschools.org) in the "School Board" Section.

I am aware that the District offers AFLAC availability, at my own cost.  
Information is available upon request.

I am aware the the District provides an EAP (Employee Assistance Program) through Lytle.  
Information is included in the payroll packet and also on our District website.

I also understand that these notices and other forms are available on the District website in the "Employees Only" section. I may also request paper copies of any form or policy at any time.

---

Signature

---

Date

---

Printed Name



# LOCAL SERVICES TAX – EXEMPTION CERTIFICATE

Tax Year \_\_\_\_\_

## APPLICATION FOR EXEMPTION FROM LOCAL SERVICES TAX

- A copy of this application for exemption from the Local Services Tax (LST), and all necessary supporting documents, must be completed and presented to your employer AND to the political subdivision levying the Local Services Tax where you are employed.
- This application for exemption from the Local Services Tax must be signed and dated.
- **No exemption will be approved until proper documentation has been received.**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State: \_\_\_\_\_

Soc Sec #: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Zip: \_\_\_\_\_

### REASON FOR EXEMPTION

1. \_\_\_\_\_ MULTIPLE EMPLOYERS: Attach a copy of a current pay statement from each employer that shows the name of the employer, the length of the payroll period, the amount of Local Services Tax withheld, and total earnings. List all employers on the reverse side of this form. **You must notify your other employers of a change in principal place of employment within two weeks of the change.**
2. \_\_\_\_\_ EXPECTED TOTAL EARNED INCOME AND NET PROFITS FROM ALL SOURCES WITHIN FREEDOM AREA SCHOOL DISTRICT \_\_\_\_\_ (municipality or school district) WILL BE LESS THAN \$ 12,000 : Attach copies of your last pay statement(s) or your W-2 for the relevant year.  
  
If you are self-employed, please attach a copy of your PA Schedule C, F, or RK-1 for the relevant year.
3. \_\_\_\_\_ ACTIVE DUTY MILITARY EXEMPTION: Please attach a copy of your orders directing you to active duty status. Annual training is not eligible for exemption. You are required to advise the tax office when you are discharged from active duty status.
4. \_\_\_\_\_ MILITARY DISABILITY EXEMPTION: Please attach copy of your discharge orders and a statement from the United States Veterans Administrator documenting your disability. Only 100% permanent disabilities are recognized for this exemption.

**EMPLOYER:** Once you receive this Exemption Certificate, you shall not withhold the Local Services Tax for the portion of the calendar year for which this certificate applies, unless you are otherwise notified or instructed by the tax collector to withhold the tax.

Tax Office: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State: \_\_\_\_\_

Phone #: \_\_\_\_\_  
Zip: \_\_\_\_\_

### IMPORTANT NOTE TO EMPLOYERS

1. The municipality is required by law to exempt from the LST employees whose earned income from all sources (employers and self-employment) in their municipality is less than \$12,000 when the levied rate exceeds \$10.00.
2. The school district for the municipality in which your worksite(s) is located may or may not levy an LST. If it does, the income exemption provided may differ from the municipality and can be anywhere from \$0 to \$11,999.
3. Contact the tax office where your business worksites are located to obtain this information.

**Employment Information:** List all places of employment for the applicable tax year. Please list your **PRIMARY EMPLOYER** under #1 below and your secondary employers under the other columns. If self employed, write **SELF** under Employer Name column.

**1. PRIMARY EMPLOYER 2.**

**3.**

Employer Name			
Address			
Address 2			
City, State Zip			
Municipality			
Phone			
Start Date			
End Date			
Status (FT or PT)			
Gross Earnings			

**4.**

**5.**

**6.**

Employer Name			
Address			
Address 2			
City, State Zip			
Municipality			
Phone			
Start Date			
End Date			
Status (FT or PT)			
Gross Earnings			

**PLEASE NOTE:**

All information received by the Tax Collector is considered to be **CONFIDENTIAL** and is only used for official purposes relating to the collection, administration and enforcement of the **LOCAL SERVICES TAX**.

**I DECLARE UNDER PENALTY OF LAW THAT THE INFORMATION STATED ON AND ATTACHED TO THIS FORM IS TRUE AND CORRECT:**

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**DRUG TESTING IS REQUIRED FOR ALL FULL AND PART  
TIME EMPLOYEES-COACHES AND SUBS ARE EXEMPT**

*Do not complete this form unless directed to do so*

The drug testing policy is available at [www.freedomareaschools.org](http://www.freedomareaschools.org) in the School Board  
Section.

**PRE-EMPLOYMENT DRUG TESTING INFORMED CONSENT FORM**

I, \_\_\_\_\_, Social Security No. **ON FILE** -in accordance with  
the Pre-Employment Drug Testing Policy of the Freedom Area School District, which I have  
read and understand, do hereby give my consent for the Freedom Area School District-approved  
laboratory to perform urine tests on me for the purpose of determining the presence of drugs  
pursuant to the policies and procedures developed by the Freedom Area School District, and  
agree to hold all parties harmless.

I authorize the release of these results to the Freedom Area School District and understand that if  
the test results indicate the presence of any drug, other than a drug prescribed by my doctor, I  
will not be recommended for employment.

I am taking the following medications: (Include over-the-counter medication taken for  
headache, colds, allergy, weight control, pain, indigestion, asthma, etc. Reporting birth control  
medication and doctor's diagnoses are not required).

Name of Medication

Doctor Issuing Prescription

_____	_____
_____	_____
_____	_____
_____	_____

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
FASD Representative's Signature

\_\_\_\_\_  
Date

ALL PERMANENT EMPLOYEES ONLY (NOT subs or coaches)

## Drug & Alcohol Testing of PA Authorization Form NON- DOT

\_\_\_\_\_  
(Employee Name)

Freedom Area School District  
(Company)

Testing needed (Highlighted Below)

- **Urine Drug Collection**
- Urine Drug Collection & BAT Alcohol Collection
- BAT Alcohol Collection Only

Reason for Testing (please circle choice below)

- **Pre-employment**
- Random
- Post-Accident
- Reasonable Suspicion
- Return To Duty

**\*\*\* TEST CODE TO USE 19023N SAP 9-50**

**\*\*\* CFF Account Number is 10793723**

**\*\*\*If having an issue, please go to the 123E Screen to find our account.**

Collection Site: PLEASE EMAIL all tests that were completed once done; Drug & Alcohol forms & CCF's to: (WE CANNOT REPORT TO CUSTOMER UNLESS WE RECEIVE THESE COPIES).

Email: [drug.alcoholtestingofpa@gmail.com](mailto:drug.alcoholtestingofpa@gmail.com)

MRO:

Susan Eisenman, MD

724-567-5115 fax

Should you have any questions regarding testing please do not hesitate to contact me:

Lisa Guernsey

724-775-9470

**SCHOOL PERSONNEL HEALTH RECORD**  
**(FOR USE AFTER OFFER OF EMPLOYMENT HAS BEEN MADE)**

**I. INFORMATION**

School Position Offered \_\_\_\_\_

Last Name	First	MI	Sex	Date of Birth
-----------	-------	----	-----	---------------

Home Phone	Cell Phone	Work Phone
------------	------------	------------

Mailing Address: Street	City	State	Zip
-------------------------	------	-------	-----

**Emergency Contact**

Name:	Relationship:
-------	---------------

Address:
----------

Telephone number:	(Home)	(Work)	(Cell)
-------------------	--------	--------	--------

**II. IMMUNIZATION HISTORY** (Recommended, but not mandated by law)

VACCINE Check appropriate box	Enter Month, Day, and Year Each Immunization DOSE Was Given				
Diphtheria, Tetanus with Pertussis <input type="checkbox"/> Td <input type="checkbox"/> TdaP	1	2	3	4	5
Hepatitis B	1	2	3		
Measles-Mumps-Rubella (MMR)	1	2	Rubella Serology/Date/Titer  Mumps disease diagnosed by a physician: Date Measles Serology/Date/Titer		
Varicella <input type="checkbox"/> Vaccine <input type="checkbox"/> Disease <input type="checkbox"/> Serology Date: Neg/Pos	1	2			
Influenza	1	2	3		

**III. TUBERCULOSIS SKIN TEST RESULTS** (Testing required per Regulations of the Department of Health)

DATE GIVEN	SITE: LA / RA	GIVEN BY:	ANTIGEN NAME	MANUFACTURER / LOT # / EXP DATE	SIGNATURE
DATE READ	RESULTS in MM		READ BY SIGNATURE		

**OR**



**IGRA TEST RESULTS**

DATE COLLECTED	TEST NAME (QFT-GIT, T-SPOT, etc)	POSITIVE	NEGATIVE	INDETERMINATE	QUANTITATIVE RESULT

DATE TEST COMPLETED \_\_\_\_\_

SIGNATURE \_\_\_\_\_

Previously known/new positive reactors: \_\_\_\_\_

Chest X-ray:  
(Attach a copy of the report.)

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

Results: \_\_\_\_\_

Other: \_\_\_\_\_

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

Results: \_\_\_\_\_

(Attach a copy of the report.)

Preventive Anti-Tuberculosis Chemotherapy ordered: ☐ No ☐ Yes Date: \_\_\_\_\_

IF SIGNIFICANT REACTION WAS REPORTED, THE PRIMARY CARE PROVIDER REPORT MUST STATE THAT THE APPLICANT IS CURRENTLY FREE FROM TUBERCULOSIS DISEASE.

**IV. MEDICAL CONDITIONS (✓)**

	Yes	No	If Yes, Explain:
Allergies .....	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiac.....	<input type="checkbox"/>	<input type="checkbox"/>	
Chemical Dependency .....	<input type="checkbox"/>	<input type="checkbox"/>	
Drugs .....	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol .....	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes Mellitus .....	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	
Hypertension.....	<input type="checkbox"/>	<input type="checkbox"/>	
Neuromuscular Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	
Orthopedic Condition .....	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory Illness .....	<input type="checkbox"/>	<input type="checkbox"/>	
Seizure Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	
Skin Disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	
Vision Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	
Other (Specify) .....	<input type="checkbox"/>	<input type="checkbox"/>	

**V. PHYSICAL EXAMINATION (✓)**

	NORMAL	ABNORMAL	NOT EXAMINED	COMMENTS
Height (inches)				
Weight (pounds)				
Pulse				
Blood Pressure				
Hair/Scalp				
Skin				
Eyes – Visual Acuity: RL				
Eyes – Color Vision				
Ears – Hearing (dB) RL				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart – Murmur, etc...				
Lungs – Adventitious Findings				

Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				

Are there any special medical problems or chronic diseases which require restriction of activity, medication which might affect his/her work role? If so, specify

Are there any special equipment or accommodations needed to enable this person to perform their duties? If so, specify

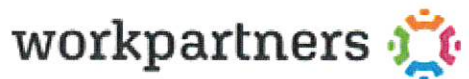
Physician Name (Print) Signature of Examiner Date

Physician Address

The statements and answers as recorded above are full, complete and true to the best of my knowledge and belief. I understand that any false or misleading statements may cause termination of my employment.

I authorize the physician or other person to disclose any knowledge or information pertaining to my health to the employing authority for whom this examination is performed.

Signature of Employee Date



## WORKERS' COMPENSATION INFORMATION

To All Employees:

The workers' compensation law provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury.

Benefits are required to be paid by your employer if self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers' compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place. It is also required to be posted in any areas used for treatment of injured employees or for the administration of first aid.

You should report immediately any injury or work-related illness to your employer. Your benefits could be delayed or denied if you do not notify your employer immediately.

If your claim is denied by your employer, you have the right to request a hearing before a Workers' Compensation Judge.

The Bureau of Workers' Compensation cannot provide legal advice. However, you may contact the Bureau of Workers' Compensation for additional general information:

Department of Labor & Industry  
Bureau of Workers' Compensation  
651 Boas Street 8th Fl  
Harrisburg, Pennsylvania 17121-0750  
Telephone No. within Pennsylvania: 1-800-482-2383  
Telephone No. outside of this Commonwealth: 717-772-4447  
TTY: 1-800-362-4228 (for hearing and speech impaired only)  
[www.state.pa.us](http://www.state.pa.us), PA keyword: workers' comp

For a complete list of panel physicians, please contact your employer. Please call 1-800-633-1197 with any additional questions.

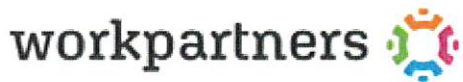
I, \_\_\_\_\_, employee of \_\_\_\_\_,  
(employer)

certify that I have been provided with, read, and understood the information set forth above consistent with the requirements of the Pennsylvania Workers' Compensation Act.

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

**Fax this form to Workpartners (412-454-8717) if it is being completed as a result of a work injury; then place the original in the employee file. If this form is being completed for any reason other than in conjunction with an injury please do not fax to Workpartners, only place in the employee file.**

Workpartners Claims Management Services PO Box 2971 Pittsburgh PA 15230



**EMPLOYEE'S ACKNOWLEDGEMENT FORM UNDER  
SECTION 306(f)(1)(i) OF THE PENNSYLVANIA WORKER'S COMPENSATION ACT**

I recognize and agree that my employer has provided a list of at least six (6) designated health care providers, no more than two (2) of whom are coordinated care organizations and no fewer than three (3) of whom are physicians. Therefore, I acknowledge that I must treat with one of these health care providers for ninety (90) days from the date of my first visit. If I fail to treat with one of these designated health care providers, I understand that my employer will not be liable for the payment for services rendered during this ninety (90) day period. Subsequent treatment may be provided by any health care provider of my choice. However, I must advise my employer within five (5) days of my first visit to each and every non-designated health care provider. Failure to do so may affect whether my employer is liable for payment for services rendered prior to appropriate notice.

My employer has informed me of my rights and duties, and my signature acknowledges that I have been so informed and that I understand my rights and duties.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

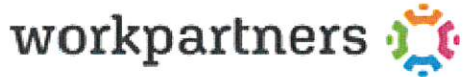
Employee's Name (Print)	Employee Number
-------------------------	-----------------

Employer	Department
----------	------------

\_\_\_\_\_  
Witness' Signature Date

**Fax this form to Workpartners (412-454-8717) if it is being completed as a result of a work injury; then place the original in the employee file. If this form is being completed for any reason other than in conjunction with an injury please do not fax to Workpartners, only place in the employee file.**





**Freedom Area School District - Freedom (15042)**  
YOUR WORKERS COMPENSATION CLAIMS ARE MANAGED BY WORKPARTNERS  
Send Bills To: PO Box 2971, Pittsburgh, PA 15230  
Fax: (412) 454-8717  
To Report a Claim Call: 1-800-633-1197  
WC Policy: WC100-2033212  
Policy Effective Date: 07/01/2024

**NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES**

1. If you suffer a work-related injury, your employer or its insurance company must pay for reasonable surgical and medical services and supplies, orthopedic appliances and prosthesis, including training in their use.
2. In order to insure that your medical treatment will be paid for by your employer or the insurance company, you must select from one of the following health care providers.
3. You must continue to visit one of the physicians listed below, if you need treatment, for ninety (90) days from the date of your first visit.
4. If one of the persons below refers you to another licensed specialist, your employer or their insurer will pay the bill for these services.
5. After this ninety- (90) day period, if you still need treatment and your employer has provided a list as set forth below, you may choose to go to another health care provider for treatment. You should notify your employer of this action within five days of your visit to said provider.
6. If a physician on the list prescribes invasive surgery, you may obtain a second opinion from any physician of your choice. If the second opinion is different than the listed physicians opinion, you may determine which course of treatment to follow; however, the second opinion must contain a specific and detailed treatment plan. If you choose the second opinion, the procedures in that opinion must be performed by one of the physicians on the list for the first ninety- (90) days. Therefore, in this situation, the employee may be required to treat with an employer-designated provider for up to 180 days.
7. If you are faced with a medical emergency, you may secure assistance from a hospital, physician, or health care provider of your choice for your work-related injury. However, when the emergency is resolved, you must seek treatment from a provider listed below.

**Please contact your Claims Adjuster for any specialty need not listed on this panel.**

<u>Name</u>	<u>Address</u>	<u>Scheduling</u>	<u>Area of Specialty</u>
Worksite Medical	510 Jamison Ave Ellwood City, PA 16117	724-716-6742	Occupational Medicine
*Concentra Medical Center - Robinson (All Locations - Concentra.com)	4390 Campbells Run Rd Pittsburgh, PA 15205	412-429-9675	Occupational Medicine
MedExpress Urgent Care - Center Township (All Locations - MedExpress.com)	3944 Brodhead Rd, Ste 7B Monaca, PA 15061	724-773-0777	Urgent Care
Heritage Valley Medical Group Surgical Associates	93 Boundary Ln Bridgewater, PA 15009	724-773-6400	General Surgery
*Tri-State Neurosurgical Associates - UPMC - Wexford	12680 Perry Hwy, Ste 201 UPMC Passavant Spine Center Wexford, PA 15090	877-635-5234	Neurosurgery
*Orthopaedic Specialists - UPMC - Cranberry	8000 Cranberry Springs Dr UPMC Lemieux Sports Complex Cranberry Township, PA 16066	877-471-0935	Orthopedics
Tri-State Orthopaedics & Sports Medicine - Seven Fields	400 Northpointe Circle, Ste 101 Seven Fields, PA 16046	724-776-2488	Orthopedics
HVMG Orthopedics	1030 Beaner Hollow Rd Heritage Valley Health System Beaver, PA 15009	724-775-4242	Orthopedics
*UPMC Vision Institute - Wexford	1603 Carmody Ct, Ste 104 Sewickley, PA 15143	412-647-2200	Ophthalmology
One Call Physical Therapy	Call Toll-Free for Closest Location	1-844-284-2525	Physical Therapy
One Call Chiropractic	Call Toll-Free for Closest Location	1-844-284-2525	Chiropractic
One Call Imaging Services	Call Toll-Free for Closest Location	1-844-284-2525	Diagnostic Imaging
One Call Durable Medical Equipment	Call Toll-Free for Supplier	1-844-284-2525	DME
myMatrixx (an Express Scripts company)	Call Toll-Free for Closest Location BIN# 003858, Group# KYHA	1-800-945-5951	Pharmacy



# Freedom Area SD

## Are you aware of your 403(b) benefit?

### THE OPPORTUNITY

You have the opportunity to save for retirement by participating in your Employer's 403(b) retirement plan. A 403(b) plan is a retirement plan for certain employees of public schools, tax-exempt organizations and ministries.

We recommend that all employees visit our education page which can be found here: <https://www.omni403b.com/Employees/Education>

### WHY SAVE WITH 403(b)?

- > You do not pay income tax on allowable contributions until you begin making withdrawals from the plan, usually after your retirement.
- > Investment gains in the plan are not taxed until distributed.
- > Retirement assets can be carried from one employer to another in most cases.

#### Future retirement savings value assuming 6% growth.

Monthly Contributions	5 Years	15 Years	20 Years
\$50	\$3,489	\$14,541	\$23,102
\$200	\$13,954	\$58,164	\$92,408
\$500	\$34,885	\$145,409	\$231,020

### HOW CAN I PARTICIPATE?

Prior to contributing you must open an account with an investment provider participating in the Plan, a list of which is available on the right. You may then complete a Salary Reduction Agreement (SRA) at:

<https://www.omni403b.com/SRA>

If you are already contributing to your Employer's Plan and you want to change your contribution amount or investment provider, simply complete and submit a new SRA. You can begin or change your contributions as soon as your next payment cycle following our receipt of a completed SRA.

### HOW MUCH CAN I CONTRIBUTE ANNUALLY?

In 2022, you may contribute up to \$20,500 if you are 49 years of age and below and up to \$27,000 if you are 50 years of age and over. Your plan may also permit additional catch up provisions. Please contact OMNI's Customer Care Center at 877-544-6664 for further details.

Contribution Limits		15 Yr. Service Catch-up (if eligible)	Maximum Employer Contributions	Combined Limit	
Age 49 & below	Age 50 & above			Age 49 & below	Age 50 & above
\$20,500.00	\$27,000.00	\$3,000.00	\$61,000.00	\$61,000.00	\$67,500.00

## Looking for Help?

Click the link below for an investment professional to reach out to you.

<https://www.omni403b.com/PlanDetail>

### New accounts may be opened with following approved service providers

AMERIPRISE FINANCIAL RIVERSOURCE  
EQUITABLE FORMERLY AXA  
HORACE MANN LIFE INS CO  
KADES MARGOLIS  
LINCOLN INVESTMENT PLANNING  
METLIFE  
PRIMERICA FINANCIAL SERVICE  
ROTH EQUITABLE FORMERLY AXA  
ROTH HORACE MANN LIFE INS CO  
ROTH LINCOLN INVESTMENT  
ROTH METLIFE  
ROTH PRIMERICA FINANCIAL SERVICES  
ROTH SECURITY BENEFIT  
SECURITY BENEFIT



## 403(b) NEW HIRE INFORMATION PACKET

Please take the time to review this information about the 403(b) retirement plan offered by your employer. While most employees choose to take advantage of their 403(b) plan immediately, even if you choose not to contribute at this time, it is important to be familiar with the opportunities associated with your plan.

### What is a 403(b) Plan?

A 403(b) plan is a tax sheltered retirement savings plan. Eligible employees can contribute pre-tax dollars to their plan, which are invested in either an annuity contract or custodial account (mutual fund). Contributions will be allowed to grow tax free until the funds in question are withdrawn (usually at retirement, although it may be possible to access your funds prior to retirement in certain circumstances). U.S. OMNI strongly recommends that you seek the input of a financial professional to select the proper investments to meet your retirement planning goals.

### Why should I contribute?

403(b) plans can play a vital role in building a secure retirement. The value of your investments may increase based upon fund performance and other factors, making it possible to build account balances that far exceed the amounts withdrawn from your paycheck. It is also important to remember that your taxable income will be lowered in proportion to the amount you choose to defer, minimizing the impact to your take home pay.

### Who is eligible to contribute to a 403(b) Plan?

All full time employees are eligible. Part time employees may or may not be eligible, depending on the specifics of your employer's plan.

### How do I contribute?

Your first step will be to contact a participating 403(b) investment provider to establish your investment account. A list of participating investment providers for your employer is available on OMNI's website at [www.omni403b.com](http://www.omni403b.com). After working with your provider to establish your account and select investment vehicle(s), you will then need to complete an OMNI Salary Reduction Agreement (SRA) to initiate your deductions.

### Who/what is U.S. OMNI? Do I need to invest with OMNI?

OMNI is a Third Party Administrator (TPA) of 403(b) plans. We work with your employer to help ensure compliance with IRS regulations governing the operation of 403(b) plans. OMNI also helps your employer remit 403(b) contributions to participating service providers. OMNI is NOT an investment provider- we do not offer and cannot recommend any specific investment vehicle.

### I don't want to contribute right now; do I still need to fill out a Salary Reduction Agreement (SRA)?

IRS regulations mandate that all employees be provided meaningful notice of their eligibility to participate in a 403(b) plan. Accordingly, OMNI requires employees who do not wish to participate to complete a SRA form indicating that they do not wish to contribute for recordkeeping purposes.

### Who can I call if I have more questions?

OMNI's Customer Care Team is available at 877-544-6664 between the hours of 7:30 AM and 8:00 PM Eastern Standard Time.

Please sign and date to acknowledge receipt of this notice, and return to your employer along with the completed Salary Reduction Agreement found on the next page.

Employee Signature

Date

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# 403(b) SALARY REDUCTION AGREEMENT FORM (SRA) For Tax Sheltered Annuities and Custodial Accounts

- Please supply the information requested below.
- Read all agreements on this form before submitting.
- Fields having an asterisk notation are required.

# 403(b)

## IMPORTANT NOTICE: Before You Sign, Read All Information on this form:

A Tax Sheltered Annuity ("TSA") is an investment account that is set aside for your retirement (only), and is paid for with "pre-tax" dollars. A Custodial Account ("CA") is the group or individual custodial account or accounts, established for each Employee, by the Employer, or by each Employee individually, to hold assets of the Plan. Unless utilizing the catch-up provisions, your Maximum Allowable Contribution ("MAC") cannot exceed \$20,500 (\$27,000 if age 50 or over) in 2022. Both TSA & CA receive tax deferred treatment.

## Part 1: Employee Information

☐ Check here if you have contributed to another 403(b), 401(a), or 401(k) plan offered by another employer in the current calendar year. **NOTE: Do not check this box if you have only contributed to the 403(b) plan associated with this SRA.** If so, please provide the amount of the year-to-date contributions you have made to the other plan(s): \$ \_\_\_\_\_ and, if applicable, the name of the other Plan: \_\_\_\_\_

\* Social Security Number: \_\_\_\_\_ \* First Name: \_\_\_\_\_ MI: \_\_\_\_\_ \* Last Name: \_\_\_\_\_  
 \* Address: \_\_\_\_\_  
 \* City: \_\_\_\_\_ \* State: \_\_\_\_\_ \* Zip: \_\_\_\_\_  
 \* Date of Birth: \_\_\_\_\_ \* Phone: \_\_\_\_\_ \* Email address: \_\_\_\_\_

## Part 2: Employer Information

\* Full Organization Name, City and State: \_\_\_\_\_ \* Date of Hire: (mm/dd/yyyy) \_\_\_\_\_

## Part 3: Contribution Information

### OPTION 1: Recurring Contributions

**WARNING!!! Any new recurring contributions will supercede all current recurring contributions to your employer's 403(b) plan administered by OMNI. If you are currently contributing to multiple service providers under your employer's 403(b) plan, please be sure to list all contributions you wish to continue. Any active 403(b) contributions found in our records, but not listed below WILL BE DISCONTINUED. Also, a contribution may be discontinued by listing it below with an amount of zero.**

Please withhold funds from my pay for the following 403(b) contributions until further notice:

Plan Type	Service Provider	Account #	Effective Date	Amount Per Pay	OR	Percent Per Pay Period
<input type="checkbox"/> 403(b) <input type="checkbox"/> ROTH 403(b)	_____	_____	_____	_____		_____
<input type="checkbox"/> 403(b) <input type="checkbox"/> ROTH 403(b)	_____	_____	_____	_____		_____
<input type="checkbox"/> 403(b) <input type="checkbox"/> ROTH 403(b)	_____	_____	_____	_____		_____
<input type="checkbox"/> 403(b) <input type="checkbox"/> ROTH 403(b)	_____	_____	_____	_____		_____
<input type="checkbox"/> 403(b) <input type="checkbox"/> ROTH 403(b)	_____	_____	_____	_____		_____

If you have requested a percentage amount for any of the contributions above, please supply:

Your Annual Salary: \_\_\_\_\_ Number of Pay Periods Per Year: \_\_\_\_\_

☐ Please check here if you are NOT a full-time employee

### OPTION 2: One-Time Contributions (Elective Contributions Only)

Plan Type	Service Provider	Account #	Effective Date	Amount	After this contribution, any 403(b) recurring contributions to this service provider should be:
<input type="checkbox"/> 403(b) <input type="checkbox"/> ROTH 403(b)	_____	_____	_____	_____	<input type="checkbox"/> DISCONTINUED <input type="checkbox"/> RESUMED
<input type="checkbox"/> 403(b) <input type="checkbox"/> ROTH 403(b)	_____	_____	_____	_____	<input type="checkbox"/> DISCONTINUED <input type="checkbox"/> RESUMED
<input type="checkbox"/> 403(b) <input type="checkbox"/> ROTH 403(b)	_____	_____	_____	_____	<input type="checkbox"/> DISCONTINUED <input type="checkbox"/> RESUMED
<input type="checkbox"/> 403(b) <input type="checkbox"/> ROTH 403(b)	_____	_____	_____	_____	<input type="checkbox"/> DISCONTINUED <input type="checkbox"/> RESUMED
<input type="checkbox"/> 403(b) <input type="checkbox"/> ROTH 403(b)	_____	_____	_____	_____	<input type="checkbox"/> DISCONTINUED <input type="checkbox"/> RESUMED

☐ Please check here if you are NOT a full-time employee

### OPTION 3: Participation Opt Out

☐ I do not wish to participate at this time. I understand that I may participate in the future simply by filling out a new Salary Reduction Agreement form.



#### Part 4: Agreements and Acknowledgements

The above named Employee where applicable, agrees as follows:

1. To modify his/her salary reduction as indicated above.
2. That his/her Employer transfers the above stated funds on Employee's behalf to OMNI for remittance to the selected Service Provider(s).
3. This SRA is legally binding and irrevocable with respect to amounts paid.
4. This SRA may be changed with respect to amounts not yet paid.
5. This SRA may be terminated at any time for amounts not yet paid or available, and that a termination request is permanent and remains in effect until a new SRA is submitted.
6. (a) That OMNI does not choose the annuity contract or custodial account in which your contributions are invested.  
(b) OMNI does not endorse any authorized Service Provider, nor is it responsible for any investments.  
(c) OMNI makes no representation regarding the advisability, appropriateness, or tax consequences of the purchase of the TSA and/or CA described herein.  
(d) (i) OMNI shall not have any liability whatsoever for any and all losses suffered by Employee with regard to his/her selection of the TSA and/or CA, its terms, the selection of any service provider, the financial condition, operation of or benefits provided by said service provider, or his/her selection and purchase of shares by any service provider. Nothing herein shall affect the terms of employment between Employer and Employee.  
(ii) Employee acknowledges that Employer has made no representation to Employee regarding the advisability, appropriateness, or tax consequences of the purchase of the annuity and/or custodial account described herein.  
(iii) The Employer shall not have any liability for any and all losses suffered by an Employee with regard to the selection(s) of any TSA and/or CA, any related terms and conditions, the selection of any service provider, the financial condition, operation of or benefits provided by any service provider or the selection and purchase of shares by any service provider.
7. To be responsible for setting up and signing the legal documents necessary to establish a TSA or CA.
8. To be responsible for naming a death beneficiary under their TSA or CA. This is normally done at the time the contract or account is established. Beneficiary designations should be reviewed periodically.
9. That some service providers may take administration fees from your 403(b) account.
10. When provided all required information in a timely manner, OMNI is responsible for determining that salary reductions do not exceed the allowable contribution limits under applicable law, and will complete MAC calculations as required by law.
11. To contact OMNI and complete the appropriate OMNI forms for any requests for distributions, loans, hardship withdrawals, account exchanges plan-to-plan transfers or rollover contributions. Processing fees for the foregoing transactions may apply.
12. This SRA is subject to the terms of the Services Agreement between OMNI and Employer, and to the Information Sharing Agreement between OMNI and the Service Providers.
13. This agreement supercedes all prior salary reduction agreements and shall automatically terminate if Employee's employment is terminated.

#### Part 5: Employee Signature (Mandatory)

I certify that I have read this complete agreement and that my requested salary reduction(s), if in excess of my base limit, represent(s) my wish to utilize any catch-up provisions for which I may be eligible. I further certify that I will notify OMNI in the event I begin contributing to another 403(b), 401(k) or 401(a) plan. I understand my responsibilities as an Employee under this Program, and I request that Employer take the action specified in this agreement. I understand that all rights under the TSA or CA established by me under the Plan are enforceable solely by my beneficiary, my authorized representative or me.

Employee Signature: \_\_\_\_\_

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

#### Part 6: Acknowledgement and Representation of Sales Agent/Representative (Not Required to Submit SRA)

I agree to comply with all pertinent written directives regarding the solicitation of Employee. In the event I provide OMNI with an Employee's date of birth ("DOB"), I acknowledge and agree that I must provide accurate information based on documentation provided to me by the Employee. Furthermore, I understand that any DOB information I provide to OMNI is utilized by OMNI to calculate the Employee's Maximum Allowable Contribution limits, which must be accurate to keep the Employer's plan in compliance with IRS regulations. All indemnification or other responsibility for a claim or demand arising from an error in employee DOB I provide will be governed by the Information Sharing Agreement between my employer and OMNI.

Sales Agent/Representative Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Signature: \_\_\_\_\_

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

☐ I wish the above named agent to be copied on all e-mail communications sent to the plan participant, including certificate(s) of approval, which may be associated with this transaction.

#### Part 7: Employer Acknowledgement (If Applicable)

Salary: \_\_\_\_\_

# of TSA/CA Pay Periods: \_\_\_\_\_

Effective Payroll Date: \_\_\_\_\_

Employer Name & Title: \_\_\_\_\_

Employer Signature: \_\_\_\_\_

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

**Please return this agreement to Omni Financial Group, Inc., unless otherwise advised by your employer:**

Omni Financial Group, Inc.  
220 Alexander Street, Suite 400 • Rochester, NY 14607  
Toll Free: (877) 544-OMNI • Fax: (585) 672-6194  
Please visit our website at [www.omni403b.com](http://www.omni403b.com)

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# New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved  
OMB No. 1210-0149  
(expires 6-30-2023)

## 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.<sup>1</sup>

**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 Linda Eldridge, Payroll Coordinator [leldridge@freedomarea.org](mailto:leldridge@freedomarea.org)/724-775-7644 Ext. 126

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

<sup>1</sup> 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 FREEDOM AREA SCHOOL DISTRICT		4. Employer Identification Number (EIN) 25-1141849	
5. Employer address 1702 SCHOOL STREET		6. Employer phone number 724-775-7644	
7. City FREEDOM	8. State PA	9. ZIP code 15042	
10. Who can we contact about employee health coverage at this job? Linda Eldridge, Payroll Coordinator			
11. Phone number (if different from above) 724-775-7644 ext. 126		12. Email address leldridge@freedomarea.org	

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

- ☒ As your employer, we offer a health plan to:

All employees. Eligible employees are:

FT Employees

- ☐ Some employees. Eligible employees are:  
Those working 30 + hours per week-at their own cost

- With respect to dependents:

- ☐ We do offer coverage. Eligible dependents are:  
Spouse (FT Only)  
Children to 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.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.





## What is the Employee Assistance Program?

The Employee Assistance Program is provided by ComPsych® GuidanceResources and offers counseling, legal and financial consultation, work-life assistance and crisis intervention services to all our employees and their household family members.

### Why provide an EAP?

Because we care about our employees and their dependents. The EAP can be used free of charge as needed when you or your dependents are facing emotional, financial, legal or other concerns.

### Are the services confidential?

Yes, the EAP is strictly confidential. No information about your participation in the program is provided to your employer.

### Why might my family or I use the services?

There are many reasons to use these services. You may wish to contact the EAP if you:

- Are feeling overwhelmed by the demands of balancing work and family
- Are experiencing stress, anxiety or depression
- Are dealing with grief and loss
- Need assistance with child or elder care concerns
- Have legal or financial questions
- Have concerns about substance abuse for yourself or a dependent

## Here when you need us.

Call: 855.387.9727

TDD: 800.697.0353

Online: [guidanceresources.com](https://guidanceresources.com)

App: GuidanceResources® Now

Web ID: ONEAMERICA3

ONEAMERICA® is the marketing name for the companies of OneAmerica. OneAmerica markets ComPsych services. ComPsych is not an affiliate of OneAmerica and is not a OneAmerica company.

### What happens when I call?

When you call, you will speak with a GuidanceConsultant<sup>SM</sup>, a master's- or PhD-level counselor who will collect some general information about you and will talk with you about your needs. The GuidanceConsultant will provide the name of a counselor who can assist you. You can then set up an appointment to speak with the counselor over the phone or schedule a face-to-face visit.

### What counseling services does the EAP provide?

The EAP provides free short-term counseling with counselors in your area who can help you with your emotional concerns.

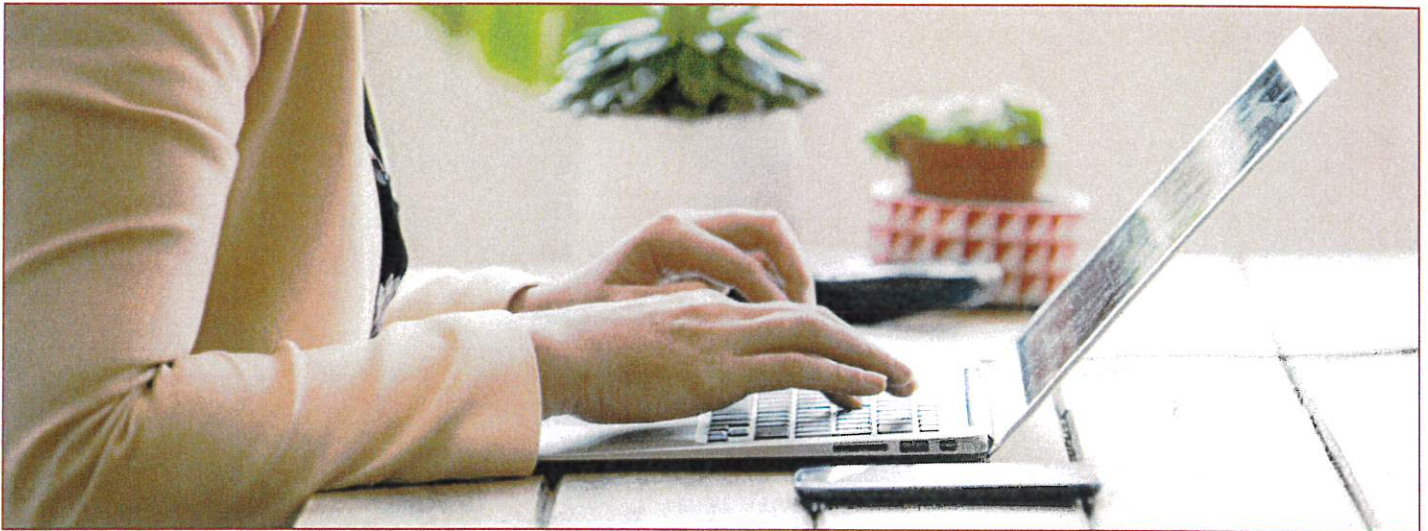
If the counselor determines that your issues can be resolved with short-term counseling, you will receive counseling through the EAP. However, if it is determined that the problem cannot be resolved in short-term counseling in the EAP and you will need longer-term treatment, you will be referred to a specialist early on and your insurance coverage will be activated.

### Can my children use the EAP?

Yes. The EAP is a confidential benefit for employees and their household family members.







## Work-Life Benefits

### Are you:

**A parent looking for answers to parenting questions? Get help with:**

- Child care
- Nanny services
- Before- and after-school care
- Camps
- Financial assistance
- Adoption information

**A family member of an elder? Learn about:**

- Home health care
- Respite care
- Community services
- Help determining the right level of care
- Screened referrals for assisted living and nursing homes
- Hospice information

**Looking for a place to live? Get help with:**

- Finding an apartment
- Finding movers

- Relocating to another city
- Choosing a realtor
- School and neighborhood information
- Housing and utility assistance

**A pet owner? Get information on:**

- Dog walkers
- Kennels and pet care
- Veterinarians
- Obedience classes
- Pet insurance

**Sending a child off to school? Learn about:**

- Choosing schools, from preschool through college and beyond
- Financial aid
- Scholarships
- Tutors
- Special needs

**Planning a major project? Find resources and qualified experts for:**

- Weddings and other events
- Home improvement products
- Vacation planning
- Making a big purchase, such as a home or car

### Get the Help You Need.

Just call your GuidanceResources toll-free number. You'll be connected to a GuidanceConsultant<sup>SM</sup> who will talk with you about your specific needs. Our work-life specialists will research your question and, in just a few business days, send you a complete packet of practical information, including prescreened referrals (as appropriate), HelpSheets<sup>SM</sup> on your subject and much more. The materials can be delivered to you via email, fax or second-day air.

## Your GuidanceResources® Program

Call: 855.387.9727

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# Contact Us... Anytime, Anywhere

No-cost, confidential solutions to life's challenges.



## Confidential Emotional Support

Our highly trained clinicians will listen to your concerns and help you or your family members with any issues, including:

- Anxiety, depression, stress
- Grief, loss and life adjustments
- Relationship/marital conflicts



## Work-Life Solutions

Our specialists provide qualified referrals and resources for just about anything on your to-do list, such as:

- Finding child and elder care
- Hiring movers or home repair contractors
- Planning events, locating pet care



## Legal Guidance

Talk to our attorneys for practical assistance with your most pressing legal issues, including:

- Divorce, adoption, family law, wills, trusts and more
- Need representation? Get a free 30-minute consultation and a 25% reduction in fees.



## Financial Resources

Our financial experts can assist with a wide range of issues. Talk to us about:

- Retirement planning, taxes
- Relocation, mortgages, insurance
- Budgeting, debt, bankruptcy and more



## Online Support

GuidanceResources® Online is your 24/7 link to vital information, tools and support. Log on for:

- Articles, podcasts, videos, slideshows
- On-demand trainings
- "Ask the Expert" personal responses to your questions



## Free Online Will Preparation

EstateGuidance® lets you quickly and easily create a will online.

- Specify your wishes for your property
- Provide funeral and burial instructions
- Choose a guardian for your children

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Your ComPsych® GuidanceResources® program offers someone to talk to and resources to consult whenever and wherever you need them.

Call: 855.387.9727

TDD: 800.697.0353

Your toll-free number gives you direct, 24/7 access to a GuidanceConsultant™, who will answer your questions and, if needed, refer you to a counselor or other resources.

Online: [guidanceresources.com](http://guidanceresources.com)

App: GuidanceResources® Now

Web ID: ONEAMERICA3

Log on today to connect directly with a GuidanceConsultant about your issue or to consult articles, podcasts, videos and other helpful tools.

# 24/7 Support, Resources & Information



## Contact Your GuidanceResources® Program

Call: 855.387.9727

TDD: 800.697.0353

Online: [guidanceresources.com](http://guidanceresources.com)

App: GuidanceResources® Now

Web ID: ONEAMERICA3

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## Guide to Using GuidanceResources® Online

First-time users, follow these simple instructions and start exploring the resources offered to you on GuidanceResources Online.

1. Go to **guidanceresources.com** to reach the website.
2. Once on the guidanceresources.com home page, click the **Register** tab.
3. You will then be asked to enter your **Organization Web ID**.

Your Company/Organization Web ID: **ONEAMERICA3**

You will then be asked to enter a **User Name** and **Password**. Both can be anything you would like them to be but should be something you will remember. The **User Name** (often your name) must be at least six characters long and should have no spaces (for example: joesmith). The **Security Questions** are meant to prompt you if you forget your password. You must select the button verifying that you are at least 13 years of age, as required by federal law.

Make sure that you complete all fields that have red asterisks, as these are required fields. When you've finished, click the **Submit** button at the bottom of the page.

4. On the next page, you will be asked to provide some demographic information. All of the fields are optional. Be sure to read the **Terms of Use** and click inside the check box to indicate your agreement to those terms. When you've finished, click the **Submit** button at the bottom of the page.
5. You should now be on the website.

## For Future Logins

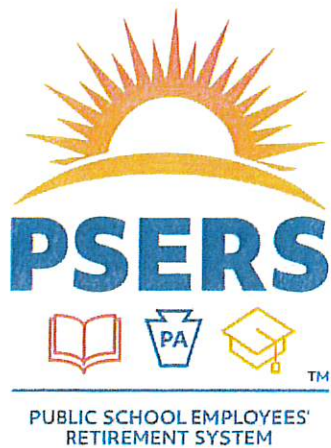
You will NOT have to enter all of the demographic information again. You will only need to remember your User Name and Password. When you get to step 2 above, instead of clicking on the register tab, use the Login section and enter your User Name and Password and click the login button. This will take you directly to GuidanceResources Online.

If you have any problems registering or logging into GuidanceResources Online, email Member Services at **memberservices@compsych.com**.



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# Information for New School Employees



## About PSERS

PSERS is a governmental, cost-sharing, multiple-employer pension plan to which public school employers, the Commonwealth, and school employees (members) contribute. Once you qualify for membership, you will have a defined benefit (DB) plan, a defined contribution (DC) plan, or a hybrid with both DB and DC components.

### PSERS Defined Benefit (DB) Plan

In the DB plan, the retirement benefit is based on a formula. The calculation used by PSERS includes a pension multiplier, your credited years of service, and your final average salary. Class T-C, Class T-D, Class T-E, and Class T-F have only a DB component.

$$\text{Final Average Salary} \times \text{Membership Class Multiplier} \times \text{Years of Service} = \text{Annual Maximum Single Life Annuity}$$

### PSERS Defined Contribution (DC) Plan

In the DC Plan, the retirement benefit is based on the amount of contributions made to the plan and the investment performance of those contributions. Your DC contributions and earnings, if any, are available for you to withdraw when you retire or leave employment. Class DC has only a DC component.

$$\text{Participant Contribution} + \text{Employer Contribution} + \text{Voluntary Contributions (after-tax/rollover)} + \text{Investment Performance of Your Account} = \text{Total Account Value}$$

### Hybrid Plan

The hybrid plan consists of both DB and DC components. Class T-G and Class T-H have both DB and DC components.

## With PSERS, you're on your way!

The Public School Employees' Retirement System (PSERS) and your school employer have partnered to assist you with planning and saving for your retirement.

When you become a PSERS member, you join one of the nation's largest public pension funds. That means you're now in good company with more than 500,000 fellow PSERS members.

PSERS has been proudly serving Pennsylvania public school employees for the past 100 years. Last year alone, PSERS disbursed more than \$6.6 billion to retirees. When it's your turn to retire, you can count on PSERS to be there for you and your retirement journey.

## Questions?

### PSERS Retirement Plan Information:

5 N 5th Street | Harrisburg PA 17101-1905

Toll-Free: 1.888.773.7748 (8 a.m. - 5 p.m., M-F)  
Harrisburg Local: 717.787.8540

ContactPSERS@pa.gov | [psers.pa.gov](http://psers.pa.gov)

### PSERS DC Plan Information:

Toll-Free: 1.833.432.6627 (8 a.m. - 8 p.m., M-F)

Participant Web: [PSERSDC.voya.com](http://PSERSDC.voya.com)



## Qualifying for PSERS Membership

All full-time employees must become members of PSERS and must make retirement contributions starting their first day of employment. "Full-time," for retirement purposes with PSERS, is defined as employees who work 5 or more hours a day/5 days a week or its equivalent (25 or more hours a week), even if your employer considers you to be part-time.

Part-time salaried employees qualify for PSERS membership as of their first day of employment and must have retirement contributions withheld.

Part-time hourly and part-time per diem employees must meet minimum service requirements to qualify for PSERS membership (500 hours or 80 days). Once you meet membership requirements, subsequent service for any school employer is qualified service unless there is a break in membership. Refer to *PSERS Active Member Handbook* for more information.

Part-time employees may waive membership in PSERS. To qualify for the waiver, a part-time employee must have an Individual Retirement Account and request a waiver within 90 days of notification from PSERS that they qualify for PSERS membership. When you waive membership in PSERS, you forfeit all future rights to benefits for the waived time period.

## Membership Class of Service

For school employees who become new members of PSERS on or after July 1, 2019, there are three membership classes that govern your retirement contribution amounts and future benefits with PSERS: Class T-G, Class T-H, and Class DC. New members are automatically enrolled as Class T-G, but have a one-time opportunity to elect Class T-H or Class DC membership. Look for class election material from PSERS when your election period is open either through your PSERS Member Self-Service (MSS) account if you sign up or in the mail if you did not sign up for MSS.

## Withheld Contributions

If you are a full-time or part-time salaried employee, your employer will begin withholding DB and DC contributions from your first day of work. The amount withheld is determined by your membership class. Full-time and part-time salaried employees who first qualify on or after July 1, 2019, and remain in Class T-G, will have a percentage withheld for both the DB and DC components of their retirement.

If you are a part-time hourly or per diem employee, your employer may withhold contributions for the DB component. The amount withheld will be returned to you if you do not qualify for membership. DC contributions cannot be withheld until you qualify for membership. Once you meet PSERS membership eligibility requirements, your employer must withhold both DB and DC contributions.

If you previously were a PSERS member, you will remain in your previous membership class and your employer may withhold contributions at the rate for that class.

## Retired Members Returning to Service

The Retirement Code prohibits retirees from working for a public school in any capacity, full-time or part-time, qualifying or non-qualifying service, while receiving a PSERS retirement benefit. If you are a PSERS retiree and return to Pennsylvania public school service as a school employee, your monthly retirement benefit will be stopped unless a return to service exception applies. Please visit the PSERS website or contact PSERS for more information.

## Your Responsibilities

Please refer to **PSERS website** for **PSERS Active Member Handbook** and other detailed information.

### ☒ Read PSERS Communications

Once qualified, new members will receive some important items such as the **Welcome Packet** and **Class Election Packet (if applicable)**. If you have a PSERS Member Self-Service (MSS) account, you are automatically enrolled in **Paperless Delivery** which means that PSERS will deliver information to you electronically instead of through physical mail. You should check your account periodically to ensure you do not miss important information.

### ☒ Nominate and Maintain Beneficiaries

A beneficiary is the person(s) or entity(ies) you wish to receive your retirement benefits upon your death. You may nominate and change your beneficiary nomination electronically at any time through the MSS Portal. Alternatively, you may submit a **Nomination of Beneficiaries (PSRS-187)** form to PSERS. Please note that your most recently submitted **Nomination of Beneficiaries** will supersede previous nominations.

### ☒ Review Information on PSERS website and take advantage of available resources such as free **Foundations for Your Future (FFYF)** programs conducted by PSERS retirement representatives.

### ☒ Keep your email and mailing address current through the MSS Portal.