Below are the list of forms/documents that must be completed before you begin your position at Arlington Public Schools. Please complete and/or review the following documents that apply to you. If you have any questions please contact us at 703-228-6189/703-228-6101.

Form Name	Instructions	Requirement
Benefits At a Glance	Please review	Required for all new hires. Not all employees may be eligible for listed benefits
Direct Deposit	Please attach a voided check and bring to orientation	Required for all new hires
TB Screening	Please call the number on the form to make an appointment. Please complete and bring to orientation	Required for all new hires
Federal Tax Form	Please contact your tax advisor for advice	Required for all new hires
State Tax Form (DC, MD, VA)	Please contact your tax advisor for advice	Required for all new hires
Fingerprint form	Please complete and bring to orientation	Required for all new hires
Virginia Department of Social Services Central Registry Form	Do not sign or mail form and no fee is required. Form will be notarized at orientation. Employees that have lived in other states during the past five years will have additional forms to complete during orientation.	Required for all new hires
Virginia Retirement System (VRS) designation of beneficiary	Please complete and bring to orientation	Hourly/temporary employees are not eligible
Benefits Enrollment Form	Please review. You must sign the form even if you choose to waive coverage.	Hourly/temporary employees are not eligible
Virginia Teaching Experience Verification Form	Please complete and bring to orientation	For instructional new hires only
College Verification Form	Please complete and bring to orientation	For instructional new hires only
Previous Teaching Experience verification form	Please complete and bring to orientation	For instructional new hires only
403(b) vendor contact list	Please contact the vendors directly for information. Enrollment is optional.	Hourly/temporary employees are not eligible
STAN Profile	Please complete and bring to orientation	Substitute teachers/assistants only

Arlington Public Schools Benefits at a Glance

Benefit	Description	Benefits	Description
Medical & Dental	Point-of-Service and Open Access programs are available through CIGNA. An HMO plan is available through Kaiser Permanente. APS offers the Delta Dental plan.	Flexible Spending	Health Care and Dependent Care Flexible Spending Accounts are offered. Employees may contribute pre-tax funds from gross earnings for medical and child care expenses. A Transportation Flexible Spending Account is also offered for qualified commuting expenses.
Life Insurance	Employees who are members of the Virginia Retirement System (VRS) are covered by the VRS term life insurance program. Life insurance is valued at two times the employee's annual salary rounded up to the next $1,000. The School Board pays the full cost of premiums. VRS employees also may purchase additional coverage for themselves, for their spouse and/or for their dependent children. The cost of optional insurance is borne by the employee.	Defined Contribution Accounts	Employees may contribute pre-tax earnings to a defined contribution account (403(b)). APS contributes 0.4% or $10 per pay period for 24-pay employees ($12 for 20-pay employees) into a 401(a) account for permanent employees qualifying for all benefits. Employees must elect the maximum deduction for their VRS Hybrid defined contribution plan before receiving the School Board match for the 403(b).
Long Term Care Insurance	Employees may enroll in a long-term care (LTC) insurance plan through payroll deductions. Coverage is available for employees, their spouses, parents and spouses' parents. The group plan is offered through the Genworth Life Group). The cost of Long-term care insurance is borne entirely by the employee.	Short-Term and Long-Term Disability	APS pays the full cost of Short- and Long-term Disability insurance which provides an income in the event of an illness or injury. Eligibility is one year as a participant of the VRS Hybrid Retirement Plan and benefits are based on length of service.
Paid Leave	**Annual**: Twelve-month employees earn 14 days per fiscal year, plus bonus days on July 1 equal to number of years of 12-month service (maximum of 14 days). There is a maximum carryover of 40 days per fiscal year with the remainder transferred to the sick leave balance. **Personal**: 3 days are advanced to all 10- and 11-month employees at beginning of school year. A maximum balance of three days may be carried over with the remainder transferred to the sick leave balance. **Sick**: Employees earn one day per month. There is no limit on accrual. Sick leave may be advanced, up to the number of days that will be earned during that fiscal year.	Family Medical Leave	Up to 12 weeks of family and medical leave may be granted for childbirth and/or to care for a newborn, newly adopted or foster child(ren); for caring for an immediate family member with serious health condition; or for the employee's own serious health condition. To be eligible, an employee must have worked for APS for at least 12 months and have worked at least 1,250 hours prior to the start of the leave.

This chart is intended as a brief summary of benefits offered to employees by APS. For full details, please consult the Benefits Summary available at http://www.apsva.us/benefits or the APS School Board Policies and Policy Implementation Procedures. **Rev. 1/14**

Leave of Absence	A leave of absence may be granted for professional full-time study, personal family responsibility, service in the Teacher Corps, VISTA, or the Peace Corps, or for any other reasonable purpose. Leaves of Absence may be granted only to employees who have completed their probationary periods.	Study Leave	A period of up to twenty days every three years may be approved for E/P scale employees to complete a specified course of study. No leave is charged to the employee.
Other Leaves	Military Leave Professional Leave Civil Leave Leave for Religious Observation	Sick Leave Donations	Employees on an approved Family Medical Leave may request that the Assistant Superintendent for Human Resources approve donations of leave from colleagues at their work site. If approved, Human Resources sends a donation form to the employee's supervisor for distribution to employees interested in donating leave.
Holidays	APS observes the following holidays: • New Year's Day • Martin Luther King's Birthday • President's Day • Memorial Day • Fourth of July • Labor Day • Columbus Day • Veterans' Day • Thanksgiving Day (and following Friday) • Christmas Eve • Christmas Day • New Year's Eve	Pay Advance for New Hires	New hires may be approved to receive a salary advance that must be repaid over the course of the first year of employment.
Housing Grants	APS offers grants to employees who work 30 or more hours per week who are purchasing a primary residence in Arlington. Funds are budgeted annually and may be limited.	Mileage Reimbursement	Employees required to travel between locations as part of their regular assignments are eligible for travel reimbursement at a rate of 50.5 cents per mile.
Scholarships	The School Board funds scholarships to permanent employees pursuing courses of study that are related to their job responsibilities. Payments are based on the University of Virginia undergraduate tuition rate. Funds are budgeted annually and may be limited.	The Children's School	School system employees are eligible to enroll their children in The Children's School, an employee-owned cooperative day care facility that provides day care for infants through five-year-olds during the school year.

Non-Resident APS Employee Tuition Initiative	Full-time employees who are not Arlington County residents may apply through a lottery process to enroll their students in a limited number of APS schools and programs for a nominal fee. Such enrollment is based upon the annual availability of space and funding.	Retirement	APS participates in the Virginia Retirement System (VRS) Hybrid Retirement plan for newly hired employees effective January 1, 2014. Employees are vested after 5 years of service. The employee's pay their share into the defined benefit and contribution plan; APS pays the employer match. The plan includes life insurance and a Health Care Credit for professional employees. Employees who are members of the Arlington County Employees Retirement System pay their share into a 457 plan.
Retiree Medical Benefits	Employees who are enrolled in an APS sponsored medical and/or dental insurance plan may retain their coverage upon retirement. Rates are calculated based on years of service with APS.	Separation Pay	All annual leave is paid out at employee's daily rate. A maximum of 40 days of annual leave will be paid to employees hired on or after July 1, 2011. Upon retirement under the Virginia Retirement System or Arlington County Employees Retirement System, sick leave is paid out at 25% for employees hired after July 1, 2011.

HUMAN RESOURCES

Arlington Public Schools
1426 N. Quincy Street, Arlington, VA 22207
TEL 703.228.6189 FAX 703.841.2138 http://www.apsva.us/careers

Arlington Public Schools Adult Tuberculosis Screening for Employment

2100 Washington Blvd, 2nd Floor, Arlington, VA, 22204

Arlington County Occupational Health Unit (Ask for the Occupational Health Nurse Sharon Ying Liu); must call for an appointment at 703.228.4815 OR email the nurse at syingliu@arlingtonva.us – *there will be no charge at this office for Arlington Public Schools new hires; but you must ask for the Occupational Health Nurse.*

Arlington County Immunization Clinic 703.228.1200; WALK-IN Clinic Schedule Hours as follows:
● Tuesdays 3:00 p.m. - 6:30 p.m. ● Wednesdays 9:00 a.m. - 12:30 p.m. ● Fridays 7:30 a.m. to 11:00 a.m.
There will be a fee for the TB test/screening; Arlington Public Schools (APS) is not responsible for the fee.

We encourage you to call and confirm above schedule before your visit, as changes may occur without notice. Please keep in mind that your waiting time could be from 5 minutes to an hour, and if you require a PPD test (not a screening) you will be instructed to return in 2-3 days for the PPD reading/results.

TB screening can also be performed by the applicant's health care provider.

The screening certificate form must be completed, stamped and signed by the physician or nurse before it is returned to the Arlington Public Schools Human Resources Department.

If an applicant is under 18 years of age, he/she must be accompanied by a parent/legal guardian. Parent/legal guardian may be required to complete the "Parental Consent for Occupational Health Evaluation and Deemed Consent" form provided by the medical facility.

As a condition of employment, Arlington Public Schools employees shall submit a TB Screening Certificate signed by a licensed physician or by the physician's licensed designee stating that such employee appears free of communicable tuberculosis. Such screening shall be based on a symptoms assessment, risk assessment, x-rays, and other exams, alone or in combination, as deemed necessary by a licensed physician.

The screening must have been performed within a 12 month period immediately preceding submission of the certificate. The preferred certificate is the Arlington County Public Health Division's Adult Tuberculosis Screening Certificate (see other side). A certificate from another health facility, properly documented with facility's address, phone number, doctor's signature and date, may be submitted.

Please see other side for the screening certificate.

ADULT TUBERCULOSIS SCREENING CERTIFICATE

Public Health
Prevent. Promote. Protect.

1. Does applicant have any of the following symptoms?

   ☐ Cough > 3 weeks ☐ Night sweats ☐ Unexplained fever ☐ Unexplained weight loss

   If **no**, go to #2

   If **yes**, stop here and evaluate for active Tuberculosis. Proceed to #2 when active TB ruled out.

2. Has applicant had a prior documented **positive** TB skin test (TST)?
   - ☐ **If No,** go to #3.
   - ☐ **If Yes,** but no X-ray documentation, refer for chest x-ray and evaluate.
   - ☐ **If Yes,** and X-ray results documented and abnormal, evaluate for possible active TB. Sign below when active TB ruled out.
   - ☐ **If Yes**, and X-ray results documented and normal, sign this certificate below.

3. Ask **all** the following risk assessment questions and check if "yes" since the applicant's last documented negative TST or last negative risk assessment.

   a. ☐ *Was the individual born in a high risk country* and been in the US for fewer than 5 years?*
   b. ☐ *During the past two (2) years, did the individual live more than three (3) months in a high risk country*?*
   c. ☐ *Has the individual been in close contact with a person known to have active tuberculosis?*
   d. ☐ *Has the individual worked in or been a resident in a congregate living setting such as a shelter, prison, jail, nursing home or assisted living facility?*
   e. ☐ *Has the individual injected illicit drugs?*

If **no** to 3 *a* through *e*, sign this certificate below now.

If any one answer is **yes,** plant a TST and read the results at 48 to 72 hours.

If the TST is **negativ**e, sign this certificate below.

If the TST is **positive** (see box), evaluate as usual.

CDC Classification of Positive TST Reaction
≥5mm: HIV+ persons, recent contacts of TB case, patients with organ transplant, and other immunosuppressed patients
≥10mm: anyone else with positive response to the risk questions above

**High Risk Countries=countries other than the US, Canada, Australia, New Zealand, or in Western Europe*

Clip along dotted line and give portion below to applicant for Arlington Public Schools HR DEPARTMENT
1426 N. Quincy Street, Arlington, VA 22207 Fax 703.841.2138.

Name of applicant: _____DOB: _____

Signature and date of Applicant: _____

This certifies that the screening is complete and that the applicant listed above is free of communicable TB disease.

Print Name of Arlington Co. Health Dept. Practicing Nurse: _____ Date: _____

Signature of Arlington Co. Health Dept. Practicing Nurse: _____Extension #: _____

↓ **AFFIX ARLINGTON COUNTY HEALTH DEPARTMENT OFFICE STAMP IN SPACE BELOW:** ↓

ARLINGTON
VIRGINIA

NOTE: Private practice (non-county medical office), please submit TB Screening, TB Test, or X-rays results on your office's letterhead stationery, make sure that it's signed and dated by Doctor OR Practicing Nurse.

ARLINGTON PUBLIC SCHOOLS
AUTHORIZATION FOR DIRECT DEPOSIT
(PLEASE PRINT)

EMPLOYEE NAME	EMPLOYEE I.D. NO.	SCHOOL OR DEPARTMENT

I authorize the Arlington Public Schools and the bank indicated below to deposit automatically my net pay into my checking or savings account each payday. If monies to which I am not entitled are deposited into my account, I authorize the Arlington Public Schools to direct the bank to return such funds. This authority shall remain in effect approximately two weeks after I have notified the Arlington Public Schools Payroll Office **in writing** that it is to be cancelled. If I change banks or accounts, I understand that deposits to my former account will terminate in the pay period following the receipt of the new authorization form. For new accounts, I understand that my pay will be deposited directly into my new account as of the next pay period.
I understand that the amount to be deposited each payday will be the net amount shown on my payroll statement (check stub), which may vary from one pay to another due to changes in gross pay, deductions, tax rates, etc. I further understand that the payroll statement will be the only and the official notice of the net amount deposited.

I understand that neither the Arlington Public Schools nor any of its employees are to be held legally responsible for failure of any Depository Financial Institution to make a deposit as scheduled. I further understand that adjustments may be initiated to my account to reverse deposits that are made incorrectly.
I further understand that under no circumstances shall the Arlington Public Schools and its officers, agent or employees, be responsible for, and I agree to hold them harmless for any charges, fees, costs, liabilities, expenses or damages that might be imposed or arise out of delays, mistakes or errors made by the Arlington Public Schools, its agent or employees, or any member of the Mid-Atlantic Clearing House Association or its affiliates in any way relating to the direct deposit of my net pay.

EMPLOYEE SIGNATURE _____ DATE _____

Direct Deposit #1 **$ NET AMOUNT**

New/Change/Cancel Primary Net Account: ☐ Add ☐ Change ☐ Cancel

Type of Account (Check only one): ☐ Checking ☐ Savings

Bank: _____
Address: _____
Bank Routing and Transit No.: _____
Employee Bank Account No.: _____

Ensure to attach a Voided Check

Direct Deposit #2 (Not Required) Amount: $_____ **(Only use this account for a set dollar figure)**

Add/Change for a Second Account only: ☐ New ☐ Change ☐ Cancel

Type of Account (Check only one): ☐ Checking ☐ Savings

Bank: _____
Address: _____
Bank Routing and Transit No.: _____
Employee Bank Account No.: _____

Ensure to attach a Voided Check

This form *must* be complete to be processed. Routing numbers are always 9 digit numbers.

PAYROLL APPROVAL _____ DATE _____

Form W-4 (2016)

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

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2016 expires February 15, 2017. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2016. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A** _____
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	**B** _____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C** _____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D** _____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	**E** _____
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F** _____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child	**G** _____
H	Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ►	**H** _____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074

2016

1	Your first name and middle initial	Last name	**2** **Your social security number**
	Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
	City or town, state, and ZIP code	**4** **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐	
5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6** $	
7	I claim exemption from withholding for 2016, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ►	**7**	

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

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

8	Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2016 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1952) of your income, and miscellaneous deductions. For 2016, you may have to reduce your itemized deductions if your income is over $311,300 and you are married filing jointly or are a qualifying widow(er); $285,350 if you are head of household; $259,400 if you are single and not head of household or a qualifying widow(er); or $155,650 if you are married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,600 if married filing jointly or qualifying widow(er); $9,300 if head of household; $6,300 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2016 adjustments to income and any additional standard deduction (see Pub. 505)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2016 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2016 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $4,050 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note: Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	1	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3"	2	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	3	

Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4	Enter the number from line 2 of this worksheet	4	
5	Enter the number from line 1 of this worksheet	5	
6	**Subtract** line 5 from line 4	6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	$
9	Divide line 8 by the number of pay periods remaining in 2016. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2016. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $6,000	0	$0 - $9,000	0
6,001 - 14,000	1	9,001 - 17,000	1
14,001 - 25,000	2	17,001 - 26,000	2
25,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 75,000	5
44,001 - 55,000	6	75,001 - 85,000	6
55,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$610	$0 - $38,000	$610
75,001 - 135,000	1,010	38,001 - 85,000	1,010
135,001 - 205,000	1,130	85,001 - 185,000	1,130
205,001 - 360,000	1,340	185,001 - 400,000	1,340
360,001 - 405,000	1,420	400,001 and over	1,600
405,001 and over	1,600		

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 who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

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

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

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

FORM VA-4

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF TAXATION
PERSONAL EXEMPTION WORKSHEET

(See back for instructions)

1. If you wish to claim yourself, write "1" ..... _____
2. If you are married and your spouse is not claimed on his or her own certificate, write "1" ..... _____
3. Write the number of dependents you will be allowed to claim on your income tax return (do not include your spouse) ..... _____
4. Subtotal Personal Exemptions (add lines 1 through 3) ..... _____
5. Exemptions for age
   (a) If you will be 65 or older on January 1, write "1" ..... _____
   (b) If you claimed an exemption on line 2 and your spouse will be 65 or older on January 1, write "1" ..... _____
6. Exemptions for blindness
   (a) If you are legally blind, write "1" ..... _____
   (b) If you claimed an exemption on line 2 and your spouse is legally blind, write "1" ..... _____
7. Subtotal exemptions for age and blindness (add lines 5 through 6) ..... _____
8. Total of Exemptions - add line 4 and line 7 ..... _____

Detach here and give the certificate to your employer. Keep the top portion for your records

---

FORM VA-4 EMPLOYEE'S VIRGINIA INCOME TAX WITHHOLDING EXEMPTION CERTIFICATE

Your Social Security Number	Name	
Street Address		
City	State	Zip Code

COMPLETE THE APPLICABLE LINES BELOW

1. If subject to withholding, enter the number of exemptions claimed on:
   (a) Subtotal of Personal Exemptions - line 4 of the Personal Exemption Worksheet ..... _____
   (b) Subtotal of Exemptions for Age and Blindness line 7 of the Personal Exemption Worksheet ..... _____
   (c) Total Exemptions - line 8 of the Personal Exemption Worksheet ..... _____
2. Enter the amount of additional withholding requested (see instructions) ..... _____.
3. I certify that I am not subject to Virginia withholding. I meet the conditions set forth in the instructions ..... (check here) ☐
4. I certify that I am not subject to Virginia withholding. I meet the conditions set forth Under the Service member Civil Relief Act, as amended by the Military Spouses Residency Relief Act ..... (check here) ☐

Signature Date

EMPLOYER: Keep exemption certificates with your records. If you believe the employee has claimed too many exemptions, notify the Department of Taxation, P.O. Box 1115, Richmond, Virginia 23218-1115, telephone (804) 367-8037. Note: Employers may establish a system to electronically receive Forms VA-4 from employees, provided the system meets Internal Revenue Service requirements as specified in § 31.3402(f)(5)-1(c) of the Treasury Regulations (26 CFR).

2601064 Rev. 08/11

FORM VA-4 INSTRUCTIONS

Use this form to notify your employer whether you are subject to Virginia income tax withholding and how many exemptions you are allowed to claim. You must file this form with your employer when your employment begins. If you do not file this form, your employer must withhold Virginia income tax as if you had no exemptions.

PERSONAL EXEMPTION WORKSHEET

You may not claim more personal exemptions on form VA-4 than you are allowed to claim on your income tax return unless you have received written permission to do so from the Department of Taxation.

Line 1. You may claim an exemption for yourself.

Line 2. You may claim an exemption for your spouse if he or she is not already claimed on his or her own certificate.

Line 3. Enter the number of dependents you are allowed to claim on your income tax return.

NOTE: A spouse is not a dependent.

Line 5. If you will be age 65 or over by January 1, you may claim one exemption on Line 5(a). If you claim an exemption for your spouse on Line 2, and your spouse will also be age 65 or over by January 1, you may claim an additional exemption on Line 5(b).

Line 6. If you are legally blind, you may claim an exemption on Line 6(a). If you claimed an exemption for your spouse on Line 2, and your spouse is legally blind, you may claim an exemption on Line 6(b).

FORM VA-4

Be sure to enter your social security number, name and address in the spaces provided.

Line 1. If you are subject to withholding, enter the number of exemptions from:

(a) Subtotal of Personal Exemptions - line 4 of the Personal Exemption Worksheet

(b) Subtotal of Exemptions for Age and Blindness - line 7 of the Personal Exemption Worksheet

(c) Total Exemptions - line 8 of the Personal Exemption Worksheet

Line 2. If you wish to have additional tax withheld, and your employer has agreed to do so, enter the amount of additional tax on this line.

Line 3. If you are not subject to Virginia withholding, check the box on this line. You are not subject to withholding if you meet any one of the conditions listed below. Form VA-4 must be filed with your employer for each calendar year for which you claim exemption from Virginia withholding.

(a) You had no liability for Virginia income tax last year and you do not expect to have any liability for this year.

(b) You expect your Virginia adjusted gross income to be less than the amount shown below for your filing status:

	Taxable Years 2005, 2006 and 2007	Taxable Years 2008 and 2009	Taxable Years 2010 and 2011	Taxable Years 2012 and Beyond
Single	$7,000	$11,250	$11,650	$11,950
Married	$14,000	$22,500	$23,300	$23,900
Married, filing a separate return	$7,000	$11,250	$11,650	$11,950

(c) You live in Kentucky or the District of Columbia and commute on a daily basis to your place of employment in Virginia.

(d) You are a domiciliary or legal resident of Maryland, Pennsylvania or West Virginia whose only Virginia source income is from salaries and wages and such salaries and wages are subject to income taxation by your state of domicile.

Line 4. Under the Servicemember Civil Relief Act, as amended by the Military Spouses Residency Relief Act, you may be exempt from Virginia income tax on your wages if (i) your spouse is a member of the armed forces present in Virginia in compliance with military orders; (ii) you are present in Virginia solely to be with your spouse; and (iii) you maintain your domicile in another state. If you claim exemption under the SCRA check the box on Line 4 and attach a copy of your spousal military identification card to Form VA-4.

MARYLAND FORM

MW507

Purpose. Complete Form MW507 so that your employer can withhold the correct Maryland income tax from your pay. Consider completing a new Form MW507 each year and when your personal or financial situation changes.

Basic Instructions. Enter on line 1 below, the number of personal exemptions you will claim on your tax return. However, if you wish to claim more exemptions, or if your adjusted gross income will be more than $100,000 if you are filing single or married filing separately ($150,000, if you are filing jointly or as head of household), you must complete the Personal Exemption Worksheet on page 2. Complete the Personal Exemption Worksheet on page 2 to further adjust your Maryland withholding based on itemized deductions, and certain other expenses that exceed your standard deduction and are not being claimed at another job or by your spouse. However, you may claim fewer (or zero) exemptions.

Additional withholding per pay period under agreement with employer. If you are not having enough tax withheld, you may ask your employer to withhold more by entering an additional amount on line 2.

Exemption from withholding. You may be entitled to claim an exemption from the withholding of Maryland income tax if:

a. Last year you did not owe any Maryland Income tax and had a right to a full refund of any tax withheld; AND,
b. This year you do not expect to owe any Maryland income tax and expect to have a right to a full refund of all income tax withheld.

If you are eligible to claim this exemption, complete Line 3 and your employer will not withhold Maryland income tax from your wages.

Students and Seasonal Employees whose annual income will be below the minimum filing requirements should claim exemption from withholding. This provides more income throughout the year and avoids the necessity of filing a Maryland income tax return.

Certification of nonresidence in the State of Maryland. Complete Line 4. This line is to be completed by residents of the District of Columbia, Virginia or West Virginia who are employed in Maryland and who do not maintain a place of abode in Maryland for 183 days or more.

Residents of Pennsylvania who are employed in Maryland and who do not maintain a place of abode in Maryland for 183 days or more, should complete line 5 to exempt themselves from the state portion of the withholding tax. These employees are still liable for withholding tax at the rate in effect for the Maryland county in which they are employed, unless they qualify for an exemption on either line 6 or line 7. Pennsylvania residents of York and Adams counties may claim an exemption from the local withholding tax by completing line 6. Pennsylvania residents living in other local jurisdictions which do not impose an earnings or income tax on Maryland residents may claim an exemption by completing line 7. Employees qualifying for exemption under 6 or 7, should also write "EXEMPT" on line 4.

Line 4 is **NOT** to be used by residents of other states who are working in Maryland, because such persons are liable for Maryland income tax and withholding from their wages is required.

If you are domiciled in the District of Columbia, Pennsylvania or Virginia and maintain a place of abode in Maryland for 183 days or more, you become a statutory resident of Maryland and you are required to file a resident return with Maryland reporting your total income. You must apply to your domicile state for any tax credit to which you may be entitled under the reciprocal provisions of the law. If you are domiciled in West Virginia, you are not required to pay Maryland income tax on wage or salary income, regardless of the length of time you may have spent in Maryland.

Under the Servicemembers Civil Relief Act, as amended by the Military Spouses Residency Relief Act, you may be exempt from Maryland income tax on your wages if (i) your spouse is a member of the armed forces present in Maryland in compliance with military orders; (ii) you are present in Maryland solely to be with your spouse; and (iii) you maintain your domicile in another state. If you claim exemption under the SCRA enter your state of domicile (legal residence) on Line 8; enter "EXEMPT" in the box to the right on Line 8; and attach a copy of your spousal military identification card to Form MW507. **In addition, you must also complete and attach Form MW507M.**

Duties and responsibilities of employer. Retain this certificate with your records. You are required to submit a copy of this certificate and accompanying attachments to the Compliance Division, Compliance Programs Section, 301 West Preston Street, Baltimore, MD 21201, when received if:

1. You have any reason to believe this certificate is incorrect;
2. The employee claims more than 10 exemptions;
3. The employee claims an exemption from withholding because he/she had no tax liability for the preceding tax year, expects to incur no tax liability this year and the wages are expected to exceed $200 a week;
4. The employee claims an exemption from withholding on the basis of nonresidence; or
5. The employee claims an exemption from withholding under the Military Spouses Residency Relief Act.

Upon receipt of any exemption certificate (Form MW 507), the Compliance Division will make a determination and notify you if a change is required.

Once a certificate is revoked by the Comptroller, the employer must send any new certificate from the employee to the Comptroller for approval before implementing the new certificate.

If an employee claims exemption under 3 above, a new exemption certificate must be filed by February 15th of the following year.

Duties and responsibilities of employee. If, on any day during the calendar year, the number of withholding exemptions that the employee is entitled to claim is less than the number of exemptions claimed on the withholding exemption certificate in effect, the employee must file a new withholding exemption certificate with the employer within 10 days after the change occurs.

FORM
MW507

Employee's Maryland Withholding Exemption Certificate

Print full name	Social Security Number
Street Address, City, State, ZIP	County of residence (Nonresidents enter Maryland county (or Baltimore City) where you are employed.)

Single Married (surviving spouse or unmarried Head of Household) Rate Married, but withhold at Single rate

1. Total number of exemptions you are claiming not to exceed line f in Personal Exemption Worksheet on page 2. . . . . 1._____
2. Additional withholding per pay period under agreement with employer. . . . . 2._____
3. I claim exemption from withholding because I do not expect to owe Maryland tax. See instructions above and check boxes that apply.
   - ☐ a. Last year I did not owe any Maryland Income tax and had a right to a full refund of all Income tax withheld and
   - ☐ b. This year I do not expect to owe any Maryland income tax and expect to have the right to a full refund of all income tax withheld. (This includes seasonal and student employees whose annual income will be below the minimum filing requirements).

   If both a and b apply, enter year applicable _____ (year effective) Enter "EXEMPT" here . . . . . 3._____
4. I claim exemption from withholding because I am domiciled in one of the following states. Check state that applies.
   ☐ District of Columbia ☐ Virginia ☐ West Virginia
   I further certify that I do not maintain a place of abode in Maryland as described in the instructions above. Enter "EXEMPT" here. . . . . 4._____
5. I claim exemption from Maryland **state** withholding because I am domiciled in the Commonwealth of Pennsylvania and I do not maintain a place of abode in Maryland as described in the instructions on Form MW507. Enter "EXEMPT" here. . . . . 5._____
6. I claim exemption from Maryland **local** tax because I live in a local Pennysylvania jurisdiction within York or Adams counties. Enter "EXEMPT" here and on line 4 of Form MW507. . . . . 6._____
7. I claim exemption from Maryland **local** tax because I live in a local Pennsylvania jurisdiction that does not impose an earnings or income tax on Maryland residents. Enter "EXEMPT" here and on line 4 of Form MW507. . . . . 7._____
8. I certify that I am a legal resident of the state of _____ and am not subject to Maryland withholding because I meet the requirements set forth under the Servicemembers Civil Relief Act, as amended by the Military Spouses Residency Relief Act. Enter "EXEMPT" here. . 8._____

Under the penalty of perjury, I further certify that I am entitled to the number of withholding allowances claimed on line 1 above, or if claiming exemption from withholding, that I am entitled to claim the exempt status on whichever line(s) I completed.

Employee's signature	Date
Employer's name and address including ZIP code (For employer use only)	Federal Employer Identification Number

Personal Exemptions Worksheet

Line 1

a. Multiply the number of your personal exemptions by the value of each exemption from the table below. (Generally the value of your exemption will be $3,200; however, if your federal adjusted gross income is expected to be over $100,000, the value of your exemption may be reduced. **Do not claim any personal exemptions you currently claim at another job, or any exemptions being claimed by your spouse.** To qualify as your dependent, you must be entitled to an exemption for the dependent on your federal income tax return for the corresponding tax year. **NOTE:** Dependent taxpayers may not claim themselves as an exemption. . . . . a. _____

b. Multiply the number of additional exemptions you are claiming for dependents 65 years old or older by the value of each exemption from the table below. . . . . b. _____

c. Enter the estimated amount of your itemized deductions (excluding state and local income taxes) that exceed the amount of your standard deduction, alimony payments, allowable childcare expenses, qualified retirement contributions, business losses and employee business expenses for the year. Do not claim any additional amounts you currently claim at another job or any amounts being claimed by your spouse. **NOTE:** Standard deduction allowance is 15% of Maryland adjusted gross income with a minimum of $1,500 and a maximum of $2,000. . . . . .c. _____

d. Enter $1,000 for additional exemptions for taxpayer and/or spouse at least 65 years old and/or blind. . . . . d. _____

e. Add total of lines **a** through **d**. . . . . e. _____

f. Divide the amount on line e by $3,200. **Drop any fraction. Do not round up.** This is the **maximum** number of exemptions you may claim for withholding tax purposes. .....f. _____

If Your federal AGI is		**If you will file your tax return**	
		Single or Married Filing Separately **Your Exemption is**	Joint, Head of Household or Qualifying Widow(er) **Your Exemption is**
$100,000 or less		**$3,200**	**$3,200**
Over	**But not over**		
$100,000	**$125,000**	**$1,600**	**$3,200**
$125,000	**$150,000**	**$800**	**$3,200**
$150,000	**$175,000**	**$0**	**$1,600**
$175,000	**$200,000**	**$0**	**$800**
In excess of $200,000		**$0**	**$0**

FEDERAL PRIVACY ACT INFORMATION

Social Security numbers must be included. The mandatory disclosure of your Social Security Number is authorized by the provisions set forth in the Tax-General Article of the Annotated Code of Maryland. Such numbers are used primarily to administer and enforce the individual income tax laws and to exchange income tax information with the Internal Revenue Service, other states and other tax officials of this state. Information furnished to other agencies or persons shall be used solely for the purpose of administering tax laws or the specific laws administered by the person having statutory right to obtain it.

Government of the District of Columbia

_____ Year

D-4 Employee Withholding Allowance Certificate

Your first name | M.I. | Last name

Home address (number and street) | Apartment number

Social security number

City | State | Zip code +4

1 Tax filing status *Fill in only one:* ○ Single ○ Married/domestic partners filing jointly ○ Married filing separately ○ Head of household ○ Married/domestic partners filing separately on same return

2 Total number of withholding allowances from worksheet below

3 Additional amount, if any, you want withheld from each paycheck $

4 If claiming exemption from withholding, read below and, if qualified, write "EXEMPT" in this box.

I am exempt because: last year I did not owe any DC income tax and had a right to a full refund of all DC income tax withheld from me; and this year I do not expect to owe any DC income tax and expect a full refund of all DC income tax withheld from me; and I qualify for exempt status on federal Form W-4.

If claiming withholding exemption, are you a full-time student. ○ Yes ○ No

Signature Under penalties of law, I declare that I have completed this certificate and, to the best of my knowledge, it is correct.

Employee's signature | Date

Employer Keep this certificate with your records. If 10 or more exemptions are claimed or if you suspect this certificate contains false information please send a copy to: Office of Tax and Revenue, 941 North Capitol St., NE, Washington, DC 20002-4259 Attn: Compliance Administration

Detach and give the top portion to your employer. Keep the bottom portion for your records.

Government of the District of Columbia

D-4 Employee Withholding Allowance Worksheet

Section A Number of withholding allowances

a	Enter 1 for yourself and	a
b	Enter 1 if you are filing as a head of household and	b
c	Enter 1 if you are 65 or over and	c
d	Enter 1 if you are blind	d
e	Enter number of dependents	e
f	Enter 1 for your spouse/registered domestic partner if filing jointly	f
g	Enter 1 if married/registered domestic partners filing jointly and your spouse/registered domestic partner is 65 or over and	g
h	Enter 1 if married/registered domestic partners filing jointly and your spouse/registered domestic partner is blind	h
i	Number of allowances Add Lines a through h and enter on Line 2 of the certificate. If you want to claim additional withholding allowances, complete section B below.	i

Section B Additional withholding allowances

j	Enter estimate of your itemized deductions	j
k	Enter $2,000 if married/registered domestic partners filing separately; all others enter $4,000	k
l	Subtract k from j	l
m	Multiply $1,675 by the number of allowances on Line i	m
n	Divide l by m. Round to the nearest whole number.	n
o	Add Lines n and i and enter on Line 2 above.	o

Detach and give the top portion to your employer. Keep the bottom portion for your records.

Who must file a Form D-4?
Every new employee who resides in DC and is required to have DC taxes withheld, must fill out Form D-4 and file it with his/her employer.

If you are not liable for DC taxes because you are a nonresident you must file Form D-4A. Certificate of Nonresidence in the District of Columbia, with your employer.

When should you file?
File Form D-4 whenever you start new employment. Once filed with your employer, it will remain in effect until you file an amended certificate. You may file a new withholding allowance certificate any time the number of withholding allowances you are entitled to increases. You must file a new certificate within 10 days if the number of withholding allowances you claimed decreases.

How many withholding allowances should you claim?
Use the worksheet on the front of this form to figure the number of withholding allowances you should claim. If you want less money withheld from your paycheck, you may claim additional allowances by completing Section B of the worksheet, Lines j through o. However, if you claim too many allowances, you may owe additional taxes at the end of the year.

Should I have an additional amount deducted from my paycheck?
In some instances, even if you claim zero withholding allowances, you may not have enough tax withheld. You may, upon agreement with your employer, have more tax withheld by entering on Line 3, a dollar amount of your choosing.

What to file
After completing Form D-4, detach the top portion and file it with your employer. Keep the bottom portion for your records.

VA Department of Social Services
Office of Background Investigations – Search Unit
801 East Main Street, 6th Floor, Richmond, VA 23219-2901

Central Registry Release of Information Form

Search Fee $10.00 (PAID BY APS)

INSTRUCTIONS

Purpose

The Virginia Child Abuse and Neglect Central Registry is mandated by the Virginia Child Protective Law and contains the names of individuals identified as an abuser or neglector in founded child abuse and/or neglect investigations conducted in the state of Virginia. The findings are made by Child Protective Services staff in local departments of social services and are maintained by the Virginia Department of Social Services. Legal mandates for the Virginia Department of Social Services to provide a Central Registry and a mechanism for conducting searches of the registry are found in § 63.2-1515 of the Code Virginia.

Read all instructions before completing the form: (Incomplete forms will be returned)

1. Answer all questions completely and accurately by printing clearly in black ink or typing your answers. Failure to complete or print clearly may delay or deny your request. Given the nature of the form and the actions to be taken when received, the **Office of Background Investigations shall not accept forms that have been altered in any fashion.** Forms that contain strike outs, correction tape or white-out will be returned.
2. If a middle name is an initial, indicate "initial only" otherwise, enter a full middle name given at birth.
3. For "other names used" list all previous names; nick names, all previous married names, legal name changes, changes due to adoption, etc. Circle appropriate title description on the form.
4. If the answer to any question is none, write "N/A".
5. Sign the Central Registry Release of Information Form in the presence of an official Notary Public. Each request form must be notarized. Only original signatures will be accepted. No copies of the form will be accepted.
6. A $10.00 fee is charged for each search. Payment must accompany search forms. Only money orders, company/business checks, or cashier checks will be accepted. (If multiple requests are mailed together, payment may be combined on in one money order, company/business check, or cashier's check.
   (ex. 4 requests at $10.00 each will total $40.00). A $50 fee will be charged for all returned checks.)

   All money orders, company/business checks, or cashier checks should be made payable to:
   Virginia Department of Social Services.

   Personal checks and cash will not be accepted. **Search Fee $10.00 (PAID BY APS)**
7. For agencies and facilities that require several searches per year, an agency code will be assigned to expedite processing of the search requests.
8. If additional space is needed to complete the form (ie. providing information on addresses, spouses, and children) attach an 8x11 sheet sheet of paper along with your form to be mailed.
9. Search results are not transferable and are not considered official beyond the requesting agency or individual.
10. Mail your completed form and additional sheets (if used) to:

    Virginia Department of Social Services
    Office of Background Investigations - Search Unit
    801 East Main Street, 6th Floor
    Richmond, VA 23219-2901

VA Department of Social Services
Office of Background Investigations – Search Unit
801 East Main Street, 6th Floor, Richmond, VA 23219-2901

Central Registry Release of Information Form

Search Fee $10.00 (PAID BY APS)

Purpose of Search, Check one: ☐ Adam Walsh Law ☐ Adoptive Parent ☐ Babysitter/Family Day Care ☐ CASA ☐ Children's Residential Facility ☐ Custody Evaluation ☐ Day Care Center ☐ Foster Parent ☐ Institutional Employee ☐ Other Employment ■ School Personnel ☐ Volunteer ☐ Other

MAIL SEARCH RESULTS TO: Agency, Individual or Authorized Agent Requesting Search

Name	Arlington Public Schools
Address	1426 N Quincy St
City	Arlington **State** VA **Zip** 22207
Contact Name	Joseph Baumann **Tel.#** 703-228-8639 **Ext**
Contact E-Mail	joseph.baumann@apsva.us

Payment/FIPS Code
(Use only if assigned by OBI-CRU)

B10006

Mandatory if agency code has been assigned

PART I: DETAILS OF INDIVIDUAL WHOSE NAME MUST BE SEARCHED

Last Name	First Name	Full Middle Name – (given at birth) **- no initials** (if middle name is an initial, indicate "Initial Only")

Maiden Name (last name before marrage)	Sex	Date of Birth **(MM/DD/YYYY)**	Race
	☐ Male ☐ Female		

Driver's License Number or ID #	Social Security Number	Other names used; nicknames, legal names (refer to instruction page)

Current Address (Include Street # and Apt #)	City	State	Zip

Applicant's Prior Addresses

Include Street # and Apt #	City	State	Zip	Start Date **(MM/YY)**	End Date **(MM/YY)**

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner

If married, list current spouse. If previously married, list all previous spouses. If you have never been married, write 'N/A'.

Last Name	First Name	Full Middle Name (given at birth)	Maiden Name	Race	Sex	Date of Birth **(MM/DD/YYYY)**
					☐ Male ☐ Female	
					☐ Male ☐ Female	
					☐ Male ☐ Female	

List all of your children. If you have none, write **'N/A'.** Include all adult children, step and foster children not living with you.

Last Name	First Name	Full Middle Name (given at birth)	Relationship	Sex	Date of Birth **(MM/DD/YYYY)**
				☐ Male ☐ Female	
				☐ Male ☐ Female	
				☐ Male ☐ Female	

VA Department of Social Services
Office of Background Investigations – Search Unit
801 East Main Street, 6th Floor, Richmond, VA 23219-2901

Central Registry Release of Information Form

Search Fee $10.00 (PAID BY APS)

PART II: CERTIFICATION AND CONSENT FOR RELEASE OF INFORMATION

I hereby certify that the information contained on this form is true, correct and complete to the best of my knowledge. Pursuant to Section 2.2-3806 of the *Code of Virginia*, I authorize the release of personal information regarding me which has been maintained by either the Virginia Department of Social Services or any local department of social services which is related to any disposition of founded child abuse/neglect in which I am identified as responsible for such abuse/neglect. I have provided proof of my identity to the Notary Public prior to signing this in his/her presence.

_____ _____

Signature of person whose name is being searched (Sign in presence of Notary)

Parent or Guardian signature required for minor children under the age of 18

PART III: CERTIFICATE OF ACKNOWLEDGEMENT OF INDIVIDUAL

City/County of _____

Commonwealth/State of _____ Notary Seal

Acknowledged before me this _____ day of _____, year_____

_____ _____

Notary Public Signature **Notary Number**

My Commission Expires: _____

PART IV: CENTRAL REGISTRY FINDINGS – COMPLETED BY CENTRAL REGISTRY STAFF ONLY

1. We are unable to determine at this time if the individual for whom a search has been requested is listed in the Central Registry. Please answer the following questions and return to the Central Registry Unit in order for us to make a determination:

_____
_____
_____
_____
_____

Worker: _____Date: _____

2. _____ Based on information provided by the Local Department of Social Services, we have determined that _____ is listed in the Child Abuse/Neglect Central Registry with a founded disposition of child abuse/neglect. For more detailed information, contact the

_____Dept. of Social Services in reference to referral _____ phone#_____

_____Dept. of Social Services in reference to referral _____ phone#_____

3. _____ As of this date, based on the information provided, the individual whose name was being searched is **NOT** identified in the Central Registry of Child Abuse/Neglect.

Signature of worker completing search: _____Date: _____

OBI Staff Only

Arlington Public Schools Fingerprint Request & Authorization Form

Please Print Clearly

To be completed by applicant. Additional questions on back of form.

Last Name: _____ First Name: _____

Middle Name: _____ Aliases: _____

Current Address (Include City, State, and Zip Code):

_____

Gender: _____ Race: _____ Height: _____ Weight: _____ Eye Color: _____Hair Color: _____

Birth Date: _____ Birth Country: _____

Birth State: _____Social Security Number: _____ Phone Number: _____

Please list all states where you have resided in the past five years other than Virginia:

1)_____ 2)_____ 3)_____ 4)_____ 5) _____

Signature*: _____ Date: _____
*If the applicant is under 18 years of age, a parent/guardian must give consent and sign below.

Parent/Guardian Signature: _____ Date: _____

Hiring Administrator Use ONLY
APS administrator signature required to fingerprint applicant

Hiring Administrator's Name (Print): _____ Location: _____

Signature: _____ Date: _____

Human Resources Staff ONLY

Candidates Position: _____ Location: _____

Type of Picture ID verified (Circle one): Driver's License, Passport, Military ID, DMV issued ID, Government issued ID

HR Staff Name:_____ Date: _____ Return Results To: _____

Human Resources Staff ONLY
Fingerprint Result

Checked by: _____ Date: _____

Cleared For Employment ☐ Retake Required ☐ Record Being Processed by Federal/State Agency ☐

Date cleared for employment after record is processed and received by Federal/State Agency _____

Please answer the questions on the back of this form ⇒

Fingerprints will be taken in the Human Resources Office located on the 4th floor at the Education Center—1426 N. Quincy Street, Arlington, VA, 22207.

Applicants may not begin employment until Human Resources approves the fingerprint result.

- Applicant must complete and sign both sides of this fingerprint form.
- Hiring administrator must complete and sign the "Hiring Administrator Use Only" section of this form. Human Resources will not fingerprint an applicant with out the hiring administrator's signature.
- Applicant must present a valid government issued picture ID card (Driver's license, Military ID, DMV issued ID, or a Passport).

Because of the tremendous responsibility Arlington Public Schools has to its school children and community, the following information is needed from all applicants and employees regarding convictions. A record of conviction does not prohibit employment; however, failure to complete this form accurately and completely can mean disqualification from consideration for employment or can be cause for consideration of dismissal if employed. Applicants and employees must report any convictions that occur subsequent to the time they initially completed this form. Questions regarding this information should be directed to Human Resources.*

Have you ever been fired, asked to resign, and allowed to resign in lieu of dismissal, denied renewal of an employment contract or received a dishonorable or bad conduct discharge? ☐ Yes ☐ No

Have you been convicted of a felony or any offense involving the sexual molestation, physical or sexual abuse or rape of a minor (child under the age of 18)? ☐ Yes ☐ No

A Yes answer to this question will not automatically disqualify you for employment. Have you ever been convicted of any crime or offense (felony or misdemeanor)? Do not include convictions for minor traffic violations. Do include DWI/DUI convictions and habitual offender violations. ☐ Yes ☐ No

Have you ever entered a plea of guilty, been placed on probation or otherwise received a suspended imposition of sentence or deferred disposition to a charge of a felony, misdemeanor involving moral turpitude, the physical or sexual abuse or neglect of a child, sexual assault, use or possession of drugs, obscenity and related offenses. If yes, list the specific offense(s), the date of the court disposition or upcoming court date, and the name of the court and jurisdiction where the case was or will be heard. ☐ Yes ☐ No

Has a Social Services Department, Child Protective Service unit or any other governmental agency ever investigated charges of abuse or neglect against you and determined such charge to be "founded", "probably founded", "reason to suspect", or similar findings? ☐ Yes ☐ No

Are there criminal charges pending against you? ☐ Yes ☐ No

If you answered YES to any of the questions above, please attach a statement of explanation. (An affirmative response will not automatically disqualify an applicant.)

*CONVICTION means the final judgment on a verdict or a finding of guilty, or a plea of nolo contendere, in any state or federal court of competent jurisdiction in a criminal case, regardless of whether an appeal is pending or could be taken. Conviction does not include a final judgment which has been expunged by pardon, reversed, set aside, or otherwise rendered invalid.

** A.R.S. 13.3716 requires applicants to give notice of any conviction for dangerous crimes against children. These crimes are defined as second degree murder, aggravated assault, sexual assault of a child, sexual conduct with a minor, sexual exploitation of a minor, child abuse, kidnapping and sexual abuse.

I certify that I have read this form in its entirety and the information herein provided is true, accurate and complete. I understand that, should any statements I have made prove to be false, or misleading, it may result in the rejection of my application or in my immediate discharge if I am employed, I also understand that any misstatements or omission of fact on this form may result in my immediate discharge. Any such discharge following employment is without grievance rights. I further understand and agree that acceptance of this form on my part does not constitute an employment agreement, and that an offer of employment does not create a contractual obligation upon the employer to continue to employ me in the future.

Applicant's Signature_____ Date:_____

Virginia Retirement System Hybrid Plan

If your hire date is on or after January 1, 2014 and you are a new participant in the Virginia Retirement System (VRS), you are covered under the Hybrid Retirement Plan.

If you were previously a member of VRS and left your money in VRS, you will be placed back into your previous retirement plan. If you are uncertain if you remained in VRS, please contact them directly at 1-888-827-3847 to confirm.

The following is a summary of the Hybrid Retirement Plan. For additional information, please refer to the VRS website at www.varetire.org or contact VRS at 1-888-827-3847.

About the Hybrid Retirement Plan

The Hybrid Retirement Plan combines the features of a Defined Benefit Plan and a Defined Contribution Plan.

- The Defined Benefit portion of the plan is based on a formula using your age, creditable service and average final compensation at retirement. Those amounts are used to calculate a monthly retirement payment.

- The Defined Contribution Portion of the plan is based on the contributions made to that plan and the investment performance of those contributions. The default investment account is a Target Date Portfolio. For additional options, go to www.varetire.org.

Retirement Contributions

Your retirement benefit is funded through mandatory and voluntary contributions made by you and APS to both the Defined Benefit and Defined Contribution components of the plan. You contribute a mandatory 4% of your creditable compensation each month to your Defined Benefit member account and a mandatory 1% to your Defined Contribution account.

Additionally, you may choose to make voluntary contributions of up to an additional 4% to the Defined Contribution component of the plan, and your employer will match a percentage of those voluntary contributions.

Vesting

Defined Benefit Vesting is the minimum length of service you need to qualify for a future retirement benefit. You are vested under the Defined Benefit component of the Hybrid Retirement Plan when you reach five years (60 months) of creditable service.

Defined Contribution Vesting is the length of time you must be employed in order to be allowed to withdraw APS contributions from the Defined Contribution component of the plan. You are always 100% vested in the contributions that you make. Please refer to the VRS website for the vesting schedule.

Defined Contribution Plan Overview – administered by ICMA -RC

Mandatory Contributions to the Defined Contribution Plan

Both you and APS are required to make a 1% contribution into your Defined Contribution account.

Voluntary Contributions to the Defined Contribution Plan

You may voluntarily contribute up to an additional 4% in 0.5% increments to your account quarterly.

Investment Options

A number of investment options are available for Hybrid Retirement Plan participants. The default investment option is a Target Date Portfolio based on your estimated retirement date. You can change your investment selection at any time by logging into your account from the VRS website.

Employer Matching

The School Board will match the first 1% of your voluntary contribution with a corresponding contribution of 1%. Each of your additional 0.5% increases will be matched by APS with a 0.25% contribution, up to a max of 2.5% as illustrated below.

Mandatory Contributions to the Defined Contribution Plan	
Employee 1%	Employer 1%
Additional Contributions	
Employee Voluntary Contributions	Employer Match Contributions
1%	1%
.5%	.25%
.5%	.25%
.5%	.25%
.5%	.25%
.5%	.25%
.5%	.25%
Total Voluntary 4%	Total Match 2.5%
Total Employee 5%	Total Employer 3.5%

Employees who have a 403(b) account are also eligible to receive a matching contribution from the School Board (the greater of 0.4% of your salary or $120 per year.) In order to receive the match on your 403(b) account, you must contribute the maximum amount of voluntary contributions to the Defined Contribution portion of the Hybrid Plan (4%).

ACTION - How do I make voluntary contributions to the Defined Contribution portion of the plan?

You can increase or decrease your voluntary contributions on a quarterly basis. PLEASE NOTE -The plan also has an auto-escalation feature – your voluntary amount into the Defined Contribution portion of the plan will increase by one-half percent every three years unless you elect otherwise.

To make a contribution change, you can access your account online by visiting www.varetire.org and selecting Account Log-In within the Defined Contribution Plans tab, or you may call Investor Services at 1-877-327-5261 and select option 1.

The cut-off to make a change is the 15th of the month prior to the next quarter. If the 15th is not a business day, the deadline will be the next business day after the 15th. (For example, you must request the change by June 15th for the change to be effective in the first payroll of July.)

Virginia Retirement System Hybrid Plan

If your hire date is on or after January 1, 2014 and you are a new participant in the Virginia Retirement System (VRS), you are covered under the Hybrid Retirement Plan.

If you were previously a member of VRS and left your money in VRS, you will be placed back into your previous retirement plan. If you are uncertain if you remained in VRS, please contact them directly at 1-888-827-3847 to confirm.

The following is a summary of the Hybrid Retirement Plan. For additional information, please refer to the VRS website at www.varetire.org or contact VRS at 1-888-827-3847.

About the Hybrid Retirement Plan

The Hybrid Retirement Plan combines the features of a Defined Benefit Plan and a Defined Contribution Plan.

- The Defined Benefit portion of the plan is based on a formula using your age, creditable service and average final compensation at retirement. Those amounts are used to calculate a monthly retirement payment.

- The Defined Contribution Portion of the plan is based on the contributions made to that plan and the investment performance of those contributions. The default investment account is a Target Date Portfolio. For additional options, go to www.varetire.org.

Retirement Contributions

Your retirement benefit is funded through mandatory and voluntary contributions made by you and APS to both the Defined Benefit and Defined Contribution components of the plan. You contribute a mandatory 4% of your creditable compensation each month to your Defined Benefit member account and a mandatory 1% to your Defined Contribution account.

Additionally, you may choose to make voluntary contributions of up to an additional 4% to the Defined Contribution component of the plan, and your employer will match a percentage of those voluntary contributions.

Vesting

Defined Benefit Vesting is the minimum length of service you need to qualify for a future retirement benefit. You are vested under the Defined Benefit component of the Hybrid Retirement Plan when you reach five years (60 months) of creditable service.

Defined Contribution Vesting is the length of time you must be employed in order to be allowed to withdraw APS contributions from the Defined Contribution component of the plan. You are always 100% vested in the contributions that you make. Please refer to the VRS website for the vesting schedule.

DESIGNATION OF BENEFICIARY

VIRGINIA RETIREMENT SYSTEM
P.O. Box 2500 ◆ Richmond, Virginia 23218-2500
Toll Free 1-888-VARETIR (827-3847)
www.varetire.org

1. Social Security Number	
2. Employer Code	40106

PART A. MEMBER/RETIREE INFORMATION

3. Name (First, Middle Initial, Last)	**4. Are you retired?** ❑ Yes ❑ No
5. Address (Street, City, State and Zip+4)	**6. Birth Date**

PART B. BENEFICIARIES FOR VRS BASIC AND OPTIONAL GROUP LIFE INSURANCE

Check ONE:

❑ **I revoke any previous designations and elect payment of VRS basic and optional group life insurance benefits to be made by order of precedence established by law.** If you check this box, **do not** complete the beneficiary information below. Continue to Part C. (Order of precedence is explained in the form instructions.)

❑ **I revoke any previous designations and elect payment of VRS basic and optional group life insurance benefits to the beneficiaries designated below.** If you check this box, complete the beneficiary information below.

Full Name (Person or Estate) (First, Middle Initial, Last)			**Social Security Number**
Address (Street, City, State and Zip+4)			
Beneficiary Type (Check one) ❑ Primary ❑ Contingent	**Share %**	**Relationship**	**Birth Date**
Full Name (Person or Estate) (First, Middle Initial, Last)			**Social Security Number**
Address (Street, City, State and Zip+4)			
Beneficiary Type (Check one) ❑ Primary ❑ Contingent	**Share %**	**Relationship**	**Birth Date**
Full Name (Person or Estate) (First, Middle Initial, Last)			**Social Security Number**
Address (Street, City, State and Zip+4)			
Beneficiary Type (Check one) ❑ Primary ❑ Contingent	**Share %**	**Relationship**	**Birth Date**
Name of Trust Organization			**Date of Trust**
Address (Street, City, State and Zip+4)			
Beneficiary Type (Check one) ❑ Primary ❑ Contingent	**Share %**	**Trustee or Organization Executive Officer**	

Are additional beneficiaries for Part B listed on a VRS-2A continuation form?
❑ Yes ❑ No

ELIGIBLE DEPENDENTS

The following persons are eligible to be insured under the VRS Optional Group Life Insurance Plan:

- the employee's spouse, and
- the employee's unmarried, natural, or legally adopted children* who are not self-supporting, and
- the employee's unmarried step-children* who live full-time with the employee in a parent-child relationship and can be claimed as a dependent on the employee's Federal income tax return, and
- any other children* if they are in the permanent court-ordered custody of the employee.

* less than 21 years of age (age 25 if a full-time college student).

Beneficiary Information

The employee's beneficiary for Optional Group Life Insurance is the same as designated for the employee's Basic VRS Group Insurance. The employee is the beneficiary for the Optional Group Life Insurance on the employee's spouse and children.

PART C. BENEFICIARIES FOR VRS MEMBER ACCOUNT RETIREMENT CONTRIBUTIONS/BENEFITS

Check ONE:

- ❑ **I revoke any previous designations and elect payment of VRS retirement contributions/benefits to be made by order of precedence established by law.** If you check this box, **do not** complete the beneficiary information below. Continue to Part D. (Order of precedence is explained in the form instructions.)
- ❑ **I revoke any previous designations and elect payment of VRS retirement contributions/benefits to the beneficiaries designated below.** If you check this box, complete the beneficiary information below.

Full Name (Person or Estate) (First, Middle Initial, Last)			**Social Security Number**
Address (Street, City, State and Zip+4)			
Beneficiary Type (Check one) ❑ Primary ❑ Contingent	**Share %**	**Relationship**	**Birth Date**
Full Name (Person or Estate) (First, Middle Initial, Last)			**Social Security Number**
Address (Street, City, State and Zip+4)			
Beneficiary Type (Check one) ❑ Primary ❑ Contingent	**Share %**	**Relationship**	**Birth Date**
Full Name (Person or Estate) (First, Middle Initial, Last)			**Social Security Number**
Address (Street, City, State and Zip+4)			
Beneficiary Type (Check one) ❑ Primary ❑ Contingent	**Share %**	**Relationship**	**Birth Date**
Name of Trust Organization			**Date of Trust**
Address (Street, City, State and Zip+4)			
Beneficiary Type (Check one) ❑ Primary ❑ Contingent	**Share %**	**Trustee or Organization Executive Officer**	

Are additional beneficiaries for Part C listed on a VRS-2A continuation form?
❑ Yes ❑ No

PART D. CERTIFICATION

Member Certification: I do hereby revoke all previous designations of primary and contingent beneficiaries, if any, and designate the beneficiary(ies) as indicated on this form to receive the proceeds of the basic and optional group life and accidental death and dismemberment insurance policies administered by VRS if I am covered under those policies, and to receive the accumulated retirement contributions/benefits to my credit in VRS at the time of my death. I do hereby direct that should I survive all of the above-named primary and contingent beneficiaries, any amount(s) which otherwise would have been payable to such beneficiary(ies) shall be paid in the order of precedence established by law and as listed in the instructions of this form or to such other beneficiary(ies) as I shall hereafter designate by written designation filed with the VRS Board of Trustees in accordance with its procedures. The right to change the beneficiary(ies) designation without the consent of said beneficiary(ies) is reserved. All information I provide in this document is true and I understand that any willful falsification of facts presented may result in prosecution as provided by law. (Persons holding a Power of Attorney, acting under a Guardianship, or acting as a Trustee may not make or change any beneficiary designation unless the relevant documentation specifically grants the authority to do so. Persons not holding such documents may not make or change any member's beneficiary designation unless granted the authority to do so by court order.)

Member Signature _____ Date _____

7. Social Security Number:

INSTRUCTIONS FOR COMPLETING THE DESIGNATION OF BENEFICIARY

Complete this form to designate a beneficiary for VRS Basic and Optional Group Life Insurance and for your retirement contribution account. It is only necessary to designate a beneficiary if you want payment to be made in a method other than by order of precedence established by law. If you previously completed a VRS-2 and wish to change beneficiaries or now wish to choose the order of precedence, you must complete this form to revoke any prior designations.

Please read the information provided on this form to understand your options for designating a beneficiary. Additional information is provided in your *Handbook for Members,* which is available on the VRS Web site (www.varetire.org) or from your human resources representative.

Order of Precedence: You may choose the order established by law to provide payment of your benefits or you may designate specific beneficiaries to receive your benefits in the event of your death. The order of precedence is as follows:

- To your spouse;
- *If no surviving spouse*, to your natural or legally adopted children and descendents of your deceased natural or legally adopted children;
- *If none of the above*, to your parents equally or to the surviving parent;
- *If none of the above*, to the duly appointed executor or administrator of your estate;
- *If none of the above*, to your next of kin under the laws of the state where you reside at the time of your death.

Life Insurance Benefits: Your VRS Basic and Optional Group Life Insurance benefits will be paid by order of precedence unless otherwise indicated in Part B of this form.

Retirement Benefits

Death in Service:

If you are vested (have at least five years of service credit) and die while in service with a VRS-covered employer and your death is ***not*** work-related, VRS pays retirement benefits as follows:

- If no designation is made, or the death of all primary and contingent designated beneficiaries occurs prior to your death and another designation is not made, the beneficiary is determined by order of precedence.
- If you name your spouse, minor child(ren), or parent(s) as a beneficiary, or they are deemed the beneficiary by order of precedence, that person may receive a monthly benefit or may elect a refund of the contributions and accrued interest in your account to the exclusion of any other named beneficiary. The spouse will take precedence over a minor child, a minor child will take precedence over a parent.
- If the beneficiary named, or determined by order of precedence, is someone other than your spouse, minor child(ren), or parent(s), a refund of the contributions and interest credited to your account is paid.

If you are not vested and die while in service with a VRS-covered employer and your death is ***not*** work-related, VRS pays retirement benefits in the form of a refund to your designated beneficiary.

If you die while in service with a VRS-covered employer, and your death ***is*** work-related, VRS pays retirement benefits as follows regardless of whether or not you are vested:

- A refund of contributions and interest is paid to your designated beneficiary. If no designation is made, or the death of all of your primary and contingent designated beneficiaries occurs prior to your death and another beneficiary is not designated, the contributions and interest credited to your account are refunded to the beneficiary as determined by order of precedence.
- In addition to the refund of contributions and interest, a monthly benefit is paid to your surviving spouse for life. If you have no surviving spouse, the monthly benefit is paid to your minor child(ren) until age 18. If you have no minor child(ren), the benefit is paid to your parent(s) for life. All benefits are governed by and subject to the Virginia Retirement Act (Title 51.1 of the Code of Virginia.)

Death After Retirement:

If you die after your effective date of retirement and chose a payout option other than a Survivor Option, a refund of the contributions and interest that have not been paid to you as a monthly retirement benefit is refunded to your named beneficiary or, if no beneficiary designation is on file with VRS, to the first person qualifying by order of precedence.

If you die after your effective date of retirement and chose a Survivor Option, your monthly retirement benefit payment continues to the person you named as your contingent annuitant.

If you are retired, selected a survivor option and wish to change the name of the person you selected to receive the monthly benefit at the time of your death, contact VRS for further information. *This form cannot be used to change the contingent annuitant you designated at retirement*.

Death After Termination:

If you die after you have terminated your employment in a VRS-covered position but before beginning to receive a monthly retirement benefit and you have not taken a refund of the contributions and interest credited to your account prior to your death, a refund of the contributions and interest credited to your account is paid to your named beneficiary; or if no beneficiary designation is on file, to the first person qualifying by order of precedence.

Other Key Points to Remember

1. This form cannot be used to designate a beneficiary for your spouse's or children's coverage under the Optional Life Insurance Plan because you are the beneficiary of those benefits.
2. If you name multiple primary beneficiaries, other than those established by law for death in service benefits, the proceeds will be split equally, unless you instruct otherwise in the Share % box for each beneficiary on this form. If you need to designate additional beneficiaries, list them on the Designation of Beneficiary – Continuation (VRS-2A) at the time you complete the VRS-2 and send both forms to VRS.
3. To be valid, this form must be filled out completely using given names such as "Mary L. Doe" rather than "Mrs. John Doe."
4. If a **minor** (child less than 18 years of age) is named as beneficiary, a guardian for the financial estate of the minor must be appointed by the court before benefits can be paid.
5. If an **estate** is named as beneficiary, a probated will appointing an administrator or executor must be provided or the court must appoint an administrator or an executor before benefits can be paid.
6. If a **trust** is named as beneficiary, list the name of the trustee and the date that the trust agreement was completed. Do not submit a copy of the trust with this form. A copy will be requested when the claim for benefits is made.
7. Forms that have been altered cannot be accepted. If you make an error when completing this form, either complete a new form or initial the information that was changed.
8. *Beneficiary Types:* When you choose beneficiaries, you must indicate whether each beneficiary is a primary or contingent beneficiary.

   Primary: Person(s) to receive the death benefits payable upon your death.

   Contingent: Person(s) to receive the death benefits payable upon your death, if the primary beneficiary(ies) dies before you.
9. *Share %:* You may provide less than 100% share to your beneficiaries. You may break down the shares designated in Part B different from those in Part C. Designations in Part B must total 100%, and designations in Part C must also total 100%.

Completing the Form

Part A. Member/Retiree Information

Enter your personal information in boxes 1 though 6, and box 7 on the 2nd page. Your VRS identification number must be clearly displayed in boxes 1 and 7. The employer code is required in box 2 only if you are an active VRS member.

Part B. Designation of Beneficiary for VRS Basic and Optional Group Life Insurance

Check the appropriate box to indicate whether you wish to have payment of basic and optional life insurance be made by order of precedence or have the payment made to beneficiaries you designate.

If you choose to designate beneficiaries, enter each beneficiary's full name, Social Security number and complete address as well as whether the beneficiary is primary or contingent, the person's relationship to you, the percentage of life insurance to be paid to the person, and his or her birth date.

Part C. Designation of Beneficiary for Accumulated VRS Retirement Contributions/Benefits

Check the appropriate box to indicate whether you wish to have payment of VRS retirement contributions/benefits be made by order of precedence or have the payment made to beneficiaries you designate.

If you choose to designate beneficiaries, enter each beneficiary's full name, Social Security number and complete address as well as whether the beneficiary is primary or contingent, the person's relationship to you, the percentage of retirement contributions/benefits to be paid to the person, and his or her birth date.

Part D. Certification

Sign and date the member certification. Make a copy of the completed form for your records and mail the original to VRS.

ARLINGTON PUBLIC SCHOOLS
ATTN: Adora Aldana, Licensure
Human Resources Department
1426 N. Quincy Street
Arlington, VA 22207

Personnel who are required to hold a valid license in accordance with regulations prescribed by the Virginia Department of Education must complete the application (teachers, principals, guidance counselors, school psychologists, school social workers, school managers, vocational evaluators, and superintendents).

Licensure documents are due to the Human Resources Department within 60 days of your start date. Otherwise, your contract may be null and void, and you may be placed on substitute pay status.

REQUIRED Application for a Virginia License: Complete pages 1 and 2.

REQUIRED Application fee: The fee is determined by your address on the application: $50.00 for Virginia residents; $75.00 out-of-state. A check or money order, payable to the *Treasurer of Virginia*, is accepted.

REQUIRED Official transcript(s) conferring all degree(s) and transfer credits: Do **not** send photocopies, PDFs, eSCRIP-SAFE or third-party transcripts e.g. Parchment and Transcripts Network.

REQUIRED Child Abuse Recognition and Intervention Training: Submit a copy of your certificate from the free 90-minute training available at http://www.dss.virginia.gov/abuse/mr.cgi. Select the "Required Training/Courses" tab under the heading "Child Protective Services." Then, select the "Child Abuse and Neglect: Recognizing, Reporting, & Responding (for educators) (Web page).

REQUIRED Emergency First Aid, CPR, and Use of AEDs: Submit a copy of your certificate/card. An online course for $19.95 is available through the National Safety Council. Because the VDOE does not require the hands-on skills component, the online course is sufficient. It is available at https://www.nsc.org/forms/online%20training/Select-Course.aspx.

College Verification Form (if applicable): If you completed a teacher preparation program, send the form to the Licensure Office at the college or university where you completed your program. The university licensure official or designee should complete the required information and return it directly to APS, Human Resources.

Report on Experience Form (if applicable): If you have full-time contracted teaching experience in grades K-12, complete the upper portion of the form and send it to your previous employer. The Human Resources Official or manager must sign, date, and return the form directly to APS, Human Resources.

Out-of-State Teaching Licenses (if applicable): If you have a valid out-of-state teaching licenses, submit a copy.

Test scores (if applicable): If you have your Virginia test scores, provide a copy. We can still apply for the license without test scores or if you meet the test exemption criteria.

Teachers who meet the test exemption criteria must verify 3+ years full-time K-12 experience on the Report on Experience Form and provide a copy of a valid, out-of-state full teaching license.

IMPORTANT NOTE: Teachers who do not meet the test exemption criteria must submit the passing score on the Virginia Praxis II Specialty Area Test by February 1. Send a hard copy of your score report to the Human Resources Department by February 1. Register at www.ets.org. Failure to meet this timeline could result in non-renewal of your employment.

Industry Certification (if applicable): Every teacher seeking initial licensure with an endorsement in the area of career and technical education shall have an industry certification credential in the area in which the teacher seeks endorsement. The eight broad career and technical areas required to hold an industry certification include: Agriculture Education, Business and Information Technology, Family and Consumer Sciences Education, Health and Medical Sciences Education, Marketing, Military Science, Technology Education, Trade and Industrial Education. An Industry certification credential is earned by successfully completing a Board of Education-approved industry certification examination, being issued a state professional license, or successfully completing an occupational competency examination. For more information, refer to the Industry Credential Guidance Document available on the Virginia Department of Education's Web site.

Questions? Contact Adora Aldana at adora.aldana@apsva.us or 703-228-6308.

SEND YOUR SIGNED ORIGINAL PAGES TO APS HUMAN RESOURCES, ATTN: ADORA ALDANA

Revised May 2, 2016

Virginia Department of Education
Division of Teacher Education and Licensure
P. O. Box 2120 • Richmond, VA 23218-2120

FOR OFFICE USE ONLY

APPLICATION FOR A VIRGINIA LICENSE (Page 1 of 2)

Please Check:

License Requested: _____ Initial License (Fee: $50-in-state; $75-out-of-state) _____ Division Superintendent License (Fee: $100-in-state; $150-out-of-state)

Make checks payable to Treasurer of Virginia. The fee is nonrefundable. There is a $50 fee for a returned check.

PART I--INFORMATION **PLEASE PRINT OR TYPE**

Social Security Number		Date of Birth (Month/Day/Year)	
Last Name	First Name	Middle Name	Suffix (Jr., Sr., III, etc.)
Address (Street, City, State, Zip Code) [Please note that the address provided is public information.]*			
Daytime Telephone Number (include area code) ( )	Home Telephone Number (include area code) ( )	Gender (for statistical purposes only) _____ Male _____ Female	
Race (optional - for statistical purposes only - check one) ____ 1. American Indian/Alaskan Native ____ 2. Asian ____3. Black (not of Hispanic origin) ____ 4. Hispanic ____ 5. White (not of Hispanic origin) ____6. Native Hawaiian/ Pacific Islander ____ 7. Non-Hispanic, two or more races			

***THE APPLICANT MUST NOTIFY THE OFFICE OF LICENSURE, DEPARTMENT OF EDUCATION, IN WRITING OF AN ADDRESS CHANGE. Name and address (of persons applying for a license) may be disseminated pursuant to a request under § 2.2-3802(5) of the *Code of Virginia*.**

PART II

Have you ever been convicted of, or entered a plea of guilty or no contest to, a felony? (If yes, please attach a letter of explanation and a copy of the court documents indicating judgment and disposition of the case from the court of conviction.)	**___Yes**	**___No**
Have you ever been convicted of, or entered a plea of guilty or no contest to, a criminal offense in another country? (If yes, please attach a letter of explanation and a copy of the court documents indicating judgment and disposition of the case from the court of conviction.)	**___Yes**	**___No**
Have you ever been convicted of, or entered a plea of guilty or no contest to, a misdemeanor involving a child (minor)? (If yes, please attach a letter of explanation and a copy of the court documents indicating judgment and disposition of the case from the court of conviction.)	**___Yes**	**___No**
Have you ever been convicted of, or entered a plea of guilty or no contest to, a misdemeanor involving drugs (not alcohol)? (If yes, please attach a letter of explanation and a copy of the court documents indicating judgment and disposition of the case from the court of conviction.)	**___Yes**	**___No**
Have you ever had a teaching, administrator, pupil personnel services, or other education-related certificate or license revoked, suspended, invalidated, cancelled, or denied by another state, territory, or country; surrendered such a license; or had any other adverse action taken against such a license? (If yes, please attach a statement giving full details and official documentation of the action taken.)	**___Yes**	**___No**
Have you ever been the subject of a founded complaint of child abuse or neglect by a child protection agency? (If yes, please attach a statement giving full details and official documentation of the founded complaint.)	**___Yes**	**___No**
Have you ever left any education- or school-related employment, voluntarily or involuntarily, while the subject of an investigation, inquiry, or review of alleged misconduct or when you had reason to believe an investigation of alleged misconduct was under way or imminent? (If yes, please attach a statement giving full details and any official documentation available regarding the investigation, inquiry, or review.)	**___Yes**	**___No**
To your knowledge, are you currently the subject of any investigation, inquiry, or review of alleged misconduct that could warrant discipline or termination by a school division or other education-related employer or an adverse action against a teaching, administrator, pupil personnel services, or other education-related license or certificate? (If yes, please attach a statement giving full details and any official documentation available regarding the investigation, inquiry, or review.)	**___Yes**	**___No**

BY MY SIGNATURE, I CERTIFY THAT THE INFORMATION ON THIS FORM IS ACCURATE AND COMPLETE. I UNDERSTAND THAT MISREPRESENTATION MAY RESULT IN THE DENIAL, REVOCATION, CANCELLATION, OR SUSPENSION OF THE VIRGINIA LICENSE.

Date _____ **Applicant's Signature** _____

The application is continued on the following page. Pages 1 and 2 must each include the applicant's signature. A complete application must be sub

Virginia Department of Education
Division of Teacher Education and Licensure
P. O. Box 2120 • Richmond, VA 23218-2120

APPLICATION FOR A VIRGINIA LICENSE (Page 2 of 2)

PART III--EDUCATION (Include colleges and universities where coursework was completed and degrees earned.)

Name of Institution	Location	Dates Attended	Degree (if earned)	Major/Major Subjects

PART IV--EXPERIENCE (Grades K-12 only–full-time, contractual experience only. Do not include substitute, summer school, or aide experience.)

Name of School	Location	Dates of Employment (Month/Year to Month/Year)	Grade(s)/Subject(s) Taught

PART V--OUT-OF-STATE EDUCATIONAL LICENSE – This section must be completed, if applicable. (Enclose a copy of each license.)

State:	**First issue date:**	**Last expiration date:**
State:	**First issue date:**	**Last expiration date:**
State:	**First issue date:**	**Last expiration date:**

PART VI--COMPLETE IF YOU HAVE ACCEPTED A POSITION IN VIRGINIA REQUIRING A LICENSE

Name of Employer :	Beginning Date of Employment:	Assignment:
Address:		

BY MY SIGNATURE, I CERTIFY THAT THE INFORMATION ON THIS FORM IS ACCURATE AND COMPLETE. I UNDERSTAND THAT MISREPRESENTATION MAY RESULT IN THE DENIAL, REVOCATION, CANCELLATION, OR SUSPENSION OF THE VIRGINIA LICENSE.

Date _____ Applicant's Signature _____

Pages 1 and 2 must each include the applicant's signature. A complete application must be submitted.

This form is completed by your university's teacher program coordinator, certification office or dean. Return to adora.aldana@apsva.us OR Mail to Arlington Public Schools, HR ATTN: Adora Aldana 1426 N. Quincy Street Arlington, VA 22207

Revised May 2, 2016

Virginia Department of Education
Division of Teacher Education and Licensure
P. O. Box 2120
Richmond, VA 23218-2120

COLLEGE VERIFICATION FORM

The primary purpose of this form is to determine whether an applicant for licensure has completed a state-approved preparation program at the undergraduate or graduate level. In these cases, the form must be completed by the appropriate certification/licensure official of the college/university where the program has been completed. The completed form must be submitted to this office by the applicant along with other items required for licensure or to the Virginia school administrator with whom the applicant has accepted employment. **[Note: Part IV is to be completed by Virginia colleges/universities only.]**

PART I

Social Security Number:		**Date of Birth: (Month/Day/Year)**	
Last Name	**First Name**	**Middle Name**	**Suffix (Jr., Sr., III)**
Address (Street, City, State, Zip Code)			
Name of Institution	**Degree Earned**	**Date of Degree Conferral**	

PART II: Please circle the appropriate response:

YES NO **By my signature, I certify that the applicant satisfactorily completed a state-approved preparation program and completed endorsements (teaching areas, administration and supervision, or pupil personnel services) in the following areas:**
ENDORSEMENTS: _____

PART III: Student Teaching, Internship, and/or Practicum Experience:

Course Title: _____ **Course Number:** _____ **Clock Hours:** _____

A. **High School grade (s):** _____ **(Do not include special education experience–use line C)**

B. **Elementary grade (s):** _____ **(Do not include special education experience–use line C)**

C. **Specific special education area(s)* and grade level (s)**_____
***Please specify the exact nature of the exceptional child (children) included in the student teaching/practicum experience.**

D. **Special subject area(s) (e.g., Art, Music, P.E.):**_____ **Grade level (s):**_____

PART IV: To be completed by Virginia colleges and universities only:
If I am signing as a Virginia college or university representative, my signature below certifies that the individual has met the following requirements checked below:
_____child abuse recognition and intervention training and technology standards for instructional personnel; and
_____certification or training in emergency first aid, CPR, and the use of automated external defibrillators.

Requisite to compliance with the licensure regulations established by the Virginia Board of Education are the following conditions: the applicant must be at least 18 years of age and must possess good moral character. By my signature, I certify on the basis of my information and belief that the applicant possesses good moral character.

DATE: _____ SIGNATURE: _____

NAME: _____

TITLE: _____

INSTITUTION: _____

This form is completed by your previous employer. Return to adora.aldana@apsva.us OR Mail to Arlington Public Schools, HR ATTN: Adora Aldana 1426 N. Quincy Street Arlington, VA 22207

Revised May 2, 2016

Virginia Department of Education
Division of Teacher Education and Licensure
P. O. Box 2120
Richmond, VA 23218-2120

REPORT ON EXPERIENCE

DIRECTIONS: A report verifying experience must be completed by the appropriate public school division or accredited nonpublic school official if the applicant for initial licensure has had a total of at least one year of full-time, contractual teaching experience or held other professional positions in a public school or accredited nonpublic school. The completed form must be submitted to this office by the applicant along with all other items required for licensure or to the Virginia school administrator with whom the applicant has accepted employment.

Last Name	First Name	Middle Name

Social Security Number: _____-_____-_____ **or Virginia License #** _____

Address of Applicant (Street, City, State, Zip Code)

NAME OF ACCREDITED SCHOOL (Please report only full-time, contractual teaching experience in a public or accredited nonpublic school. Experience as a substitute teacher or aide should not be listed.)	POSITION HELD	GRADE LEVEL OR SPECIFIC SUBJECT TAUGHT	LENGTH OF SERVICE (MONTH/YEAR TO MONTH/YEAR)

Total number of years of full-time teaching experience: _____

Total number of years of full-time experience in administration supervision: _____

Total number of years of full-time experience in a pupil personnel services area (counselor, psychologist, social worker, speech pathologist, vocational evaluator): _____

By my signature, I verify that the above-named person was successfully employed full-time, under contract in the public schools or accredited nonpublic school(s) and for the period(s) listed above.

DATE: _____

SIGNATURE: _____

NAME: _____

TITLE: _____

SCHOOL DIVISION/SCHOOL: _____

ADDRESS: _____

_____

TELEPHONE NUMBER: _____

Enrollment Application For VRS Optional Group Life Insurance

VRS-39

Minnesota Life Insurance Company - A Securian Company
Richmond Branch Office ● P.O. Box 1193 ● Richmond, VA 23218-1193

MINNESOTA LIFE

Employer code (5 digits)	Employer name	Employee's annual salary
		$

1 - EMPLOYEE INFORMATION

Social Security number	Employee name (last, first, middle initial)				
Street address		**City**	**State**	**Zip code**	
Sex ☐ Male ☐ Female	☐ Married ☐ Single	**Age**	**Date of birth (mo/day/yr)**	**Employment date (mo/day/yr)**	**Payroll frequency**

2 - ELECTION OF INSURANCE AMOUNTS

I wish to insure myself ☐ and ☐ my spouse and ☐ my child(ren).

Sign and date section 4, Payroll Deduction Authorization. (If you do not elect to be insured under the VRS Optional Plan you must complete section 5 below.)

	OPTIONAL INSURANCE AMOUNTS		
Option	Employee	Spouse	Child(ren)
☐ 1	1 X Salary	.5 X Salary	$ 10,000
☐ 2	2 X Salary	1.0 X Salary	$ 10,000
☐ 3	3 X Salary	1.5 X Salary	$ 20,000
☐ 4	4 X Salary	2.0 X Salary	$ 30,000

If the option you elected will provide insurance of $350,000 or higher, you must complete an Evidence of Insurability form (EOI). Your spouse must also complete an EOI form if you elected options 2,3, or 4. Optional amounts of insurance in excess of $700,000 for an employee and $350,000 for a spouse are not provided. If you and your spouse are insured as employees under the Basic VRS Group Life insurance plan neither of you is eligible for coverage as a spouse. If you do not apply when you are first eligible to do so, or within 31 days immediately thereafter, you must complete an EOI for yourself and eligible dependents you subsequently elect to insure.

3 - DEPENDENT INFORMATION

See reverse side for definition of Eligible Dependents (eligibility must be verified by Employer's Representative.)

How many children do you have who are less than 21 years of age? _____

How many children do you have who are age 21 to 25 and who are currently full-time students? _____

List information about your spouse and youngest child below:

Name First	MI	Last	Relationship	Sex M or F	Social Security Number	Date of Birth Month Day Year
			Your Spouse			
			Youngest Child			

4 - PAYROLL DEDUCTION AUTHORIZATION

I hereby authorize my Employer to deduct from my compensation the amount necessary to provide the insurance amounts indicated above. I understand that the deduction amount will change as my age and annual salary change.

Signature	Date signed
X	

5 - WAIVER OF COVERAGE

I DO NOT wish to enroll for myself or for my eligible dependents in the VRS Optional Insurance Plan. I understand that once coverage is waived, I will have to furnish evidence of insurability for myself and eligible dependents if I wish to become insured at a later date.

Signature	Date signed
X	

6 - STATEMENT BY EMPLOYER'S REPRESENTATIVE

I certify that I believe the statements made herein are true and accurate, as disclosed by the records of this office, and the Social Security Number and Annual Salary are correct as entered.

Employer's representative	Title	Date signed
X		

NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Introduction

You are receiving this notice because you may become covered under a group health plan (Arlington Public Schools). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), created the right to COBRA continuation coverage). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee's becomes entitled to Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child:

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Arlington Public School, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Event

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

Arlington Public Schools
Attn: Human Resources
1426 N. Quincy Street, 4th Floor
Arlington, VA 22207

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under part A, part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage last for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA

continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experience another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 mont6hs, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under part A, part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would hav3 caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or COBRA continuation coverage rights should be addressed to the contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the US Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Information about the plan and COBRA continuation coverage can be obtained on request from:

Arlington Public Schools
1426 N. Quincy Street, 4th Floor
Arlington, VA 22207
Human Resources Department
703-228-6105

Arlington Public Schools
Medical Insurance "Benefits at a Glance"
Plan Year 2016

	Cigna Open Access Low Option		Cigna Open Access High Option		Kaiser Permanente (HMO)	
	In-Network	**Out-of-Network****	**In-Network**	**Out-of-Network****	**In-Network**	**Out-of-Network****
Provider Network Design	National Network of Doctors	Not Applicable	National Network of Doctors	Not Applicable	Kaiser providers located in Kaiser Medical Centers **ONLY**	No out-of-network benefits available
Referral required from PCP to seek care from a Specialist?	No	No	No	No	Yes	No out-of-network benefits available
PCP Necessary?	No	No	No	No	Yes	N/A
PCP Office Visit	$40	*40% after deductible	$20	*30% after deductible	$10	N/A
Specialist Office Visit	$80	*40% after deductible	$40	*30% after deductible	$10	N/A
Mental Health Provider Office Visit	$40	*40% after deductible	$20	*30% after deductible	$10	N/A
Deductibles	$400/person $800/family	$800/person $1,600/family	$300/person $600/family	$750/person $1,500/family	None	N/A
Out of Pocket Maximum	$3,000/person $6,000/family	$5,000/person $10,000/family	$3,000/person $6,000/family	$3,750/person $7,500/family	$3,500/person $9,400/family	N/A
Inpatient Hospital, Facility	After deductible, $250 per admission copay and *20% coinsurance	After deductible, $250 per admission copay and *40% coinsurance	After deductible, $250 per admission copay and *10% coinsurance	After deductible, $250 per admission copay and *30% coinsurance	Covered 100%	Emergency admissions covered for non-plan providers
Outpatient Hospital, Facility	After deductible, $100 copay and *20% coinsurance	After deductible, $100 copay and *40% coinsurance	After deductible, $100 copay and *10% coinsurance	After deductible, $100 copay and *30% coinsurance	$10	Not covered
Emergency Room	$250 copay (waived if admitted)	$250 copay (waived if admitted)	After deductible, $200 copay (waived if admitted)	After deductible, $200 copay (waived if admitted)	$50	$50
Urgent Care	$50	$50	$50	$50	$10	$10 Non-plan providers are covered only outside the service area

*** Coinsurance after deductible is met**
****When utilizing Out-of-Network benefits, member may be subject to "balance billing" by the provider.**

Arlington Public Schools
Medical Insurance "Benefits at a Glance"
Plan Year 2016

	Cigna Open Access Low Option		Cigna Open Access High Option		Kaiser Permanente (HMO)	
	In-Network	**Out-of-Network****	**In-Network**	**Out-of-Network****	**In-Network**	**Out-of-Network****
Retail Pharmacy (up to a 30-day supply)						
Generic	$4	$4	$4	$4	$10 at Kaiser Medical Center; $20 at Community Pharmacy	Not Covered
Preferred Brand	35% Coinsurance *Minimum $35; Maximum $70*	35% Coinsurance *Minimum $35; Maximum $70*	$25	$25	$20 at Kaiser Medical Center; $40 at Community Pharmacy	Not Covered
Non-Preferred Brand	50% Coinsurance *Minimum $50; Maximum $100*	50% Coinsurance *Minimum $50; Maximum $100*	$45	$45	$35 at Kaiser Medical Center; $55 at Community Pharmacy	Not Covered
Mail Order Pharmacy (up to a 90-day supply)						
Generic	$0	Not Covered	$0	Not Covered	$20	Not Covered
Preferred Brand	35% Coinsurance *Minimum $70; Maximum $140*	Not Covered	$50	Not Covered	$40	Not Covered
Non-Preferred Brand	50% Coinsurance *Minimum $100; Maximum $200*	Not Covered	$90	Not Covered	$70	Not Covered
Preventive Care Includes routine preventive care, immunizations, well child care, well woman care, mammogram, PSA, pap smear, maternity screening	No Charge	No Charge for Mammogram *40% (after deductible) for all others	No Charge	No Charge for Mammogram *30% (after deductible) for all others	No Charge	Not Covered

*** Coinsurance after deductible is met**
****When utilizing Out-of-Network benefits, member may be subject to "balance billing" by the provider.**

Benefit Enrollment and Change Form for Active Employees *(please print)*

Arlington Public Schools

Employee Last Name: _____ Employee First Name: _____ Middle Initial: _____

Employee #_____ Social Security Number: _____ Daytime Phone Number: _____

Date of Hire: _____ Work Location: _____ Effective Date of Coverage: ***(internal use only)*** _____

Life Event: *(only select one)*

Attach supporting documentation to justify all Life Events. Coverage elections and changes are only allowed if requested within allowed timeframe (usually 31-days) per the list of Life Events.

- ◯ New Hire
- ◯ Marriage
- ◯ Divorce
- ◯ Birth or Adoption of Child
- ◯ Death of Spouse or Child
- ◯ Dependent Lost Eligibility Status
- ◯ Dependent Gains Eligibility Status
- ◯ Spouse/Dependent Gains other Coverage
- ◯ Spouse/Dependent Loses other Coverage
- ◯ Hours Increased
- ◯ Hours Decreased
- ◯ Unpaid Leave of Absence
- ◯ Open Enrollment
- ◯ Rehired
- ◯ Return from Unpaid Leave of Absence
- ◯ Other (list event below) _____ _____

Medical Coverage

REQUEST
- ◯ Enrollment
- ◯ Change
- ◯ Cancel
- ◯ Waive

SELECT ONE PLAN ONLY
- ◯ Kaiser Permanente HMO
- ◯ Cigna Open Access LOW Option
- ◯ Cigna Open Access HIGH Option

SELECT ONE COVERAGE LEVEL
- ◯ Employee Only
- ◯ Employee + Spouse
- ◯ Employee + Child(ren)
- ◯ Family

Dental Coverage

REQUEST
- ◯ Enrollment
- ◯ Change
- ◯ Cancel
- ◯ Waive

SELECT PLAN
- ◯ Delta Dental

SELECT ONE COVERAGE LEVEL
- ◯ Employee Only
- ◯ Employee + Spouse
- ◯ Employee + Child(ren)
- ◯ Family

Voluntary Disability Buy-Up Coverage**

REQUEST
- ◯ Enrollment
- ◯ Cancel
- ◯ Waive

**Employees enrolled in the Virginia Retirement System (VRS) Hybrid Plan are not eligible for the Disability Buy-Up coverage.

Flexible Spending Accounts

Health Care FSA

For eligible health care expenses incurred by you and your qualifying dependents.

Plan Year:
Your effective date of coverage through December 31st.
Maximum Annual Election: $2,550

REQUEST
- ◯ Enrollment
- ◯ Change
- ◯ Cancel
- ◯ Waive

$ _____
Annual Election Amount (Calendar Year)

Dependent Care FSA

For eligible day care expenses for qualifying child(ren) and qualifying adult dependents.

Plan Year:
Your effective date of coverage through December 31st.
Maximum Annual Election: $5,000

REQUEST
- ◯ Enrollment
- ◯ Change
- ◯ Cancel
- ◯ Waive

$ _____
Annual Election Amount (Calendar Year)

Spouse / Dependent Information: *(please print)*

If you are enrolling your eligible family members for benefits, you will need to provide the dependent's full name, date of birth, and Social Security number. If covering a spouse, you will need to provide a copy of your marriage certificate. If covering a dependent child, you will need to provide a copy of your child's birth certificate, or proof of adoption or legal guardianship.

Dependent's Social Security Number	Dependent's Name (Last, First, MI)	Relationship	Gender (M/F)	Dependent's Date of Birth	Medical (Yes / No)	Dental (Yes / No)	Add / Drop

I hereby request enrollment and authorize deductions from my earnings of the required contributions for the above elected plan(s):
Employee Signature: _____ Date: _____

Return your completed and signed form and applicable documents to the Human Resources Department.

TIP! Go to www.apsva.us/benefits to view detailed benefit and coverage information.

Rev. April 2016

Arlington Public Schools

Health and Dental Insurance Rates for 2016 Plan Year

Your Cost of Coverage

The following Payroll Deductions apply to medical and dental coverage in effect from January 1, 2016 through December 31, 2016. The premiums shown are the semi-monthly cost for coverage based on 24 paychecks per year.

Medical and Dental

Coverage Level Employee Hours	Kaiser Permanente HMO Signature	Cigna Open Access Low	Cigna Open Access High	Dental
Individual				
30-40 hours	$58.25	$69.20	$111.46	$13.99
15-29 hours	$155.75	$158.16	$229.89	$17.73
Individual + Spouse				
30-40 hours	$140.17	$171.26	$263.32	$27.36
15-29 hours	$329.67	$345.12	$497.39	$34.69
Individual + Child(ren)				
30-40 hours	$126.50	$154.95	$238.25	$28.12
15-29 hours	$297.51	$312.25	$450.02	$35.66
Family				
30-40 hours	$243.12	$281.73	$449.33	$40.73
15-29 hours	$501.44	$511.56	$747.14	$51.65

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources / Benefits Department at 703-228-6105.

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name	4. Employer Identification Number (EIN)
Arlington Public Schools	54-6001128
5. Employer address	**6. Employer phone number**
1426 N. Quincy St., 4th Fl	703-228-6000

7. City	8. State	9. ZIP code
Arlington	VA	22207

10. Who can we contact about employee health coverage at this job?

Human Resources / Benefits Department, Attn: Ann Irby

11. Phone number (if different from above)	12. Email address
703-228-6105	Ann.Irby@apsva.us

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

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

  ☐ All employees. Eligible employees are:

  ☑ Some employees. Eligible employees are:

  Full-time employees scheduled to work 30+ hours per week.
  Part-time employees scheduled to work 15+ hours per week.

- With respect to dependents:

  ☑ We do offer coverage. Eligible dependents are:

  -- Legal spouse
  -- Biological children, legally adopted children, stepchildren, children assumed under legal guardianship, up to age 26.

  ☐ We do not offer coverage.

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

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

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

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

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

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☑ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $58.25 for 2016 for full-time employee
b. How often? ☐ Weekly ☐ Every 2 weeks ☑ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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

16. What change will the employer make for the new plan year? Premium Change for 2017
☐ Employer won't offer health coverage
☑ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $59.63 for 2017 for full-time employee
b. How often? ☐ Weekly ☐ Every 2 weeks ☑ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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

Arlington Public Schools
Substitute Teacher Assignment Network (STAN) Profile

Date: _____ Email: _____

Name: _____
Last First Middle

Address: _____

_____

Payroll Telephone Number (include area code)_____ STAN Call Number_____
May we release your telephone number to schools or teachers: Yes or No

Degree Type (s) with subject area (s): _____

Certified: Yes or No If yes, list area of certification _____

Please indicate one: _____ New Substitute _____ Addition _____ Complete change

I am available to work on the following days (please circle):

AM	M	T	W	TH	F
PM	M	T	W	TH	F

Please indicate the category that applies to you:

_____ I am willing to work at all schools

_____ I am willing to work at all elementary schools

_____ I am willing to work at all middle schools

_____ I am willing to work at all high schools

If you are willing to work only at specific schools or locations, indicate the schools below (please circle):

Abingdon	Hoffman Boston	Tuckahoe	H-B Woodlawn
Arlington Traditional	Jamestown		Career Center
Ashlawn	Key	Gunston	Stratford Program
Barcroft	Long Branch	Jefferson	Arlington Mill
Barrett	McKinley	Kenmore	Langston
Campbell	Nottingham	Swanson	Family Center
Carlin Springs	Oakridge	Williamsburg	New Directions
Claremont Immersion	Randolph		Outdoor Learning Lab
Drew Model	Reed	Wakefield	
Glebe	Science Focus	Washington-Lee	
Henry (Patrick Henry)	Taylor	Yorktown	

Subject areas are listed on the reverse side of this form… **…Over**

Please indicate the subject area preferences for which you are qualified to substitute or have an interest in substituting:

Teacher Assignments

_____Art
_____Career Center
_____Computer Science
_____Biology
_____Business Education
_____Chapter1/Title 1 Reading
_____Chemistry
_____Drama
_____Drivers Education
_____Elementary
_____English
_____ESOL / HILT
_____French
_____German
_____History
_____Home Economics/Family
Consumer Science
_____Technology Education
_____Interlude
_____Kindergarten
_____Latin
_____Librarian
_____Math
_____Montessori
_____Music
_____Vocal
_____Instrumental
_____Pre-School
_____Physical Education
_____Physics
_____Reading
_____Science
_____Secondary
_____Secondary Vocational Education
_____Social Studies
_____Special Education
_____ Pre-School
_____ Elementary
_____ Secondary
_____Spanish
_____ Study Skills

Assistant Assignments

_____Kindergarten Assistant
_____Library Assistant
_____Montessori Assistant
_____Personal Assistant
_____Pre-School Assistant
_____Pre-School Special Ed Asst.
_____Resource Assistant
_____Special Education Asst.
_____Teacher's Assistant

EMERGENCY INFORMATION (OPTIONAL)

NAME: _____
ADDRESS: _____
RELATIONSHIP: _____
PHONE: _____
REMARKS: _____

careers @ APS
Inspire generations.

TO: _____

_____

_____

In order to receive salary credit for my previous teaching experience, I need to verify my service as a teacher in your school system. Please complete the bottom of this form below and mail/e-mail the completed form to:

Supervisor, Employment Services
human.resources@apsva.us
Arlington Public Schools
1426 North Quincy Street
Arlington, VA 22207

I was employed in your school system from _____ to
(Month/Year)
_____ under the name of _____.
(Month/Year)

Signature _____ Date_____

This is to certify that _____ was employed as a teacher under
(Name)
contract in _____, _____ during the school terms below.
(City/County) (State)

SCHOOL TERM	PERCENTAGE OF POSITIONS ** FULL TIME	PART TIME	NUMBER OF DAYS EMPLOYED

(For Virginia school districts only) Was the employee listed above on a continuing contract their last year at your school system: __Yes __No

Signature: _____ Date: _____

Title: _____

***Please indicate whether full-time or part-time; if part-time indicate percentage of position.*