

NEW HIRE CHECKLIST-UNCLASSIFIED WAE
GOVERNOR'S OFFICE OF ELDERLY AFFAIRS

A. FORMS TO BE COMPLETED BY EMPLOYEE - MANDATORY

- STATEMENT OF AGREEMENT AND UNDERSTANDING EMPLOYMENT IN A NON-PERM APPOINTMENT
- LASERS RE-EMPLOYMENT OF RETIREE
- Direct Deposit Enrollment Authorization Main Bank. EMPLOYEE MUST COMPLETE THIS FORM AND ATTACH A VOIDED CHECK. (If transferring from another state agency can enter "NO CHANGE" on form and sign.)
- Emergency contact information
- Employment eligibility verification I-9 form. MUST HAVE COPIES OF DOCUMENTS ATTACHED.
- Tax form W-4 federal taxes (Optional if transferring from other state agency. Can write "NO CHANGE" on form.)
- Recoupment of Overpayments
- Medicare tax eligibility form
- Tax form L-4 state taxes (Optional if transferring from other state agency. Can write "NO CHANGE" on form.)
- Statement Concerning Your Employment in a Job Not Covered by Social Security
- Deferred Compensation enrollment (optional)
- Louisiana Second Injury Fund E-2 form. Employee must review and sign EMPLOYEE NOTIFICATION FORM and CSO2 to verify
- Online W-2 Selection
- OTS User Agreement
- Newly Hired Employee Offer of Coverage
- Planned working time change notification
- Voluntary Self-Identification of disability form

INFORMATION TO REVIEW WITH NEW EMPLOYEE

- Change in information to be reported to HR
- Check issuance
- Dress code
- Holidays
- LEO self-service
- Parking
- Personnel manual (have employee sign acknowledgement form and send it to HR.)
- Political Activity policy (employee must receive copy)
- Position title and starting salary
- Safety manual (have employee sign acknowledgement form and send it to HR.)
- E-VERIFY

STATE CIVIL SERVICE

STATEMENT OF AGREEMENT AND UNDERSTANDING
 EMPLOYMENT OF A NON-PERMANENT APPOINTMENT

Revision Date: 6/2017

Employee Name:	Agency/Section/Unit:
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In accordance with Civil Service Rules, agencies may establish temporary, non-permanent appointments of a limited duration to assist with work of a temporary nature or work overloads. Your signature below indicates that you agree and accept the conditions of this temporary, non-permanent appointment.

I, _____ understand that I am accepting a temporary, non-permanent appointment. I understand that the agency has the discretion to extend this appointment under certain conditions or may terminate this appointment at any time for any reason.

<input type="checkbox"/> Classified WAE Appointment	<input type="checkbox"/> Unclassified WAE Appointment
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If hired in a WAE Appointment, I understand that I am **not** eligible for or entitled to state benefits, leave earning and paid holidays. I am only authorized to work up to **1245 hours** within a twelve-month period, regardless of the job title or state agency that I work within. The twelve-month period is established upon initial date of hire and the 1245 hours may be worked on a full-time, part-time, or intermittent basis within the twelve-month period. Only the State Civil Service Commission may grant exceptions to this rule. In the event the appointing authority determines that a layoff is necessary, I do not have rights to offers of relocation to another position.

<input type="checkbox"/> Job Appointment

If hired in a Job Appointment, I understand that I **may not** be eligible for or entitled to state benefits. I understand that in the event the appointing authority determines that a layoff is necessary I do not have rights to offers of relocation to another position and this appointment may be terminated.

I have read the above and agree to accept this temporary, non-permanent appointment. I further understand that as long as I remain employed in such a temporary, non-permanent capacity, the aforementioned conditions apply.

Employee Signature: _____	Date _____
HR Representative: _____	Date _____

NOTE: If you have any questions concerning these terms, please consult with your Human Resources Office.

LASERS

Louisiana State Employees'
Retirement System

P.O. Box 44213, Baton Rouge, LA 70804-4213
225.922.0600 • Toll-Free 1.800.256.3000
Fax 225.935.2856

PRINT ALL INFORMATION
www.lasersonline.org

Re-employment of Retiree

Member's First Name	Middle Name	Last Name	Today's Date	Social Security Number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

IMPORTANT: Complete the entire form. Follow the specific instructions for each section. All dates should be in MM/DD/YYYY format.

SECTION 1: RETIREE INFORMATION

INSTRUCTIONS: In accordance with La. R.S. 11:416, this form must be completed and returned to LASERS immediately upon your re-employment. It is your responsibility to determine the appropriate re-employment option based on the type of position and estimated earnings for your period of employment. Upon termination, depending on the option chosen, Form 10-02B *Re-employed Retiree Option 3 Certification at End of Employment*, or Form 10-02C *Re-employed Retiree Option 1A or 1B Certification at End of Employment* must be completed and returned to LASERS.

Member's Mailing Address	City	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Daytime Area Code/Phone Number	Evening Area Code/Phone Number	Email Address	Birth Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Rehired Date	Position Title
<input type="text"/>	<input type="text"/>

Employment Status: Full Time Part Time

Classified Unclassified

Are you receiving a benefit from LASERS or another state or statewide retirement system? Yes No

If you answered "Yes" to the question above, list the name of the system from which you are receiving benefits:

Social Security Number

SECTION 2: SELECTION OF RE-EMPLOYMENT OPTION

I elect the following option during the period of my re-employment after retirement. I will notify LASERS immediately if any condition of my re-employment changes. I understand that this option is irrevocable for the full period of my re-employment.

OPTION 1A: I elect to limit my earnings during each fiscal year to 50% of my annual retirement benefit (as adjusted by the Consumer Price Index). I may contact LASERS to request a calculation of the earnings limit for each fiscal year. I understand that the estimated earnings must be reported to LASERS at the beginning of the fiscal year and the actual earnings must be reported at the end of each fiscal year. It is my responsibility to monitor the actual earnings during the fiscal year to ensure that the earnings limit is not exceeded. I understand that if my earnings do exceed my earnings limit, my future retirement benefit will be reduced to the amount the earnings exceeded the limit. You should consider another option if your estimated earnings are expected to exceed the earnings limit.

OPTION 1B: I certify that I am at least 70 years of age and retired with at least 30 years of service credit (exclusive of converted leave) and I am exempt from any suspension or reduction of benefits.

OPTION 2: I elect to repay all retirement benefits received since the date of my retirement plus interest at the actuarial rate. This will restore my service credit, and I will return to active member status. (This option is not available to any retiree who participated in DROP, elected to retire with an Initial Benefit Option (IBO), or retired under an early retirement provision. The 20 years at any age actuarially reduced retirement is not an early retirement.)

OPTION 3: I elect to suspend my benefits during the period of my re-employment. Employee and employer contributions must be paid on the amount of my earnings and there is no limit on the amount of my earnings. If I work at least 36 months, a supplemental retirement benefit will be calculated based on this period of service and the average compensation. If I work less than 36 months, I will receive a refund of my contributions, without interest. When I subsequently retire, my suspended benefit will be restored.

SECTION 3: MEMBER SIGNATURE

I hereby certify that the employment information stated above is correct to the best of my knowledge. If I select Option 1A, I understand that it is my responsibility to monitor my earnings to ensure that I do not exceed the limitation. I understand that this choice is irrevocable for the full term of my re-employment.

Member's Signature

Date

SECTION 4: AGENCY SIGNATURE AND CERTIFICATION

Name of Personnel Officer

Title

Personnel Officer Email Address

Daytime Area Code/Phone Number

Name of Agency

LASERS Agency Number

Signature of Personnel Officer

Date

EARNINGS REPORTING: This employee's earnings will be reported as:

9 months 10 months 12 months

Reset Form

**STATE OF LOUISIANA
LAGOV ERP-HUMAN CAPITAL MANAGEMENT
DIRECT DEPOSIT ENROLLMENT AUTHORIZATION
MAIN BANK (PRIMARY ACCOUNT)**



EMPLOYEE SSN	DEPARTMENT/OFFICE OR AGENCY
ACTION TYPE (✓ one) <input type="checkbox"/> NEW <input type="checkbox"/> CHANGE <input type="checkbox"/> TERMINATE THIS OPTION	

**PRIMARY ACCOUNT INFORMATION
(Main Bank)**
DEPOSIT AMOUNT TO THIS ACCOUNT WILL BE EQUAL TO NET PAY LESS ANY DEPOSITS TO SECONDARY ACCOUNTS.

FINANCIAL INSTITUTION NAME	FINANCIAL INSTITUTION ROUTING (ABA) NUMBER (Bank Key)				
BANK ACCOUNT NUMBER	ACCOUNT NAME * (Ex: Mr. and Mrs. John Doe, John or Jane Doe, John Doe)				
ACCOUNT TYPE (✓ one) (Bank Control Key) <input type="checkbox"/> **CHECKING (provide voided check or account verification) <input type="checkbox"/> **SAVINGS (obtain account # & ABA # from financial institution)	**Account verification or completion of enrollment form by financial institution will assure the accuracy of account data: Signature from institution: _____ <table border="1"> <tr> <td>Effective Date</td> <td>_____ PAYDAY</td> </tr> <tr> <td>Phone number:</td> <td></td> </tr> </table>	Effective Date	_____ PAYDAY	Phone number:	
Effective Date	_____ PAYDAY				
Phone number:					

(Print full name)

I _____ authorize and request the State of Louisiana to direct my net pay check to the account at the financial institution I designated above.

It is my responsibility to notify my Employee Administration Office, as appropriate, should any changes occur to account specified. Considering all above conditions are met, this authorization remains in full effect until a written, signed notification to terminate, or another signed form (OSUP/F12A) indicating termination of this option is received from me and the State of Louisiana has had reasonable opportunity to act on the termination. However, I understand and acknowledge that I am responsible for any account information indicated on this form as well as any account information that I add or any changes that I make to my accounts through Louisiana Employees Online (LEO).

For direct deposits that are affected by the International ACH Transaction (IAT) rules check one:

- I affirm that the entire amount of the payroll direct deposits sent to my account at the financial institution designated above **will not** subsequently be forwarded to a foreign financial institution.
- I affirm that the entire amount of the payroll direct deposits sent to my account at the financial institution designated above **will** subsequently be forwarded to a foreign financial institution.

Signature

Date

Phone number where you can be reached
between 8:00 am and 4:30 pm

*Deposits can only be made to accounts that belong to you. Exceptions: Deposits can be made to the accounts of dependents or a parent/guardian when the employee is a dependent of the parent/guardian.

**Agency requirements may vary. Contact your Employee Administration office if you have any questions.

TO BE COMPLETED BY EMPLOYEE ADMINISTRATION OFFICE:

MAIN BANK	FINANCIAL INSTITUTION ROUTING (ABA) NO. (If not provided above)	
PERSONNEL AREA NUMBER	PERSONNEL NUMBER	EFT VALIDITY DATE

CHECK HERE IF SECONDARY ACCOUNT FORMS ARE ATTACHED

GOEA Employee Emergency Notification



Date: _____
 New ___ Revised ___

Louisiana Governor's Office of Elderly Affairs
 Galvez Building
 602 North 5th Street, 4th Floor
 Baton Rouge, Louisiana 70802
 Phone: 225-342-7100
 Fax: 225-342-7133
www.GOEA.Louisiana.Gov

Employee Name: _____
 Title: _____
 Address: _____
 City: _____
 Zip Code: _____

Home Phone: _____
 Cell Phone: _____

Employee Supervisor:
 Name: _____
 Title: _____
 Contact Number: _____

Person to Notify in Case of Emergency

Name (1) _____
 Address: _____
 State: _____
 Home Phone: _____
 Work Phone: _____
 Cell Phone: _____
 Relationship: _____

Name (2) _____
 Address: _____
 State: _____
 Home Phone: _____
 Work Phone: _____
 Cell Phone: _____
 Relationship: _____

Other Information: _____

For emergency purposes only, please list alternate staff:

Staff Name/Title	Contact Number



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	
I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):					
		<input type="checkbox"/> 1. A citizen of the United States					
		<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)					
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)					
<input type="checkbox"/> 4. A noncitizen (other than item Numbers 2. and 3. above) authorized to work until (exp. date, if any)							
If you check item Number 4., enter one of these:		USCIS A-Number		OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance
Signature of Employee				Today's Date (mm/dd/yyyy)			

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

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

List A		OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)	Additional Information				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.					

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

Last Name, First Name and Title of Employer or Authorized Representative		Signature of Employer or Authorized Representative		Today's Date (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.

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"> 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 an individual temporarily authorized to work for a specific employer because of his or her status or parole: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the 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. 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 	OR	<ol style="list-style-type: none"> 1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">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 	AND	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security <p style="margin-left: 20px;">For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/I-9-central.</p> <p style="margin-left: 20px;">The Form I-766, Employment Authorization Document, is a List A, Item Number 4. document, not a List C document.</p>
<p>Acceptable Receipts</p> <p>May be presented in lieu of a document listed above for a temporary period.</p> <p>For receipt validity dates, see the M-274.</p>				
<ul style="list-style-type: none"> • Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee. 	OR	<p>Receipt for a replacement of a lost, stolen, or damaged List B document.</p>	AND	<p>Receipt for a replacement of a lost, stolen, or damaged List C document.</p>

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



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

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

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

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

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

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

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

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

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

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

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

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



Supplement B, Reverification and Rehire (formerly Section 3)

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

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

Last Name (Family Name) from Section 1.	First Name (Given Name) from Section 1.	Middle Initial (if any) from Section 1.
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Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the [Handbook for Employers: Guidance for Completing Form I-9 \(M-274\)](#)

Date of Rehire (if applicable) / New Name (if applicable)			
Date (mm/dd/yyyy)	Last Name (Family Name)	First Name (Given Name)	Middle Initial
<small>Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.</small>			
Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)	
I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	
Additional Information (Initial and date each notation.)			<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire (if applicable) / New Name (if applicable)			
Date (mm/dd/yyyy)	Last Name (Family Name)	First Name (Given Name)	Middle Initial
<small>Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.</small>			
Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)	
I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	
Additional Information (Initial and date each notation.)			<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire (if applicable) / New Name (if applicable)			
Date (mm/dd/yyyy)	Last Name (Family Name)	First Name (Given Name)	Middle Initial
<small>Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.</small>			
Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)	
I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	
Additional Information (Initial and date each notation.)			<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.

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.

2025

Step 1: Enter Personal Information	(a) First name and middle initial	Last name	(b) Social security number
	Address		Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
	City or town, state, and ZIP code		
	(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying 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.)		

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

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

Step 2: 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.

Multiple Jobs or Spouse Works Do **only one** of the following.

(a) Use the estimator at www.irs.gov/W4App for the most accurate withholding for this step (and Steps 3-4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate

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

Step 3: Claim Dependent and Other Credits	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly):		
	Multiply the number of qualifying children under age 17 by \$2,000 \$ _____		
	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	3	\$ _____
Step 4 (optional): Other Adjustments	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income	4(a)	\$ _____
	(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here	4(b)	\$ _____
	(c) Extra withholding. Enter any additional tax you want withheld each pay period	4(c)	\$ _____

Step 5: Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Sign Here

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

Date

Employers Only	Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

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

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 and you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2025 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 17, 2026.

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

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

1. Are submitting this form after the beginning of the year;
2. Expect to work only part of the year;
3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;
4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or
5. Prefer the most accurate withholding for multiple job situations.

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

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

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

Specific Instructions

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

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work. Submit a separate Form W-4 for each job.

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

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



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

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2025 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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



If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on only ONE Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

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

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

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



- 1 Enter an estimate of your 2025 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income. 1 \$
2 Enter: { \$30,000 if you're married filing jointly or a qualifying surviving spouse; \$22,500 if you're head of household; \$15,000 if you're single or married filing separately } 2 \$
3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" 3 \$
4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information. 4 \$
5 Add lines 3 and 4. Enter the result here and in Step 4(b) of Form W-4. 5 \$

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

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

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

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

RECOUPMENT OF OVERPAYMENTS:

It shall be the policy of the Governor's Office of Elderly Affairs to notify employee (s) when an overpayment has occurred and recoupment must take place.

Written notification will give the reason why the overpayment occurred and specify how/when the agency will start the recoupment procedure.

I have read the above statements and understand if an overpayment is generated in my bi-weekly pay, recoupment by the agency will take place.

NAME

TITLE/UNIT

DATE

MEDICARE TAX ELIGIBILITY FORM

Effective April 1, 1986, all new state employees will be subject to pay 1.45% of their gross salary for the Medicare tax. This will be in addition to their other deductions such as retirement and federal and state tax.

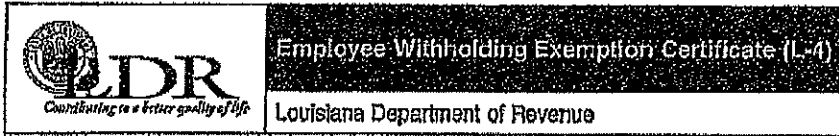
I have read the information above and understand that since:

_____ I have been continuously employed in state government since prior to April 1, 1986. I am not required to pay this tax.

_____ I have not been continuously employed in state government since April 1, 1986. I am required to pay this tax.

Employee Signature

Date



Purpose: Complete form L-4 so that your employer can withhold the correct amount of state income tax from your salary.

Instructions. Employees who are subject to state withholding should complete the personal allowances worksheet indicating the number of withholding personal exemptions in Block A and the number of dependency credits in Block B.

- Employees must file a new withholding exemption certificate within 10 days if the number of their exemptions decreases, except if the change is the result of the death of a spouse or a dependent.
- Employees may file a new certificate any time the number of their exemptions increases.
- Line 8 should be used to increase or decrease the tax withheld for each pay period. Decreases should be indicated as a negative amount.

Penalties will be imposed for willfully supplying false information or willful failure to supply information that would reduce the withholding exemption.

This form must be filed with your employer. If an employee fails to complete this withholding exemption certificate, the employer must withhold Louisiana income tax from the employee's wages without exemption.

Note to Employer: Keep this certificate with your records. If you believe that an employee has improperly claimed too many exemptions or dependency credits, please forward a copy of the employee's signed L-4 form with an explanation as to why you believe that the employee improperly completed this form and any other supporting documentation. This information should be sent to the Louisiana Department of Revenue, Criminal Investigations Division, PO Box 2389, Baton Rouge, LA 70821-2389.

Block A

- Enter "0" to claim neither yourself nor your spouse, and check "No exemptions or dependents claimed" under number 3 below. You may enter "0" if you are married, and have a working spouse or more than one job to avoid having too little tax withheld.
- Enter "1" to claim yourself, and check "Single" under number 3 below. If you did not claim this exemption in connection with other employment, or if your spouse has not claimed your exemption. Enter "1" to claim one personal exemption if you will file as head of household, and check "Single" under number 3 below.
- Enter "2" to claim yourself and your spouse, and check "Married" under number 3 below.

A.

Block B

- Enter the number of dependents, not including yourself or your spouse, whom you will claim on your tax return. If no dependents are claimed, enter "0".

B.

Cut here and give the bottom portion of certificate to your employer. Keep the top portion for your records.

Form **L-4**
Louisiana
Department of
Revenue

Employee's Withholding Allowance Certificate

1. Type or print first name and middle initial		Last name	
2. Social Security Number		3. Select one <input type="checkbox"/> No exemptions or dependents claimed <input type="checkbox"/> Single <input type="checkbox"/> Married	
4. Home address (number and street or rural route)			
5. City		State	ZIP
6. Total number of exemptions claimed in Block A			6.
7. Total number of dependents claimed in Block B			7.
8. Increase or decrease in the amount to be withheld each pay period. Decreases should be indicated as a negative amount.			8.
I declare under the penalties imposed for filing false reports that the number of exemptions and dependency credits claimed on this certificate do not exceed the number to which I am entitled.			
Employee's signature			Date

The following is to be completed by employer.

9. Employer's name and address	10. Employer's state withholding account number
--------------------------------	-------------------------------------------------

**Statement Concerning Your Employment in a Job
Not Covered by Social Security**

Employee Name _____ Employee ID# _____

Employer Name _____ Employer ID# _____

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

Windfall Elimination Provision

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

Government Pension Offset Provision

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

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

For More Information

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

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

Signature of Employee _____ Date _____

Office of Elderly Affairs
Personnel Manual
CONFIRMATION FORM

CONFIRMATION AND CONSENT FORM

OFFICE OF ELDERLY AFFAIRS

Having received a copy of the current Office of Elderly Affairs Personnel Manual, I state that I have read and understand the contents.

Signature _____ Date _____

SAFETY MANUAL

I certify that I have been trained on the following OEA Safety Policies:
Blood borne Pathogens, Violence in the Workplace, Drugs Free Workplace, Sexual Harassment, Defensive Driving, General Safety Procedures and Safety Responsibilities and Assignment of Responsibilities

Name

Date

**GOVERNOR'S OFFICE OF ELDERLY AFFAIRS
POLICY PROHIBITING SEXUAL HARASSMENT**

ACKNOWLEDGEMENT AND CERTIFICATION

My signature hereon acknowledges that:

- 1) I received a copy of GOEA's Policy Prohibiting Sexual Harassment;
- 2) I read this Policy;
- 3) I understand the content of this Policy;
- 4) I agree to abide by the terms and provisions of this Policy;
- 5) I understand that compliance with this Policy is a condition of employment; and
- 6) I understand that disciplinary action, including the possibility of dismissal, will be imposed on those who violate the terms and provisions of this Policy.

EMPLOYEE SIGNATURE

DATE

EMPLOYEE NAME (PRINT)

HUMAN RESOURCES CERTIFICATION

My signature hereon acknowledges that:

- 1) I personally discussed in detail GOEA's Policy Prohibiting Sexual Harassment with the employee identified above;
- 2) I answered this employee's questions regarding this Policy;
- 3) I confirmed this employee's completion of the online training on sexual harassment provided through CPTP; and
- 4) I informed the employee of the consequences of violating this Policy.

HR SIGNATURE

DATE

HUMAN RESOURCES NAME (PRINT)

**LOUISIANA WORKERS' COMPENSATION SECOND INJURY BOARD
POST-HIRE/CONDITIONAL JOB OFFER KNOWLEDGE QUESTIONNAIRE**

EMPLOYEE: The intent of this questionnaire is to provide your employer with knowledge about any pre-existing medical condition or disability which may entitle your employer to reimbursement from the Louisiana Workers' Compensation Second Injury Board in the event you suffer an on-the-job injury.¹ This reimbursement in no way affects the benefits owed to you by your employer or its insurance company under the Louisiana Workers' Compensation Act. La. R.S. 23:1021-1361. However, your failure to answer truthfully and/or correctly to any of the question on this questionnaire may result in a forfeiture of your workers' compensation benefits.

In order for your employer to be considered for reimbursement from the Second Injury Board, it has to show that it knowingly hired or retained you with a pre-existing medical condition or disability. To establish its knowledge, your employer is requesting that this questionnaire be completed.

INSTRUCTIONS: Please answer ALL questions completely. If a response requires an explanation, please provide a brief description on the Explanation Page. If you have any questions or need help in answering the questions on this form, please ask for assistance from the Employer Representative signing this form.

NOTE: Since this questionnaire contains medical information, you can request that the form be kept CONFIDENTIAL and not made part of your personnel file. Please let your employer know that you want the completed questionnaire placed in a sealed folder for confidentiality purposes.

EMPLOYEE WARNING

FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN A FORFEITURE OF YOUR WORKERS' COMPENSATION BENEFITS UNDER La. R.S. 23:1208.1.

Employee Signature: _____ Date: _____

Employer Representative Signature: _____ Date: _____

Employer Name: _____

Employee Name: _____

Date of Birth (mm/dd/yyyy): _____ Male: Female:

Soc. Sec. # (last 4 digits only): _____

Home Address: _____

Telephone Number: (____) _____

¹ Under La. R.S. 23:1371(A), the purpose of the Second Injury Board is to encourage the employment, re-employment, or retention of employees who have a permanent partial disability.

Disease and Other Medical Conditions you currently have or have ever had.

For all conditions that you check yes, write a brief explanation on the Explanation Page.

[Please check the appropriate box next to each. Every illness/injury requires a Yes (Y) or No (N) answer.]

Y N	Y N	Y N	Y N
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Heart Disease/Heart Attack
<input type="checkbox"/> <input type="checkbox"/> Silicosis	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis	<input type="checkbox"/> <input type="checkbox"/> Parkinson's	<input type="checkbox"/> <input type="checkbox"/> Congestive Heart Failure
<input type="checkbox"/> <input type="checkbox"/> Varicose Veins	<input type="checkbox"/> <input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> <input type="checkbox"/> Brain Damage	<input type="checkbox"/> <input type="checkbox"/> Vision Loss, one or both eyes
<input type="checkbox"/> <input type="checkbox"/> Asbestosis	<input type="checkbox"/> <input type="checkbox"/> Post Traumatic Stress	<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Disability from Polio
<input type="checkbox"/> <input type="checkbox"/> Hyperinsulinism	<input type="checkbox"/> <input type="checkbox"/> Osteomyelitis	<input type="checkbox"/> <input type="checkbox"/> Dementia	<input type="checkbox"/> <input type="checkbox"/> Psychoneurotic Disability
<input type="checkbox"/> <input type="checkbox"/> Alzheimer's	<input type="checkbox"/> <input type="checkbox"/> Nervous Disorder	<input type="checkbox"/> <input type="checkbox"/> Thrombophlebitis	<input type="checkbox"/> <input type="checkbox"/> Ruptured or Herniated Disc
<input type="checkbox"/> <input type="checkbox"/> Emphysema	<input type="checkbox"/> <input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> <input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> <input type="checkbox"/> Ankylosis or Joint Stiffening
<input type="checkbox"/> <input type="checkbox"/> Hearing Loss	<input type="checkbox"/> <input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> <input type="checkbox"/> Hodgkin's	<input type="checkbox"/> <input type="checkbox"/> High/Low Blood Pressure
<input type="checkbox"/> <input type="checkbox"/> COPD	<input type="checkbox"/> <input type="checkbox"/> Mental Retardation	<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Carpal Tunnel Syndrome
<input type="checkbox"/> <input type="checkbox"/> Hypertension	<input type="checkbox"/> <input type="checkbox"/> Kidney Disorder	<input type="checkbox"/> <input type="checkbox"/> Double Vision	<input type="checkbox"/> <input type="checkbox"/> Compressed Air Sequelae
<input type="checkbox"/> <input type="checkbox"/> Head Injury	<input type="checkbox"/> <input type="checkbox"/> Loss of Use of Limb	<input type="checkbox"/> <input type="checkbox"/> Mental Disorders	<input type="checkbox"/> <input type="checkbox"/> Disease of the Lung
<input type="checkbox"/> <input type="checkbox"/> Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> <input type="checkbox"/> Hemophilia	<input type="checkbox"/> <input type="checkbox"/> Coronary Artery Disease
<input type="checkbox"/> <input type="checkbox"/> Stroke	<input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease	<input type="checkbox"/> <input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> <input type="checkbox"/> Heavy Metal Poisoning

Surgical Treatment [Please check the appropriate box. Each illness/injury requires a Yes (Y) or No (N) answer.] For each Yes (Y) answer, please complete the information corresponding to the surgery on the right. Additional information can be provided on the Explanation Page, if necessary.

Y N

- Spinal Disc Surgery Year (approximate if unsure) _____
- Spinal Fusion Surgery Year (approximate if unsure) _____
- Amputated Foot Left Right Year (approx. if unsure) _____
- Amputated Leg Left Right Year (approx. if unsure) _____
- Amputated Arm Left Right Year (approx. if unsure) _____
- Amputated Hand Left Right Year (approx. if unsure) _____
- Knee Replacement Left Right Year (approx. if unsure) _____
- Hip Replacement Left Right Year (approx. if unsure) _____
- Other Joint Replacement Joint _____ Year _____
- Other Surgical Procedure Procedure _____ Year _____
- Other Surgical Procedure Procedure _____ Year _____
- Other Surgical Procedure Procedure _____ Year _____
- Other Surgical Procedure Procedure _____ Year _____

Employee Signature: _____ Date: _____

Employer Representative: _____ Date: _____

EXPLANATION PAGE

Please use the space below to explain the illnesses and/or conditions that you checked a Yes (Y) or any other medical conditions that may not be listed on this form. Ask your employer for additional copies of this page if needed.

CONDITION: _____ Year Diagnosed (approx): _____

Are you still treating for this condition? Yes No

Are you taking medication for this condition? Yes No

Do you have any permanent restrictions for this condition? Yes No

Brief Explanation: _____

CONDITION: _____ Year Diagnosed (approx): _____

Are you still treating for this condition? Yes No

Are you taking medication for this condition? Yes No

Do you have any permanent restrictions for this condition? Yes No

Brief Explanation: _____

CONDITION: _____ Year Diagnosed (approx): _____

Are you still treating for this condition? Yes No

Are you taking medication for this condition? Yes No

Do you have any permanent restrictions for this condition? Yes No

Brief Explanation: _____

CONDITION: _____ Year Diagnosed (approx): _____

Are you still treating for this condition? Yes No

Are you taking medication for this condition? Yes No

Do you have any permanent restrictions for this condition? Yes No

Brief Explanation: _____

Employee Signature: _____ Date: _____

Employer Representative: _____ Date: _____

Please answer the following questions.

1. Has any doctor ever restricted your activities? Yes No

If "Yes," please list the restrictions: _____

Were the restrictions: Permanent Temporary

Are your activities currently restricted? Yes No

What is the medical condition for which you have restrictions? _____

2. Are you presently treating with a doctor, chiropractor, psychiatrist, psychologist or other health-care provider? Yes No

Please list the medical condition being treated: _____

Doctor's Name: _____ Specialty: _____

Doctor's Address: _____

3. If you are currently taking prescription medication other than those listed on the Explanation Page, please complete the requested information below.

Medication: _____ Prescribing Doctor: _____

Medication: _____ Prescribing Doctor: _____

4. Have you ever had an on the job accident? Yes No

If you answered "YES," please provide the date for each injury and the nature of the injury:

How long were you on compensation? _____

Name of Employer: _____

5. Has a doctor recommended a surgical procedure, which has not been completed prior to this date, including but not limited to knee, hip or shoulder replacement? Yes No

If you answered YES, please provide:

Recommended surgery: _____

Approximate date of recommendation: _____

Doctor's Name: _____ Specialty: _____

Doctor's Address: _____

Employee Signature: _____ Date: _____

Employer Representative: _____ Date: _____

TO BE COMPLETED BY EMPLOYEE

EMPLOYEE WARNING

FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN A FORFEITURE OF ANY AND ALL WORKERS COMPENSATION BENEFITS UNDER La. R.S. 23:1208.1.

I have completed this form honestly and to the best of my knowledge. I understand that providing false information or omitting pertinent information could result in loss of my workers compensation benefits should I become injured on the job.

Employee Signature: _____ Date: _____

Employee Printed Name: _____

TO BE COMPLETED BY EMPLOYER REPRESENTATIVE

EMPLOYER WARNING

PURSUANT TO La. R.S. 23:1208 OF THE LOUISIANA WORKERS' COMPENSATION ACT, IT SHALL BE UNLAWFUL FOR A PERSON, FOR THE PURPOSE OF OBTAINING OR DEFEATING ANY BENEFIT PAYMENT UNDER THE PROVISIONS OF THIS CHAPTER, EITHER FOR HIMSELF OR FOR ANY OTHER PERSON, TO WILLFULLY MAKE A FALSE STATEMENT OR REPRESENTATION. PENALTIES FOR VIOLATIONS INCLUDE IMPRISONMENT, FINES, AND/OR THE FORFEITURE OF BENEFITS.

You must certify the following:

1. That I am an authorized representative of the employer designated to obtain and review the information provided by the employee on this questionnaire;
2. That I have provided the employee with as many copies of the Explanation Page as needed and have confirmed the number of and labeled the pages of this questionnaire;
3. That I have provided assistance to the employee (if requested) in responding to the questions on this questionnaire;
4. That the information sought by this authorization is made on an applicant for employment only after a conditional job offer has been made and accepted, or on a current employee; and
5. That the information obtained in the authorization will **NOT** be used to discriminate in any manner against the individual who is the subject of this authorization on any basis, in violation of the Americans with Disabilities Act of 1990, 42 U.S.C. §12101, *et seq.*, or any other state or federal law;
6. That if requested, a photocopy of this fully completed and signed form will be provided to the employee.

Employer Representative Signature: _____ Date: _____

Employer Representative Printed Name: _____

Title: _____



John Bel Edwards

Governor

State of Louisiana

OFFICE OF THE GOVERNOR

Office of Elderly Affairs

The Office of State Uniform Payroll (OSUP) offers active employees the option to self-view and print their W-2 in Louisiana Employee On-Line Services (LEO) in lieu of receiving a paper W-2 form via the United States Postal Service (USPS). OSUP is reminding active employees who have not elected the self-view and print option, to do so by December 31.

If you are an active employee and have already opted to self-view and print your W-2, no action is needed. It is, however, recommended that you review your record in LEO, to ensure your election was recorded and saved for future calendar years.

Participation is optional for all active employees:

- If you are actively employed and wish to take advantage of the W-2 on-line self-view and print option you must provide consent in LEO by December 31. W-2s will be available in LEO for viewing and printing by mid-January.
- If you do not provide consent by the required deadline, you revoke your consent, or you do not wish to use this service you will continue to receive a paper W-2 Form through the USPS. All paper W-2 Forms will be mailed January 31 or the next business day if January 31 falls on a weekend.
- Once consent is given, it will remain for all future reporting periods unless you revoke the decision or separate from employment. To revoke your consent, you must do so in LEO by the December 31 deadline for the current reporting year.
- Employees who separate from state service do not have the option of receiving their W-2 on-line but will receive a paper W-2 through the USPS. Paper W-2 Forms will be mailed January 31 or the next business day if January 31 falls on a weekend.

Participation is fast, easy and no cost to you:

- To provide consent, revoke consent, and view and print your W-2 you simply have to sign on to LEO using your active password. Follow the step-by-step guidelines provided to you in LEO.
- To view and print your W-2 you will need an internet connection, web browser, access to LEO with an active password and Adobe Acrobat software.
- There is no cost to you for this service; however, receiving your W-2 faster may give you a head start on completing your annual IRS tax filing and, if applicable, any refund may be received sooner.
- Once the W-2s are available in LEO (by mid-January), you may view and print your W-2 as often as needed at no cost to you.



Overview

The State of Louisiana is entrusted with sensitive, proprietary and confidential information, including Protected Health Information (PHI), Federal Tax Information (FTI), Criminal Justice Information (CJI), and Personally Identifiable Information (PII) and acknowledges that it should take steps to protect that information. One such step is to confirm that users of the State's information take responsibility for the protection and appropriate use of the State's information in accordance with the State's Information Security policies and procedures. Effective protection of such information requires the participation and support of every State employee, independent contractor and third party affiliate ("Users"). It is the responsibility of every User to acknowledge and follow the guidelines in this Policy.

Purpose

The purpose of this Policy is to provide guidance for the acceptable use of computer equipment and information within an Agency. Inappropriate use exposes the State to risks such as data loss, data corruption, unplanned service outage, unauthorized access to Agency data, and potential legal issues.

Applicability

This policy applies to all Users, including State employees, independent contractors and all other workers at an Agency, including all personnel affiliated with third parties. This policy applies to all computing systems, electronic media and printed materials that are utilized, owned, managed, or leased by an Agency or the Office of Technology Services (OTS).

General Requirements

All Users are responsible for exercising good judgment regarding use of State resources in accordance with State's Information Security policies and procedures. The State's resources may not be used for any unlawful purpose. If you have a question regarding the proper use of technical resources, contact the Information Security Hotline toll free at (844) 692-8019.

All State systems, including handheld or mobile devices, computing devices, operating systems, applications, storage media, network accounts, Internet, Intranet, Extranet, and remote access are the property of State. These systems are to be used for business purposes in serving the interests of State, and of Agency clients and customers in the course of normal operations.

Any personal device used in serving the interests of State, must be approved by applicable Agency leadership and the Information Security Team (IST).

Any data created or stored on Agency computing systems remains the property of the Agency. Any personal use of the Agency systems, including any documents or emails, are also the property of the Agency and the State makes no guarantee as to the confidentiality of personal use of Agency systems.

For security, compliance, and maintenance purposes, authorized personnel may monitor and audit Agency computing systems and networks per the State's policies and procedures and to confirm compliance.

User Accounts

The State's Users are responsible for the security of data, accounts, and systems under their control.

Keep passwords secure and do not share account or password information with anyone. For example, do not write passwords down, do not email them and always use complex passwords (e.g., at least 8 characters long using a combination of lower case, upper case, numbers, and special characters).

Providing access to another individual, either deliberately or through failure to secure its access, is a violation of this Policy.

If you believe that you have been granted access to systems or data outside the scope of your employment responsibilities or job function, please contact the Information Security Hotline toll free at (844) 692-8019.



Computing Systems

Users are responsible for ensuring the protection of assigned computing devices, including any electronic devices such as laptops, PDAs, mobile devices, and electronic media.

Users are also responsible for ensuring the protection of any personal devices used in the interest of the State.

State Employees using their vehicles to transport the State's Computing Systems should exercise the utmost caution to safeguard the privacy of and access to such devices. At no time should such equipment be left on car seats, in plain view, in unlocked vehicles or stored in vehicles overnight.

Computing Systems that are stored overnight at non State facilities must be secured with reasonable assurance of privacy to the Data residing on the Systems.

Users of Agency Computing Systems must promptly report any theft or loss to the End User Support Services.

Security and Access Requirements

All State Computer Systems or Agency approved personal devices used for State business purposes (e.g., PCs, laptops, workstations, smartphones, etc.) should be secured with a password-protected screensaver with the automatic activation feature set at 15 minutes or less.

Users shall not create new passwords that are similar to passwords that have been previously used; create passwords that contain any reference to the State in any form (i.e., Pelican, Saints, etc.); create passwords that contain any personal data such as any portion of the user ID or name, a spouse's name, or a pet's name; or create passwords that appear in the dictionary.

Users should secure their workstations by logging off or locking (control-alt-delete or Windows Key + L) the device when unattended.

Users must use due care when transmitting or storing sensitive information. Communications outside of an Agency Network should use mechanisms approved by the Information Security Team (IST) for protecting Confidential or Restricted Data (e.g., encryption).

Portable computers are especially vulnerable and will be protected by a current Antivirus solution and Personal Firewalls, installed or approved by OTS, and may not be disabled or modified by Users.

Users must use extreme caution when accessing electronic media received from outside the State.

Users shall take the necessary and appropriate precautions when opening attachments or emails and shall not open or click on attachments or emails when unsure of the legitimacy of the source or sender.

Known incidents or infections from a virus, malware, or other malicious software should be immediately reported to the Information Security Team.

Streaming media should only be accessed for business purposes from trusted commercial sites. All other streaming media is prohibited.

Meeting hosts should verify that all meeting attendees are authorized access to information shared during meetings (including online meetings). Remote meetings security features, such as pass codes or passwords, should be used to restrict access to the meeting to only authorized individuals. Remote meeting presenters should take care to close, or protect, Confidential or Restricted Data while in "desktop sharing" mode.

Users will take reasonable steps to protect all State property and information from theft, damage, or misuse. This includes maintaining and protecting User workspace, equipment, and information from unauthorized access whether working at Agency facilities or offsite.

Users must use only authorized Instant Messenger clients; all other forms of instant messenger software are prohibited.



Newsrooms, Social Media Sites, and Social Networking Sites

Postings by State Employees regarding Agency business information or news to newsgroups, chatrooms, Internet Relay Chat (IRC), Facebook, Myspace, or other social networking or social media sites is strictly prohibited unless expressly approved in writing by the Agency Communication Director or Executive Leadership. If the User identifies himself or herself as employee or agent of the Agency on any Internet site, any postings to such sites must contain a clear disclaimer that the opinions expressed are solely those of the author and do not represent the views of the Agency or the State of Louisiana.

Virtual Private Network (VPN) Usage

It is the responsibility of users with VPN privileges to protect their VPN login and account information.

Connections to State resources via the VPN must originate from Agency authorized End User devices.

Users understand and acknowledge that by using VPN technology the connected computing resource is a de facto extension of the State's network, and as such is subject to the same rules and regulations that apply as if connected locally to the network.

Connections to non-State VPNs from within a State network must be specifically authorized by the Information Security Team (IST).

Physical Security

A State issued Identification badge must be worn on your person in a visible location at all times within a State facility. The identification badge must be properly secured and a lost badge must be immediately reported to the Information Security Team (IST).

Do not facilitate the entry of non-badge personnel at any time. All visitors must check in at the reception area, clearly wear the Visitor badge at all times, and remain with their designated escort at all times. Guests are not allowed in the State facilities after hours except with the specific authorization of Agency leadership.

Individuals with Agency provided equipment must take appropriate measures to protect the equipment from theft, unauthorized use, or other activity that violates the State's Information Security Policy.

Individuals with access to Confidential or Restricted Data should maintain a clean desk, pickup printed materials in a timely manner and appropriately secure paper based documents when they are not in use.

Privileged User Accounts

Users with privileged user accounts (e.g., administrator or super-user accounts) must agree to the following:

- Individuals with Privileged User Accounts understand it is their responsibility to comply with all security measures necessary and assist in enforcing the Information Security Policy.
- Privileged User Accounts may only be used for valid business functions that require privileged access. Privileged account users must still abide by the least privilege principal and must not access or alter data for which they have no valid business reason to do so.
- Individuals will login to an Agency environment using standard user credentials and then log in to a specific privileged account, except when logging directly into a system interface console.
- Privileged user accounts may not be used to modify the individual's standard user account.
- Privileged user accounts must comply with requirements of the Information Security Policy prior to modifying any system or user account.
- Individuals with privileged user accounts understand and acknowledge that all privileged user account activity is closely monitored. Individuals with privileged user accounts may not use those accounts to modify, alter, or destroy monitoring log data, except as required by their position responsibility as it relates to log rotation.



- Individuals with privileged user accounts, and their supervisor or manager, will notify the Information Security Team when the privileged user account is no longer required to perform that individual's job function.

Unacceptable Use

The following activities are, in general, prohibited. To the extent a State User needs to be exempted from one of the following restrictions for legitimate job responsibilities (e.g., systems administration staff may have a need to disable the network access of a host if that host is disrupting production services), that State User will be provided express authorization from the Information Security Team. The activities below are by no means exhaustive, but attempt to provide a framework for activities which fall into the category of unacceptable use.

System and Network Activities

The following activities are strictly prohibited, with no exceptions:

- Engaging in any activity that is illegal under local, federal, or international law.
- Violations of the rights of any person or company protected by copyright, trade secret, patent or other intellectual property, or similar laws or regulations, including the installation or distribution of "pirated" or other software products that are not appropriately licensed for use by the State of Louisiana.
- Unauthorized copying of copyrighted material including digitization and distribution of photographs from magazines, books or other copyrighted sources, copyrighted music, and the installation of any copyrighted software for which the State or the end user does not have an active license is strictly prohibited. The use of any recording device, including digital cameras, video cameras, and cell phone cameras, within the premises of any State properties to copy or record any Internal, Confidential, or Restricted Data is prohibited.
- Connecting network devices such as wireless access points or personal laptops into the State's network environment without proper authorization from the Information Security Team (IST).
- Intentional introduction of malicious programs into the network or server (e.g., viruses, worms, Trojan horses, e-mail bombs, etc.).
- Revealing your account password to others or allowing use of your account by others. This includes family and other household members when work is being done at home.
- Using an Agency computing asset to actively engage in procuring or transmitting material that is in violation of sexual harassment or hostile workplace laws in the user's local jurisdiction.
- Making fraudulent offers of products, items, or services originating from any State issued user account.
- Effecting security breaches or disruptions of network communication. Security breaches include accessing data of which the individual is not an intended recipient or logging into a server or account that the individual is not expressly authorized to access, unless these duties are within the scope of regular duties. For purposes of this section, "disruption" includes degrading the performance, depriving authorized access, disabling or degrading security configurations.
- Port scanning or security scanning is expressly prohibited unless prior approval is granted by the Information Security Team.
- Executing any form of network monitoring which will intercept data not intended for the user's host, unless this activity is a part of the user's normal job/duty.
- Circumventing user authentication or security of any host, network or account.
- Interfering with or denying service to any User (e.g., denial of service attack).
- Intentionally restrict, disrupt, impair, or inhibit any network node, service, transmission, or accessibility.
- Utilizing unauthorized peer-to-peer networking or peer-to-peer file sharing.
- Utilizing unauthorized software, hardware, proxy avoidance websites or services, or any other means to access to any Internet resource or website that has been intentionally blocked or filtered by the State, Agency, or IST.



Email and Communications Activities

- Sending non-business related unsolicited email messages, text messages, instant messages, or voice mail, including the sending of "junk mail" or other advertising material to individuals who did not specifically request such material (email spam).
- Engaging in any form of harassment or discrimination through email or other electronic means.
- Use of personal email account from the State networks.
- Forging, misrepresenting, obscuring, suppressing, or replacing a user identity on any electronic communication to mislead the recipient about the sender.
- Soliciting email for any other email address (e.g., phishing), other than that of the poster's account, with the intent to harass or to collect replies.
- Creating or forwarding chain letters, Ponzi or other pyramid schemes to a State User, unless specifically requested by such State User.
- Posting non-business-related messages to a large numbers of Usenet newsgroups (newsgroup spam).
- E-mail may not be stored on personal devices (e.g., home computers, personal laptops, PDA's, Smartphones, etc.) except as authorized by the Information Security Team (IST).
- Text messages should not to be used for business discussions. Confidential and Restricted Data shall not be communicated over text messaging.

Users of Confidential and Restricted Information

- By signing this Agreement, Users acknowledge that they are aware of and understand the State's policies regarding the privacy and security of individually identifiable health, financial, criminal and other personal information of individuals and employees, including the policies and procedures relating to the use, collection, disclosure, storage, and destruction of Confidential and Restricted Data.
- In consideration of Users' employment or association with the State and as an integral part of the terms and conditions of such employment or association, Users covenant, warrant, and agree that they shall not at any time, during their employment, contract, association, or appointment with the State or after the cessation of such employment, contract, association, or appointment, access or use Confidential or Restricted Data except as may be required in the course and scope of their duties and responsibilities and in accordance with applicable law and corporate and departmental policies governing the proper use and release of Confidential or Restricted Data.
- Users must understand and acknowledge their obligations outlined hereinabove will continue even after the termination of employment, contract, association, or appointment with the State.
- Users must also understand that the unauthorized use or disclosure of Restricted Data shall result in disciplinary action up to and including termination of employment, contract, association, or appointment, the institution of legal action pursuant to applicable state or federal laws, and reports to professional regulatory bodies.
- Users further acknowledge that by virtue of their employment, contract, association, or appointment with the State, they may be afforded access to Confidential Information concerning the operations and practices of a State Agency, which shall specifically include, but shall not be limited to inventions and improvements, ideas, plans, processes, financial information, techniques, technology, trade secrets, manuals, or other information developed, in the possession of, or acquired by or on behalf of the State, which relates to or affects any aspect of State's operations and affairs ("Confidential Information"). Users agree that they will not use, disclose, or distribute Confidential Information or information derived therefrom except for the exclusive benefit of the State Agency.
- Users understand, acknowledge, and agree that nothing contained herein shall be deemed or regarded as an employment contract or any other guarantee of employment, and shall not otherwise alter or affect User status as an at-will employee (or where applicable, independent contractor) of the State.



Enforcement

Any User found to have violated this Policy may be subject to disciplinary action, up to and including dismissal, or criminal or civil legal actions.

	State Employee	Contractor
Name:		
Title:		
Agency:		
Phone:		
Email:		
Signature:		
Date:		

State of Louisiana—Office of State Uniform Payroll
Affordable Care Act (ACA)
Newly Hired Employee Offer of Coverage Worksheet

This worksheet is used to document the LaGov HCM Paid Agency's reasonable expectations regarding the "full-time" status of a newly hired/transferred employee. A copy of this completed form should be maintained in the employee's file.

1. Personnel Area Number/Name	2. Employee Name
3. Personnel Number	4. Date of Hire
5. Expected Length of Employment	
6. Did the newly hired/transferred employee work for any LaGov HCM paid agency in the last 12 months? <input type="checkbox"/> YES – Proceed to 7 <input type="checkbox"/> NO – Proceed to 9	
7. Was the newly hired/transferred employee in a standard or initial <u>measurement</u> period at any agency? <input type="checkbox"/> YES – Proceed to 8 <input type="checkbox"/> NO – Proceed to 8 <i>If you are unsure, contact the prior employing agency or execute the ACA report (ZP136).</i>	
8. Is the newly hired/transferred employee in a current <u>stability</u> or initial <u>stability</u> period at any agency? <input type="checkbox"/> YES – Employees continues to be eligible for health coverage. Make appropriate entries in LaGov HCM. <input type="checkbox"/> NO – Proceed to 9 <i>Note: A break in service only ends the stability period if it was: (1) at least a 13 week break in service, OR (2) a break in service of at least four (4) weeks but longer than the prior period of employment.</i>	
9. Does the agency expect the newly hired/transferred employee to work at least 30 hours per week at the time of hire/transfer? <input type="checkbox"/> YES – The offer of health coverage must be made in accordance with OGB guidelines. Enter applicable information in eEnrollment/LaGov HCM. Document the offer (GB-01) and keep copy for file. <input type="checkbox"/> NO – Proceed to 10 IMPORTANT: The offer of coverage <u>must</u> be documented and filed in the employee's file.	
10. Is the newly hired/transferred employee replacing a full-time (at least 30 hours) position? Example: the employee is filling in for a permanent position while the employee holding the position is out on leave. <input type="checkbox"/> YES – The offer of health coverage must be made in accordance with OGB guidelines. Enter applicable information in eEnrollment/LaGov HCM. Document the offer (GB-01) and keep copy for file. <input type="checkbox"/> NO – Proceed to 11 IMPORTANT: The offer of coverage <u>must</u> be documented and filed in the employee's file.	
11. Is the newly hired/transferred employee a variable hour employee? A variable hour employee is defined as an employee for whom the agency cannot reasonably determine based on the facts and circumstances upon the date of hire whether the new hire will work on average at least 30 hours per week.	

State of Louisiana—Office of State Uniform Payroll
Affordable Care Act (ACA)
Newly Hired Employee Offer of Coverage Worksheet

Example: The employee will work 36 hours one week, 27 hours the next week, and 25 hours the following week.

- YLS – The agency will measure the employee over the 24 pay period initial measurement (look-back) period. Enter applicable information in eEnrollment/LaGov HCM. Utilize the ACA report (ZP136) periodically to track hours worked. This report must be run at the end of the IMP to determine if employee meets the ACA definition of full time.
- NO – Employee is considered a part-time employee (works less than 30 hours per week) and is not eligible for health coverage. Utilize the ACA report (ZP136) periodically to track hours worked. This report must be run at the end of the IMP to determine if employee meets the ACA definition of full time.

Form Completed by (Print Name)

Title

Date

Definitions

Full-time—The employee is expected to work at least an average of 30 or more hours per week

Part-time—The employee is expected to work less than an average of 30 hours per week.

Variable— It cannot be determined at the date of hire if the employee will work an average of 30 hours per week.

**GOVERNOR'S OFFICE OF ELDERLY AFFAIRS
 PLANNED WORKING TIME CHANGE NOTIFICATION**

Employee Name	
Employee Personnel Number	

I request to set my planned working time schedule as follows: **Effective Date:** _____

Option 1: Five 8-hour workdays M-F *Schedule between 7 am - 7 pm		Time In _____ Time Out _____ *Include 30 min lunch break
Option 2: Four 10 hour work days M-F Choose a requested off day and an alternate day. => *Schedule between 6 am - 7 pm	<input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday Alternate Day _____	Time In _____ Time Out _____ *Include 30 min lunch break
Four 9-hour and One 4-hour work day Choose requested 4-hour work day and alternate day. *Schedule between 6 am - 7 pm	<input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday Alternate Day _____	Time In _____ Time Out _____ *Include 30 min lunch break

APPROVED

APPROVED WITH CHANGES

APPROVED BY MANAGER _____ **DATE** _____

- I acknowledge that I am aware that changes to working times or schedules shall be submitted at the end of each quarter (March, June, September, or December.) Requests based on medical needs may be submitted at any time although additional documentation will be required.

_____ **DATE**

Employee's Signature

Office of the State Americans with Disabilities Act Coordinator (OSADAC)
VOLUNTARY SELF-IDENTIFICATION OF DISABILITY FORM

Employee Name: _____ Personnel #: _____

Why are you being asked to complete this form?

As an executive branch state agency, the Office of Elderly Affairs is required by La. R.S. 46:2597 to establish annual strategies and goals related to employment of individuals with disabilities. In order to effectively measure and report our progress to this end, La. R.S. 46:2597 requires us to ask employees if they have a disability or have ever had a disability. Because a person may become disabled at any time, we ask all of our employees to update their information at least every five (5) years.

Identifying yourself as an individual with a disability is **voluntary**, and we hope that you will choose to do so (if applicable). Your answer will be maintained confidentially and will not be seen by hiring officials or anyone else involved in making personnel decisions. Completing the form will not negatively impact you in any way. For more information about this form or the Americans with Disabilities Act, visit the Office of the State Americans with Disabilities Act (ADA) Coordinator's website at <https://www.doa.la.gov/office-of-state-ada-coordinator/>.

How do you know if you have a disability?

You are considered to have a disability if you have a physical or mental impairment that substantially limits a major life activity, or if you have a history or record of such an impairment. Disabilities include, but are not limited, to:

- Autism
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, or HIV/AIDS
- Blind or low vision
- Cancer
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or hard of hearing
- Depression or anxiety
- Diabetes
- Epilepsy
- Gastrointestinal disorders, for example, Crohn's disease, or irritable bowel syndrome
- Intellectual disability
- Missing limbs or partially missing limbs
- Nervous system condition, for example, migraine headaches, Parkinson's disease or Multiple Sclerosis (MS)
- Psychiatric condition, for example, bipolar disorder, schizophrenia, Post Traumatic Stress Disorder (PTSD) or major depression

Please check ONE of the boxes below.

YES, I have a disability **NO**, I do not have a disability I do not wish to answer

You are encouraged to carefully review our agency's policy specific to the Americans with Disabilities Act and/or Disability Rights, and to request workplace accommodations as may be needed for your disability.

Employee Signature: _____
 Date: _____

**Governor's Office of Elderly
Affairs
State of Louisiana**

JEFF LANDRY
GOVERNOR



602 N. 5th St., Ste. 436
Baton Rouge, Louisiana 70802
(225) 342-7100
GOEA.LA.GOV

Governor's Office of Elderly Affairs

**SEXUAL HARASSMENT
NOTICE OF PERSONAL LIABILITY**

Louisiana law requires government agencies to develop and implement policies and related training to prevent sexual harassment in the workplace. The prohibitions and requirements within these policies apply to all public servants -- employees, appointees and elected officials.

Louisiana's taxpayers have been financially burdened by judgments and settlements arising from claims of workplace sexual harassment. To reduce this impact, La. R.S. 42:351 et seq., enacted in the 2019 Regular Session (Act No. 413), declares that consideration be given to requiring that a public servant, once determined to have engaged in sexually inappropriate workplace behavior, personally reimburse all or a portion of any judgment or settlement resulting from such behavior. La. R.S. 42:353 sets forth the process and factors to be considered in making this determination, and authorizes the Attorney General to file suit against a public servant to enforce the state's right to reimbursement and indemnification.

Notice of this potential personal liability is disseminated by GOEA, along with our policy prohibiting sexual harassment, during orientation to every newly hired public servant. This notice also is disseminated, on an annual basis, to every existing GOEA employee. Reference to this potential personal liability also is included in the annual CPTP training on sexual harassment available through LEO.