Dorchester School District Two - Personnel
102 GREENWAVE BOULEVARD • SUMMERVILLE, SC 29483 • (843) 873-2901 • FAX (843) 832-7014

HOURLY EMPLOYMENT-EXTENDED DAY

1. Complete and *sign*:
   - **Application Form & Criminal History Document**
   - **W-4 Form**

2. **You must complete a S.C. Retirement Form**. Please read the instructions carefully and complete the appropriate form. If you require a form other than the 1104, forms are available from the Dorchester School District Two Personnel Office.

3. The school district is required by the Department of Homeland Security, in connection with **Form I-9,** to run an electronic verification of employment status for all new employees (part time and full time). Please read and initial the
   - **E-Verify Notice**
   - **Form I-9** (top section only)

4. All employees of Dorchester School District Two are paid by direct deposit. Complete the
   - **Direct Deposit Authorization Form**
   - **Attach a voided check or deposit slip to this form**

5. A TB (skin) Test is required for all individuals who work with students in Dorchester School District Two.

REQUIRED DOCUMENTS WHICH MUST BE ATTACHED TO APPLICATION:

1) Copy of drivers license (or other photo ID)
2) Copy of social security card
3) TB Test Results (*must be within current year)*
4) A *voided* personal check or deposit slip attached to the Direct Deposit Form
5) Corporal Punishment Form-signed and dated
6) Physicians Health Statement-renew every 4 years
7) Resume
8) **Copy of High School Diploma, GED or College Degree**

Return this application to Kathy Bishop-Extended Day Director
1325-A Boone Hill Road, Summerville, SC 29483.
843-873-7372

DORCHESTER SCHOOL DISTRICT TWO

Joseph R. Pye, Superintendent

Division of Personnel Services
102 Greenwave Boulevard
Summerville, SC 29483

Phone (843) 873-2901

APPLICATION FOR HOURLY CLASSIFIED EMPLOYMENT

____
Date

Position for which you are applying:

- ☐ EXTENDED DAY – School: ______________________
- ☐ STUDENT COOP – School: ______________________
- ☐ MAINTENANCE WORKER – School: ______________
- ☐ HOMEBOUND INSTRUCTOR
- ☐ COACH – Sport: ____________ School: ____________
- ☐ OTHER: ______________________________________

____

_______ - _______ - _______
Social Security Number

Last Name ______ First Name ______ MI ______ Maiden Name ______

Address ______ City ______ State ______ Zip ______

Phone ______ Email Address ______

❑ Yes ❑ No Were you previously employed by Dorchester School District Two?

❑ Yes ❑ No Have you filed a previous application?

Please list any training you have related to this position: ______________________________

____

____

____

Dorchester School District Two is an Equal Opportunity Employer and does not discriminate against any applicant on the basis of any characteristic that is protected by state or federal law.

DORCHESTER SCHOOL DISTRICT TWO

Joseph R. Pye, Superintendent

Division of Personnel Services
102 Green Wave Boulevard
Summerville, SC 29483

Randy Eads
Director of Personnel
Phone (843) 873-2901

EDUCATION AND PROFESSIONAL TRAINING

School/Institution	Years Attended	Year Graduated

Degree(s) received: ______________________________

WORK / VOLUNTEER EXPERIENCE

Employer	From/To	Position Held

REFERENCES

Please include your last immediate supervisor.

Name	Address & Phone Number	Position

THIS APPLICATION IS NOT COMPLETE WITHOUT A SIGNATURE BELOW. This signature certifies that to the best knowledge and belief of the applicant, the information provided herein is complete and true. Any misrepresentation of information may be cause for dismissal.

Signature ______________________________ Date ______________

DORCHESTER SCHOOL DISTRICT TWO
Randy Eads,
Executive Director of Personnel
102 Green Wave Boulevard
Summerville, South Carolina 29483

CRIMINAL RECORD HISTORY REPORT

Dorchester School District Two requires that **prior** to initial employment, a criminal record history from the South Carolina Law Enforcement Division, be requested. Because of this law, we can consider for employment only persons having a criminal record history report on file. To receive a criminal record history report on you, Dorchester School District Two will have to forward to South Carolina Law Enforcement Division the information listed below.

Dorchester School District Two does not consider race, sex, and date of birth in the regular application process. Therefore, I ask that you supply the information noted below through use of this form, and that you forward it to us along with your application for employment. Availability of a record clear of any criminal history at the time of employment consideration will be to your advantage, and you should consider completion of this form as an integral part of your application.

FULL NAME ______________________________

RACE ______________________________

SEX ______________________________

DATE OF BIRTH ______________________________
Month Day Year

SOCIAL SECURITY NUMBER ______________________________

Have you ever been convicted of a criminal offense of any kind? ☐ Yes ☐ No

If yes, list dates, charges and dispositions: ______________________________

____

____

____

Please read this notice and initial in the space at the bottom.

When/if you are hired, you will be asked to come to the District Two Personnel Office to complete a DHS Form I-9. You must bring identification documents with you at that time.

Dorchester School District Two Participates in E-Verify

(Este Empleador Participa en E-Verify)

NOTICE:

Federal law requires all employers to verify the identity and employment eligibility of all persons hired to work in the United States.

This employer will provide the Social Security Administration (SSA) and, if necessary, the Department of Homeland Security (DHS), with information from each new employee's Form I-9 to confirm work authorization.

IMPORTANT: If the Government cannot confirm that you are authorized to work, this employer is required to provide you written instructions and an opportunity to contact the SSA and/or DHS before taking adverse action against you, including terminating your employment. Employers may not use E-Verify to pre-screen job applicants or to re-verify current employees and may not limit or influence the choice of documents presented for use on the Form I-9 In order to determine whether Form I-9 documentation is valid, this employer uses E-Verify's photo screening tool to match the photograph appearing on some permanent resident and employment authorization cards with the official U.S. Citizenship and Immigration Services' (USCIS) photograph.

If you believe that your employer has violated its responsibilities under this program or has discriminated against you during the verification process based upon your national origin or citizenship status, please call the Office of Special Counsel at 1-800-255-7688 (TDD: 1-800-237-2515).

Please initial here ________

For more information on E-Verify, please contact DHS at:

1-888-464-4218

AVISO:

La Ley Federal le exige a todos los empleadores que verifiquen la identidad y elegibilidad de empleo de toda persona contratada para trabajar en los Estados Unidos.

Este empleador le proporcionará a la Administración del Seguro Social (SSA), y si es necesario, al Departamento de Seguridad Nacional (DHS), información obtenida del Formulario I-9 correspondiente a cada empleado recién contratado con el propósito de confirmar la autorización de trabajo.

IMPORTANTE: En dado caso que el gobierno no pueda confirmar si está usted autorizado para trabajar, este empleador está obligado a proporcionarle las instrucciones por escrito y darle la oportunidad a que se ponga en contacto con la oficina del SSA y, o el DHS antes de tomar una determinación adversa en contra suya, inclusive despedirlo. Los empleadores no pueden utilizar E-Verify con el propósito de realizar una preselección de aspirantes a empleo o para hacer nuevas verificaciones de los empleados actuales, y no deben restringir o influenciar la selección de los documentos que sean presentados para ser utilizados en el Formulario I-9. A fin de poder determinar si la documentación del Formulario I-9 es valida o no, este empleador utiliza la herramienta de selección fotográfica de E-Verify para comparar la fotografía que aparece en algunas de las tarjetas de residente y autorizaciones de empleo, con las fotografías oficiales del Servicio de Inmigración y Ciudadanía de los Estados Unidos (USCIS).

Si usted cree que su empleador ha violado sus responsabilidades bajo este programa, o ha discriminado en contra suya durante el proceso de verificación debido a su lugar de origen o condición de ciudadanía, favor ponerse en contacto con la Oficina de Asesoría Especial llamando al 1-800-255-7688 (TDD: 1-800-237-2515).

Por favor ponga sus iniciales aquí ________

Para mayor informacion sobre E-Verify, favor ponerse en contacto con la oficina del DHS llamando al:

1-888-464-4218

IDENTIFICATION DOCUMENTS ARE LISTED ON THE BACK OF THIS NOTICE

Form W-4 (2019)

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

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. You may claim exemption from withholding for 2019 if **both** of the following apply.

• For 2018 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**

• For 2019 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2019 expires February 17, 2020. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2019 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income not subject to withholding outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2019. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married filing jointly and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

Nonwage income. If you have a large amount of nonwage income not subject to withholding, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Additional Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. *Head of household please note:* Generally, you may claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you may be eligible to claim a child tax credit for each of your eligible children. To qualify, the child must be under age 17 as of December 31, must be your dependent who lives with you for more than half the year, and must have a valid social security number. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line F. Credit for other dependents. When you file your tax return, you may be eligible to claim a credit for other dependents for whom a child tax credit can't be claimed, such as a qualifying child who doesn't meet the age or social security number requirement for the child tax credit, or a qualifying relative. To learn more about this credit, see Pub. 972. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total

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Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you're entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2019

1 Your first name and middle initial	Last name	2 **Your social security number**
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married filing separately, check "Married, but withhold at higher Single rate."	
City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card.** ▶ ☐	

5 Total number of allowances you're claiming (from the applicable worksheet on the following pages) . . . . | 5 |

6 Additional amount, if any, you want withheld from each paycheck . . . . | 6 | $

7 I claim exemption from withholding for 2019, and I certify that I meet **both** of the following conditions for exemption.

• Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and**

• This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability.

If you meet both conditions, write "Exempt" here . . . . ▶ | 7 |

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

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

8 Employer's name and address (**Employer:** Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)	9 First date of employment	10 Employer identification number (EIN)

PEBA/RETIREMENT ENROLLMENT INFORMATION

ENROLLMENT IN THE PUBLIC EMPLOYEE BENEFIT AUTHORITY STATE RETIREMENT SYSTEM IS MANDATORY FOR ALL FULL TIME EMPLOYEES, AS WELL AS PART TIME EMPLOYEES THAT ARE A CURRENT (ACTIVE OR INACTIVE) RETIREMENT SYSTEMS MEMBER. EMPLOYEES THAT ARE ELIGIBLE FOR NON-MEMBERSHIP WILL BE OFFERED THAT OPTION BY PEBA/RETIREMENT.

- For information regarding your plan enrollment options please visit the PEBA Retirement website at http://www.peba.sc.gov/retirement.html and review the information under "Retirement Plans".

- You may also watch a short video, "It's your choice: SCRS or State ORP" explaining the differences between the plans. The video can be found at https://www.youtube.com/watch?v=P2dU-HCRl-0&t=16s

The Public Employee Benefit Authority requires a working email address in order to initiate enrollment. Following the receipt of this information you will receive an email directly from the Public Employee Benefit Authority/Retirement System requesting that you select your retirement program option. Please follow the instructions contained in the email in order to finalize your enrollment choice.

Enrollment must be completed within 30 calendar days following your date of hire. Failure to respond to the email in the allotted time may result in an irrevocable default enrollment.

Please designate your email address below:

Full Name: ______________________ **Date of Hire:** ____________

Email Address: ______________________ **Worksite:** ____________

My signature below provides that I am aware of the steps necessary to complete my retirement election. I also certify my understanding that failure to complete the enrollment process within 30 days of my hire date will result in a default enrollment into the SCRS Traditional Pension Plan.

Signature: ______________________ **Date:** ____________

MR. JOSEPH PYE
Superintendent

Dorchester
School
District Two
102 GREENWAVE BOULEVARD SUMMERVILLE, SC 29483 • (843) 873-2901 • FAX (843) 832-7014

$25.00

Many health clinics, such as Doctor's Care, MedCare, Health First, Minute Clinic, etc, will administer and read the TB Tests. Present this form to the clinic. The results of your skin test must be recorded in the section at the bottom. This form must be signed by the medical professional who did the reading.

PPD/TB Screening

1. Have you had, in the last 12 months, any of the following symptoms:
   a. Night Sweats........ Y / N
   b. Unplanned Weight Loss........ Y / N
   c. Chronic Cough........ Y / N
   d. Blood in your sputum or phlegm........ Y / N
   e. Lived with someone with TB........ Y / N

2. Have you ever had a BCG injection? .... Y / N

3. Have you ever had a Positive PPD in the past? .... Y / N
   When: ___________ Where: ________________

4. Have you ever been treated for active TB? .... Y / N
   When: ___________ Where: ________________

Patient Signature: ____

A positive answer to any of the above questions requires a provider review prior to being given a PPD.

PPD given on ___/___/_____ in the R/L forearm by __________________________

Lot: _______________ **Manufacture:** __________________________ **Exp. Dtd.** ________________

Read on ___/___/_____ by ____________________________ **Result** ________mm

DORCHESTER SCHOOL DISTRICT TWO

DIRECT DEPOSIT AUTHORIZATION

In order to authorize direct deposit of payroll funds, this form must be completed in it's entirety, signed, dated and have a voided check or deposit slip attached.

Employee Name ____
(please print)
Social Security Number ______________________________________

Employee's School/Department ________________________________

****

Account Number 1 _________________________ Checking _____ Savings _____
(series of numbers following routing number) (please check one)

ABA Routing # ____
(first 9 digit number in series on bottom of check or deposit slip)

Financial Institution Name ___________________________________

Amount of Deposit $ ________________________ (if net pay, specify "NET")

****

If no second account, skip to bottom, sign, date and attach voided check or deposit slip.

Account Number 2 _________________________ Checking _____ Savings _____
(series of numbers following routing number) (please check one)

ABA Routing # ____
(first 9 digit number in series on bottom or check or deposit slip)

Financial Institution Name ___________________________________

Amount of Deposit $ ________________________ (if net pay, specify "NET")

****

Employee's Signature ________________________________ Date __________

**** A VOIDED CHECK OR DEPOSIT SLIP MUST BE ATTACHED FOR EACH ACCOUNT TO BE CREDITED**

SUBSTITUTES – Please indicate the school at which you would like to pick up your paystub each payday.

____
SCHOOL LOCATION

Revised 03/14/08

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

▶ **START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

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

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: ____________

OR

2. Form I-94 Admission Number: ____________

OR

3. Foreign Passport Number: ____________

Country of Issuance: ____________

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

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

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

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

STOP *Employer Completes Next Page* STOP

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

LIST A **Documents that Establish Both Identity and Employment Authorization**	OR	LIST B **Documents that Establish Identity**	AND	LIST C **Documents that Establish Employment Authorization**
1. U.S. Passport or U.S. Passport Card **2.** Permanent Resident Card or Alien Registration Receipt Card (Form I-551) **3.** Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa **4.** Employment Authorization Document that contains a photograph (Form I-766) **5.** For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. **6.** Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address **2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address **3.** School ID card with a photograph **4.** Voter's registration card **5.** U.S. Military card or draft record **6.** Military dependent's ID card **7.** U.S. Coast Guard Merchant Mariner Card **8.** Native American tribal document **9.** Driver's license issued by a Canadian government authority **For persons under age 18 who are unable to present a document listed above:** **10.** School record or report card **11.** Clinic, doctor, or hospital record **12.** Day-care or nursery school record		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION **2.** Certification of Birth Abroad issued by the Department of State (Form FS-545) **3.** Certification of Report of Birth issued by the Department of State (Form DS-1350) **4.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal **5.** Native American tribal document **6.** U.S. Citizen ID Card (Form I-197) **7.** Identification Card for Use of Resident Citizen in the United States (Form I-179) **8.** Employment authorization document issued by the Department of Homeland Security

Examples of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS

PART A

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. You can buy a health plan on the marketplace outside of open enrollment if you qualify for a special enrollment period. See www.HealthCare.gov for more details on special enrollment periods.

Can I save money on my health insurance premiums in the marketplace?

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

Does employer health coverage affect eligibility for premium savings through the marketplace?

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

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

How can I get more information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Benefits Office at 843-873-2901.

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

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

HEALTH COVERAGE INFORMATION FOR MARKETPLACE APPLICATION

PART B

If you decide to complete an application for coverage in the Health Insurance Marketplace, you will be asked to provide the information below. This information is numbered to correspond to the marketplace application.

3. Employer Name Dorchester School District Two		**4. Employer Identification Number (EIN)** 57-6001626
5. Employer Address 102 Green Wave Blvd.		**6. Employer Phone Number** 843-873-2901
7. City Summerville	**8. State** SC	**9. ZIP Code** 29483
10. Who can we contact about employee health coverage at this job? Yolanda Whitehead		
11. Phone Number (if different from above)	**12. Email address** ywhitehead@dorchester2.k12.sc.us	

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

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

  ☐ All employees.

  ☑ Some employees. An eligible employee is:

  Employed by the state, a higher education institution, a public school district or a participating local subdivision; works in a permanent, full-time position; and receives compensation from the state, a higher education institution, a public school district or a participating local subdivision. Eligible employees also include clerical and administrative employees of the S.C. General Assembly and judges in the state courts; General Assembly members; elected members of the councils of participating counties or municipalities who also participate in PEBA Retirement Benefits; and permanent, part-time teachers, who are considered employees for insurance purposes.

- With respect to dependents:

  ☑ We do offer coverage. An eligible dependent is:

  A lawful spouse or a former spouse who is required to be covered by a divorce decree; and a child younger than 26 who is the subscriber's natural child, adopted child, stepchild, foster child, a child for whom the subscriber has legal custody or a child the subscriber is required to cover due to a court order.

  ☐ 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 Health Insurance 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, www.HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit www.HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

COMPLETE INFO BELOW IF EMPLOYEE REQUESTS IT FOR EXCHANGE APPLICATION:

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

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

☐ **Yes** (Continue)

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

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

14. Does the employer offer a health plan that meets the minimum value standard[2]?

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

15. For the lowest-cost plan that meets the minimum value standard[1] offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan $

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

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

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

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.[1] (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan $

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

Date of change (mm/dd/yyyy):

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

DORCHESTER SCHOOL DISTRICT TWO
Randy Eads, Director of Personnel
102 Green Wave Boulevard
Summerville, South Carolina 29483

AFFORDABLE CARE ACT

HEALTH INSURANCE MARKETPLACE INFORMATION ACKNOWLEDGEMENT FORM

Dorchester School District Two requires that all new employees acknowledge receipt of the attached information regarding benefits eligibility and the Health Insurance Marketplace by signing below.

PLEASE DETACH THE HEALTH CARE INFORMATION AND KEEP IT FOR YOUR RECORDS.

Please sign this form to acknowledge that you have been given the information.

FULL NAME ______________________________________
Please Print Clearly

DATE OF BIRTH ____________ / ____________ / ____________
Month Day Year

With signing this form, I signify that I have received the Health Insurance Marketplace Coverage Options information provided by Dorchester School District Two. Further, I will direct any questions that I might have in this regard to the Dorchester School District Two Benefits Office.

Signature: ______________________________ Date: ____________

PLEASE DETACH THE HEALTH CARE INFORMATION AND KEEP IT FOR YOUR RECORDS.

You complete this form....

South Carolina Department of Social Services
Child Care Regulatory Services

MEDICAL STATEMENT

To be completed by staff, volunteers, and emergency personnel:

Name: ______________________________ SSN: ______________
Last First Middle

Home Address: ______________________________
Number Street City State Zip

Date of Birth: ______________ ☐ Male ☐ Female Telephone: ______________

Statement of your present health in your own words: ______________________________

Have you ever had or do you now have any of the following:

Illness/Condition	Yes	No	Illness/Condition	Yes	No
Vision Problems			Rupture or Hernia		
Ear, Nose, Throat Problems			Hemorrhoids		
Hearing Loss			Sugar or Albumen in Urine		
Frequent/Severe Headaches			Jaundice		
Dizziness or Fainting Spells			Diabetes		
Head Injury			Heart Problems		
Epilepsy or Seizures			Bone, Joint or other Deformity		
Shortness of Breath or Lung Problems			Back Problems		
Spitting up Blood			Tumor, Growth or Cancer		
Tuberculosis			Nervous Condition		
Skin Disease			Drug or Narcotic Habit		
Pain or Pressure in Chest			Adverse Reaction to Medication		
High Blood Pressure			Alcoholism		
Frequent Indigestion			Illnesses or injury not mentioned above		
Stomach, Liver or Intestinal Problems			Loss of consciousness		
Have you ever been refused employment or been unable to hold a job for reasons of health?					
Have you ever been denied life insurance?					
Have you ever been rejected for or discharged from military service for physical, mental or other reasons?					

If any item is checked "Yes", please explain: ______________________________

Please provide appropriate information below regarding freedom from tuberculosis (TB):

NEW EMPLOYEE: Enter below date of written evidence from a physician or health resource attesting you are free from communicable TB. ______________
Date of Verification

CURRENT EMPLOYEE: Check below if you are required to have additional tuberculosis tests.

☐ No more TB tests required ☐ TB tests required every ______________

I CERTIFY THAT THE ABOVE INFORMATION SUPPLIED BY ME IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

*______________________________ ______________
Signature Date

DSS Form 2901 (OCT 07) Edition of JUL 82 is obsolete.

South Carolina Department of Social Services
Child Care Regulatory Services

STAFF HEALTH ASSESSMENT

Name: ______________________ DOB: ______________

Type of Activity in Child Care: (Check all applicable) ☐ Caring for Children ☐ Desk Work
☐ Adult Member of Household ☐ Food Preparation ☐ Driver of Vehicle ☐ Facility Maintenance

THIS SECTION TO BE COMPLETED BY HEALTH PROFESSIONAL WHO DOES HEALTH ASSESSMENT

Part I – Medical History
Does this person have any of the following medical problems?

	Yes	No
History of myocardial infarction, angina pectoris, coronary insufficiency?		
History of epilepsy?		
Diabetes?		
Current drug or alcohol dependency?		
Disabling emotional disorder?		
Does this person have any special medical or mental problems which might interfere with the health of the children or that might prohibit this person from providing adequate care for the children. If yes, explain on reverse of form.		
Speech disorder?		
Significant physical findings/chronic medical condition or physical impairment?		
Other special medical problem or chronic disease which requires restriction of activity, medication or which might affect his/her work role? If so, specify on reverse of form.		

Part II
As shown by physical examination, does the individual have:

	Yes	No
At least 20/20 combined vision, corrected by glasses if needed?		
Normal hearing?		
Normal blood pressure?		

Part III – Communicable Diseases
Does this person have a communicable disease which would prohibit him/her from working in a child care facility?

☐ Yes ☐ No If yes, please comment: ______________________

____

Tuberculosis Certification (If medically recommended or required by the Local Health Officer)

Type of Test: ____________ Reading: ____________ Date: ____________

Immunization Status
Facility staff are at risk of exposure to childhood diseases. Prospective employees who will work with infants should have a review of their immunization status. Employees are also at risk of exposure to live virus, such as polio and CMV.

Immunization status reviewed: ☐ Yes ☐ No

Comments: ______________________

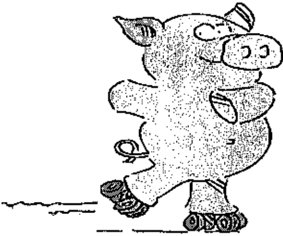
____

____
Print Name & Address of Health Care Provider Telephone Number

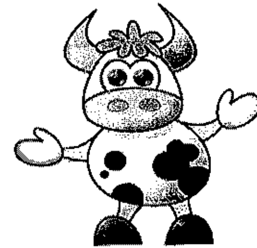
____
Signature of Health Care Provider Date of Examination

HEALTH ASSESSMENTS MUST BE OBTAINED AT LEAST EVERY FOUR (4) YEARS AFTER INITIAL ASSESSMENT AND SUBSEQUENTLY ACCORDING TO THE STATUTE.

DSS Form 2926 (JUN 09) Edition of NOV 99 is obsolete.



Code of Ethics-2019

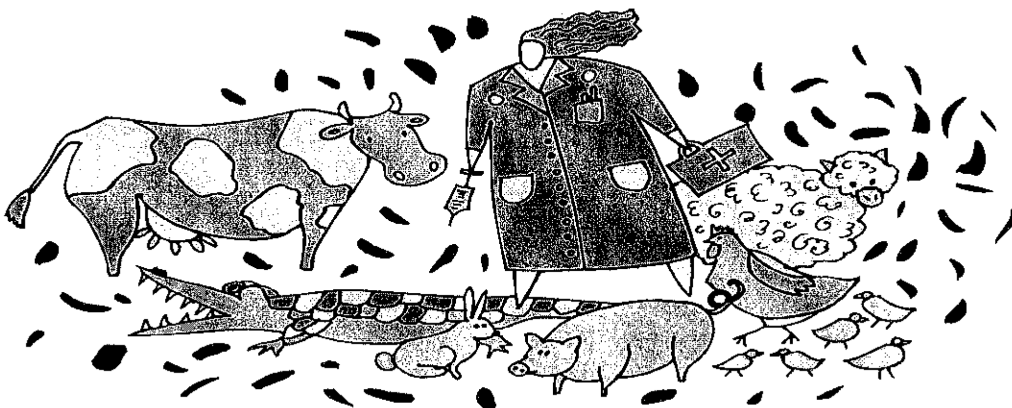


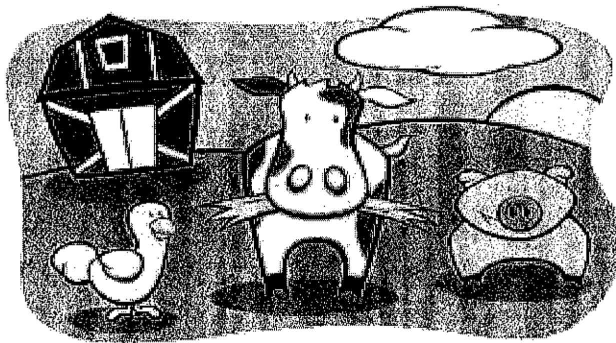
ABC Quality is committed to a code of ethics that guides the performance, conduct, and behavior of its participants including child care facilities, owners, directors, and teachers. This code offers guidance for responsible behavior and will ensure the highest level of professionalism in the operation and activities of ABC Quality providers. **ABC Quality participants will adhere to this code of ethics and relevant program standards and will be held accountable for their actions.**

1. Participants will not harm children and will not participate in practices that are emotionally or physically harmful, disrespectful, degrading, dangerous, exploitive, or intimidating to children.
2. Participants will respect colleagues in early child care and education and support them in maintaining the ABC Quality Code of Ethics.
3. Participants will promote safe and healthy working conditions and policies that foster respect, cooperation, collaboration, competence, well-being, confidentiality, and self-esteem in staff members.
4. Participants will not participate in practices that are in violation of laws and regulations protecting children in child care programs.
5. Participants will demonstrate respect and professional courtesy in their relationships with other ABC Quality participants and the public.
6. Participants will not discriminate against children or families on the basis of sex, race, national origin, religious beliefs, medical condition, disability, or the marital status/family structure, sexual orientation or religious beliefs of their families.

I have read, understand and agree to abide to the Code of Ethics.

Name______________________________ Date____________________



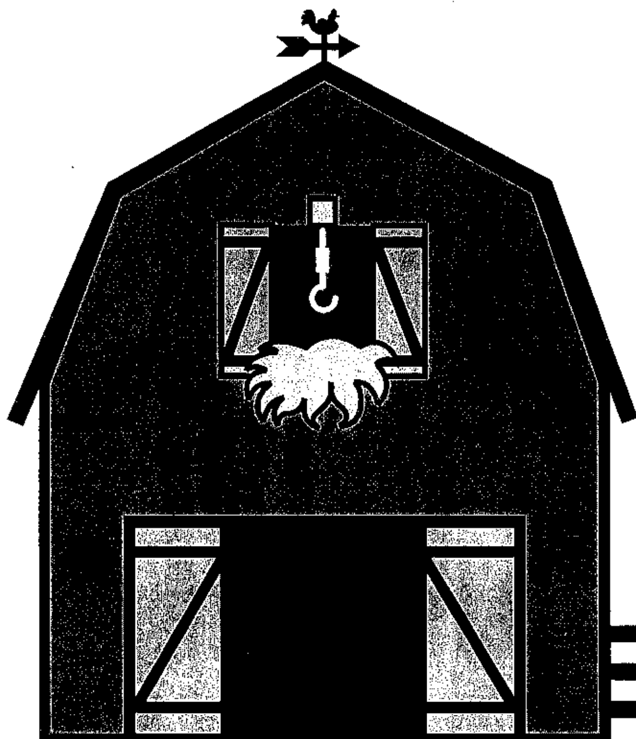


2019-20 Extended Day Expectations

As a member of the Extended Day family, I will comply with the following to maintain certification and employment.

1) The majority of my time will be spent interacting with children.
2) Encourage conversation between children and promote the development of friendships. Ask simple open ended questions that begin with why? what? where? and how? Be responsive through active listening and giving feedback.
3) Help children to become independent life long learners by using positive statements and techniques.
4) Allow students "choice" to select games provided in our rotation system. Encourage curiosity, exploration, and problem solving in daily activities.
5) Provide an environment free of comparison or criticism. Devoting energy to positive reinforcement, age appropriate, corrective action than negative punishment.
6) Keep a positive professional working relationship with all staff members, parents and students. (No DRAMA-please)
7) Adhere to the corporal punishment policy.
8) Respect children's privacy and maintain confidentiality.
9) NEW HIRE required training: SC Health & Safety Pre-Service Course (15 hours) also Certification in First Aid & CPR * Requirements must be completed within 3 months of hire.* (No training=no job) Staff members must take 15 hours of childcare coursework to remain employed. Site Coordinators will complete 5 additional hours in Program Administration.
10) Maintain a written Physician statement (renewed every 4 years) and TB Test to enhance and protect the health and safety of all children and adults.
11) Inquire about Project TEACH-scholarship program to take SAC 101.
12) Contact your Site Coordinator at least 24 hours in advance if you plan to be out. If you are sick, please call 2 hours before arrival time (especially on Early Release Days).

Signature ________________________________ Date____________



Behavior and Expectations 2019-20

As a Extended Day employee building relationships with students must be a positive one. As a staff member, you must establish and encourage realistic boundaries and high expectations for your students. Positive guidance, building self esteem, reducing threat, and creating a relationship of trust and respect will reduce any discipline problem.

Our policy specifically disallows:

1) Corporal Punishment-the use of physical force to the body as a a discipline measure. Physical force of the body includes but is not limited to spanking, slapping, biting and shaking.
2) Any strategy that hurts, shames or belittles a child.
3) The use of food as reward or punishment.
4) Any strategy that threatens, intimidates or forces a child.
5) Use or withhold physical activity as a punishment.

I____________________________understand the above policies and will use positive measures to reinforce behavior in our Extended Day Program.

____

Signature

____

Date