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, or 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. |
| Authorization for Direct Deposit | Please attach a voided check and bring to orientation. | Required for all new hires. |
| Tuberculosis (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 W-4 | 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 Request & Authorization Form | Please complete and bring to orientation. | Required for all new hires. |
| Virginia Department of Social Services Central Registry Information Form | Do not sign or mail form and no fee is required. Form will be notarized at orientation. Employees who 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 and Change 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) / ROTH 403(b) Salary Reduction Agreement<br>• 457 / ROTH 457 Participation Agreement | For more information go to https://www.apsva.us/benefits/supplementalretirement/ | All employees are eligible to participate in the 403(b) and 457 plans immediately upon employment, however, private contractors, appointed/elected trustees and/or school board members and student workers are not eligible to participate in the 403(b) plan. Employees may make voluntary elective deferrals to both the 403(b) and 457 plans. Enrollment is optional. |
| STAN Profile | Please complete and bring to orientation | Substitute teachers/assistants only. |

**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**.

DEPARTMENT OF HUMAN SERVICES
Public Health Division

2100 Washington Boulevard, 2nd floor, Arlington, VA 22204
www.arlingtonva.us

# REPORT OF TUBERCULOSIS SCREENING

Name ________________________________________ Date of Birth ___________________

**TO WHOM IT MAY CONCERN:**

**The above named individual has been evaluated by Arlington County Public Health Division.**

______ TST testing date: _________ Result: ________mm ☐ Positive ☐ Negative

______ IGRA testing date: _________ Result: ☐ Positive ☐ Negative

______ A tuberculin skin test (TST) is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis, risk factors for developing active TB or known recent contact exposure.

______ The individual has a history of a positive tuberculin skin test (latent TB infection). Follow-up chest x-ray is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis.

______ The individual either is currently receiving or has completed adequate medication for a positive tuberculin skin test (latent TB infection) and a chest x-ray is not indicated at this time. The individual has no symptoms suggestive of active tuberculosis disease.

______ The individual had a chest x-ray on _____________ that showed no evidence of active tuberculosis. As a result of this chest x-ray and the absence of symptoms suggestive of active tuberculosis disease, a repeat film is not indicated at this time.

**Based on the available information, the individual can be considered free of tuberculosis in a communicable form.**

Signature _____________________________________ Date__________________________
(MD or Health Department Official)

Print Name ____________________________________

Title ________________________________________ Phone _________________________

**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 (2017)

**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 2017 expires February 15, 2018. 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 can't claim exemption from withholding if your total 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 don't apply to supplemental wages greater than $1,000,000.

**Basic instructions.** If you aren't 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 2017. 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're single and have only one job; or
- You're married, have only one job, and your spouse doesn't 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 . . . **F** ______

(**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

**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

**2017**

| 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 2017, 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 2017 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% of your income, and miscellaneous deductions. For 2017, you may have to reduce your itemized deductions if your income is over $313,800 and you're married filing jointly or you're a qualifying widow(er); $287,650 if you're head of household; $261,500 if you're single, not head of household and not a qualifying widow(er); or $156,900 if you're married filing separately. See Pub. 505 for details . . . . . 1 $ ______
2. Enter: { $12,700 if married filing jointly or qualifying widow(er); $9,350 if head of household; $6,350 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 2017 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 2017 Form W-4* worksheet in Pub. 505.) . . . . . 5 $ ______
6. Enter an estimate of your 2017 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 2017. 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 2017. 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 - $7,000 | 0 | $0 - $8,000 | 0 |
| 7,001 - 14,000 | 1 | 8,001 - 16,000 | 1 |
| 14,001 - 22,000 | 2 | 16,001 - 26,000 | 2 |
| 22,001 - 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 - 70,000 | 5 |
| 44,001 - 55,000 | 6 | 70,001 - 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 - 95,000 | 10 | 140,001 and over | 10 |
| 95,001 - 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 Pennsylvania 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** | | | **Payment/FIPS Code (Use only if assigned by OBI-CRU)** |
| **Address** | | | |
| **City** | **State** | **Zip** | |
| **Contact Name** | **Tel.#** | **Ext.** | **Mandatory if agency code has been assigned** |
| **Contact E-Mail** | | | |

## 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)** |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

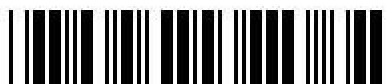
**Marital Status** Single Married Divorced Widowed Partner

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 | |



**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:__________

# Benefits at a Glance

**Plan Year 2018**

## Medical Coverage

### Plans Offered

Cigna Open Access High option
Cigna Open Access Low option
Kaiser Permanente HMO

## Dental Coverage

Delta Dental of Virginia

## Vision Coverage

Vision Service Plan (VSP)

## Group Term Life Insurance and Accidental Death & Dismemberment (AD&D) Insurance

Employees who are members of the Virginia Retirement System are covered by the VRS group term life insurance program. The life insurance benefit is 2 x times your annual base salary.

## Optional Life Insurance and AD&D Insurance

VRS member employees may also purchase additional coverage for themselves, their spouse, and their dependent children.

## Disability Insurance

Disability insurance provides income replacement in the event of a non-work related illness or injury. VRS Hybrid Plan members are eligible for disability benefits after 12-months of continuous APS service.

## Long Term Care Insurance

Long Term Care coverage, provided by Genworth Life Insurance Co., is available for employees, their spouses, parents, and spouse's parents.

*(Effective Jan. 1, 2017, the Virginia Retirement System (VRS) advised no new enrollees will be accepted due to the insurance company's restructuring plan. VRS will continue to update APS accordingly.)*

## Flexible Spending Accounts (FSAs)

Health Care FSA
Dependent Care FSA
Parking FSA and Transit FSA

## Virginia Retirement System (VRS)

### VRS Hybrid Plan Members

The VRS Hybrid Plan combines the features of a Defined Benefit plan and a Defined Contribution plan. Benefits-eligible employees with no previous VRS service credit, whose VRS membership date is on or after January 1, 2014, are automatically enrolled as Hybrid Plan members. A mandatory employee contribution applies equal to 5% of your annual salary; 4% funds the Defined Benefit plan and 1% funds your Defined Contribution plan.

VRS Hybrid Plan members can save additional money (up to 4% of your annual base salary) deposited into a Defined Contribution plan. You will receive an employer match on voluntary employee contributions. Go to www.varetire.org/hybrid to learn more.

### VRS Plan 1 and VRS Plan 2 Members

VRS Plan 1 and VRS Plan 2 are Defined Benefit plans. A mandatory employee contribution applies, equal to 5% of your annual salary. If you were previously a member of VRS and you have not received a refund of your member contributions, you will be placed back into your previous VRS Plan. If you are uncertain if you remained in VRS, please contact VRS directly at 1-888-827-3847.

## Optional Supplemental Retirement Plan

APS offers a several voluntary retirement plans to help you achieve your retirement goals. 403(b), ROTH 403(b), 457(b), and ROTH 457(b) plans are offered through Lincoln Financial Group and AXA/PlanMember Services.

### School Board Match Program

The Supplemental Retirement Plan includes the School Board Match Program. The School Board matches up to 0.4% of your base salary, or up to $240 per year, whichever is greater.

**This information is intended as a brief summary. For full plan and coverage details, read the information on the Benefits Home Page and in the Benefits Guide available at www.apsva.us/benefits, or the APS School Board Policies and Policy Implementation Procedures.**

# Benefits at a Glance

Plan Year 2018

## Medical Coverage

### Plans Offered

Cigna Open Access High option
Cigna Open Access Low option
Kaiser Permanente HMO

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Delta Dental of Virginia

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APS offers a several voluntary retirement plans to help you achieve your retirement goals. 403(b), ROTH 403(b), 457, and ROTH 457 plans are offered through Lincoln Financial Group and AXA Advisors/PlanMember Services.

### School Board Match Program

The Supplemental Retirement Plan includes a School Board Match Program. For Benefits-Eligible Employees, the School Board matches up to 0.4% of your base salary, or up to $240 per year, whichever is greater.

## Employee Assistance Program (EAP)

The Arlington EAP provides services to employees of Arlington County Government and Arlington Public Schools and their family members. The EAP works with employees and family members who have problems which may affect job performance; these can be problems at home or on the job. The EAP adheres to strict laws of confidentiality. There is no charge for EAP services.

## APS Wellness

APS Wellness promotes health, productivity, and happiness through employee wellness initiatives such as Active for Life, The Biggest Loser, Healthy Habits, and volleyball, kickball, and bowling tournaments.

## Paid Leave

### Annual leave

12-Month employees earn annual leave of 14 to 28 days each fiscal year, depending on years of service with APS.

### Personal leave

3 days are advanced to all 10 and 11-Month employees at beginning of the school year. A maximum balance of 3 days may be carried over with the remainder transferred to sick leave balance.

### Sick leave

Employees who earn annual/personal leave also earn sick leave for each month worked. Sick leave may be used for personal illness or the illness or death of a family member. There is no limit to the amount of sick leave you may accrue.

### Parental leave

APS will provide two consecutive weeks (10 work days) of paid leave to eligible employees due to the birth of a child, or placement of a child through adoption or foster care.

## Other Leave (may be paid or unpaid)

Family and Medical Leave (FML)
Military Leave
Professional Leave
Leave of Absence
Religious Observation Leave
Civil Leave
Study Leave

## Live & Work in Arlington Housing Grant Program

APS offers grants to eligible employees who work 30 or more hours per week. This program is to help employees defray the costs of purchasing or renting their first primary residence in Arlington. There are two types of grants – a housing purchase grant and a housing rental grant. Funds are budgeted annually and may be limited.

## Scholarships

The School Board funds scholarships to eligible 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.

## Retiree Medical and Dental Benefits

Employees who are enrolled in an APS sponsored medical and/or dental insurance plan may be eligible to retain their coverage upon retirement.

## 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.

## Holidays

### APS observes the following holidays:

New Year's Eve and 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 and Christmas Day

# Medical Coverage at a Glance (2018 Plan Year)

| | Kaiser Permanente HMO | | Cigna Open Access Low Option | Cigna Open Access High Option |
|---|---|---|---|---|
| **In-Network Benefits** | **You Pay** | | **You Pay** | **You Pay** |
| Provider Network | Providers located in Kaiser Permanente Medical Centers | | National Provider Network | National Provider Network |
| Primary Care Physician (PCP) referral required to see Specialist? | Yes | | No | No |
| PCP Required? | Yes | | No | No |
| PCP Office Visit | $10 copay | | $30 copay | $20 copay |
| Specialist Office Visit | $15 copay | | $60 copay | $40 copay |
| Mental Health Provider Office Visit | $10 copay | | $30 copay | $20 copay |
| Annual Deductible | None | | $400 Individual / $800 Family | $300 Individual / $600 Family |
| Annual Out-of-Pocket Maximum | $2,250 Individual / $4,500 Family | | $3,000 Individual / $6,000 Family | $3,000 Individual / $6,000 Family |
| Inpatient Hospitalization, Facility | Covered 100% | | After deductible, $250 copay and 20% coinsurance | After deductible, $250 copay and 10% coinsurance |
| Outpatient Hospitalization, Facility | $20 copay | | After deductible, $100 copay and 20% coinsurance | After deductible, $100 copay and 10% coinsurance |
| Emergency Room, Facility *(waived if admitted)* | $50 copay | | $250 copay | $200 copay |
| Urgent Care Visit | $10 copay | | $50 copay | $50 copay |
| Retail Pharmacy *(up to a 30-day supply)* | *at Kaiser Medical Center* | *at Participating Retail Pharmacy* | | |
| Generic | $15 copay | $20 copay | $4 copay | $4 copay |
| Preferred Brand | $25 copay | $45 copay | 35% *(Minimum $35; Maximum $50)* | $25 copay |
| Non-Preferred Brand | $40 copay | $60 copay | 50% *(Minimum $50; Maximum $100)* | $45 copay |
| **Out-of-Network Benefits** | **You Pay** | | **You Pay** | **You Pay** |
| Annual Deductible | No Benefits Available | | $800 Individual / $1,600 Family | $750 Individual / $1,500 Family |
| Annual Out-of-Pocket Maximum | No Benefits Available | | $5,000 Individual / $10,000 Family | $3,750 Individual / $7,500 Family |
| Coinsurance *(% of allowed amount you pay for most services)* | No Benefits Available | | 40%* | 30%* |
| **Your Cost of Coverage** | | | | |
| The semi-monthly payroll deductions listed below apply to Medical coverage in effect from January 1, 2018 through December 31, 2018. The deductions listed below are based on 24 pay checks per year. If you are a 10-month employee and elected to receive 20 pay checks per year, Reserve Deduction amounts will also apply. | | | | |
| **Individual Coverage** | | | | |
| 30 – 40 hours | $ 58.26 | | $ 68.84 | $ 124.15 |
| 15 – 29 hours | $ 161.55 | | $ 166.80 | $ 256.06 |
| **Individual + Spouse Coverage** | | | | |
| 30 – 40 hours | $ 141.16 | | $ 183.47 | $ 293.30 |
| 15 – 29 hours | $ 342.03 | | $ 369.73 | $ 554.01 |
| **Individual + Child(ren) Coverage** | | | | |
| 30 – 40 hours | $ 127.38 | | $ 166.00 | $ 265.37 |
| 15 – 29 hours | $ 308.67 | | $ 334.52 | $ 501.25 |
| **Family Coverage** | | | | |
| 30 – 40 hours | $ 246.30 | | $ 301.82 | $ 500.47 |
| 15 – 29 hours | $ 520.40 | | $ 548.05 | $ 832.19 |

** You may also be responsible for 100% of any amounts charged that exceed Cigna's allowed amounts.*

# Dental Coverage at a Glance (2018 Plan Year)

| Delta Dental of Virginia | In-Network | Out-of-Network* |
|---|---|---|
| **Service / Feature** | **You Pay** | **You Pay** |
| Provider Network | PPO or Premier Network | n/a |
| Calendar Year Deductible<br>*waived for diagnostic and preventive care* | $50 Individual / $100 Family | |
| Diagnostic and Preventive Services<br>*e.g., cleanings, oral exams* | Covered in full | Covered in full |
| Basic Services<br>*e.g., fillings, root canals* | You pay 20% after deductible | You pay 20% after deductible |
| Major Services<br>*e.g., crowns, dentures* | You pay 35% after deductible | You pay 35% after deductible |
| Orthodontic Services | You pay 50% | You pay 50% |
| Calendar Year Annual Maximum Benefit | $1,500 per family member | |
| Orthodontic Lifetime Maximum | $1,500 per family member | |

**Your Cost of Coverage**

The semi-monthly payroll deductions listed below apply to Dental coverage in effect from January 1, 2018 through December 31, 2018. The deductions listed below are based on 24 pay checks per year. If you are a 10-month employee and elected to receive 20 pay checks per year, Reserve Deduction amounts will also apply.

| Coverage | Cost |
|---|---|
| **Individual Coverage** | |
| 30 – 40 hours | $ 14.60 |
| 15 – 29 hours | $ 18.51 |
| **Individual + Spouse Coverage** | |
| 30 – 40 hours | $ 28.55 |
| 15 – 29 hours | $ 36.20 |
| **Individual + Child(ren) Coverage** | |
| 30 – 40 hours | $ 29.35 |
| 15 – 29 hours | $ 37.22 |
| **Family Coverage** | |
| 30 – 40 hours | $ 42.51 |
| 15 – 29 hours | $ 53.90 |

** You may also be responsible for the full amount an out-of-network dentist charges in excess of the fee schedule.*

# Vision Coverage at a Glance (2018 Plan Year)

| Vision Service Plan (VSP) | In-Network | Out-of-Network |
|---|---|---|
| **Service / Feature** | **You Pay** | **You Receive** |
| Provider Network | VSP Signature Network | n/a |
| WellVision Exam *(every calendar year)* | $10 copay | Reimbursement up to $52 |
| Lenses *(every calendar year)*<br>e.g., single vision, lined bifocal, lined trifocal | $20 copay | Reimbursement from $55 to $100 |
| Frame *(every calendar year)* | $150 allowance | Reimbursement up to $70 |
| Contacts *(instead of glasses, every calendar year)* | $150 allowance | Reimbursement up to $105 |

**Your Cost of Coverage**

The semi-monthly payroll deductions listed below apply to Vision coverage in effect from January 1, 2018 through December 31, 2018. The deductions listed below are based on 24 pay checks per year. If you are a 10-month employee and elected to receive 20 pay checks per year, Reserve Deduction amounts will also apply.

| Coverage | Cost |
|---|---|
| **Individual Coverage** | |
| 30 – 40 hours | $ 3.58 |
| 15 – 29 hours | $ 3.58 |
| **Individual + Spouse Coverage** | |
| 30 – 40 hours | $ 5.74 |
| 15 – 29 hours | $ 5.74 |
| **Individual + Child(ren) Coverage** | |
| 30 – 40 hours | $ 9.24 |
| 15 – 29 hours | $ 9.24 |
| **Family Coverage** | |
| 30 – 40 hours | $ 9.24 |
| 15 – 29 hours | $ 9.24 |

**This information is intended as a brief summary. For full plan and coverage details, read the information on the Benefits Home Page and in the Benefits Guide available at www.apsva.us/benefits, or the APS School Board Policies and Policy Implementation Procedures.**

# Virginia Retirement System
# Plan Overview for Hybrid Plan Participants

***Who participates in the VRS Hybrid Retirement Plan?***

Benefits-eligible employees with no previous VRS service credit, whose VRS membership date is on or after January 1, 2014, are automatically enrolled as Hybrid Plan members. Your mandatory employee contributions are made through pre-tax payroll deductions.

***What is a Hybrid Plan?***

The Hybrid Plan combines the features of a **Defined Benefit (DB)** plan and a **Defined Contribution (DC)** plan.

## Mandatory Employee Contributions

All employees enrolled in the Virginia Retirement System (VRS) contribute **5%** of their salary to VRS.

As a **VRS Hybrid Plan Participant**, **4%** of your contribution funds your **Defined Benefit (DB)** plan, and **1%** funds your **Defined Contribution (DC)** plan

**+**

(plan recordkeeper)

(plan name)

**=**

**Your 5% Mandatory Employee Contribution**

### *Defined Benefit (DB) Plan*

*(Pension Benefit)*

**4%** of your salary is your mandatory employee contribution to your VRS Defined Benefit (DB) plan.

This deduction is listed as **VRS EE SHARE** on your APS payroll summary.

**Defined Benefit:**

- Provides the foundation of your future retirement benefit when you qualify
- Pays a monthly retirement benefit based on age, total service credit, and average final compensation
- VRS manages the investments and related risks for this component
- Visit www.varetire.org/hybrid to view your member account online and learn more information about the Defined Benefit component. You may also call VRS at 1-855-291-2285.

### *Defined Contribution (DC) Plan*

*(Tax-Deferred Savings Plan)*

**1%** of your Salary is your mandatory contribution to your VRS Defined Contribution (DC) plan.**

This payroll deduction is listed as **VRS DC 401A** on your APS payroll summary.

**Defined Contribution:**

- Provides a tax-deferred savings plan to build on your benefit from the Defined Benefit component
- Pays a retirement benefit based on contributions by you and APS to the plan and the investment performance of those contributions
- You can manage the investments and related risk
- Visit ww.varetire.org/hybrid to view your Hybrid 401(a) Cash Match account online, or call ICMA-RC at 1-877-327-5261.

**APS contributes a mandatory 1% match to your Hybrid 401(a) Cash Match account.

# Virginia Retirement System
# Plan Overview for Hybrid Plan Participants

## Voluntary Employee Contributions

As a Virginia Retirement System (VRS) **Hybrid Plan Participant, you can save additional money** (up to 4% of your annual salary) deposited into a Voluntary Hybrid 457 Deferred Compensation account.**

You will receive an employer match on your voluntary employee contributions. For example, if you elect the maximum voluntary contribution (4%), you will receive 2.5% of your annual salary in matching funds from APS. *(see below Contribution Table)*

| Voluntary Employee Contribution to your Hybrid 457 Deferred Compensation Account | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **If you contribute** | 0.00% | 0.50% | 1.00% | 1.50% | 2.00% | 2.50% | 3.00% | 3.50% | 4.00% |
| **Employer Matching Contribution to your Hybrid 401(a) Cash Match Account** | | | | | | | | | |
| **You will receive** | 0.00% | 0.50% | 1.00% | 1.25% | 1.50% | 1.75% | 2.00% | 2.25% | 2.50% |

If you make a voluntary election, the deduction is listed as **VRS DC OPT** on your APS payroll summary.

*(plan recordkeeper)*

Hybrid Plan Members work directly with ICMA-RC (the plan recordkeeper) to initiate voluntary contributions.

To get started, create your account online at www.varetire.org/hybrid, or call ICMA-RC at 1-877-327-5261.

Elections or changes to voluntary contributions go into effect on the 1st pay check of the next calendar quarter. Also, local ICMA-RC retirement specialists are available to assist you with any questions you have related to your Hybrid 457 and Hybrid 401(a) accounts, including understanding investment options and managing your contributions.

*(plan name)*

**Visit www.varetire.org/hybrid to view the upcoming quarterly deadline and view contact information for your local ICMA-RC Retirement Specialists.**

**Auto-Escalation of Member's Voluntary Contributions**
The Hybrid Retirement Plan was designed with an auto-escalation feature. Every three years, members' voluntary contributions to their Hybrid 457 Deferred Compensation account will automatically increase by 0.5 percent (via payroll deduction) until reaching the maximum 4%. **The next automatic escalation takes place January 1, 2020.**

****Important:** Voluntary employee contributions to your Hybrid 457 Deferred Compensation account and voluntary employee contributions to a Lincoln Financial 457 account and/or AXA Advisors/PlanMember 457 account all contribute to the IRS Basic Contribution 457 plan annual limit. The 2018 457 Basic Contribution limit is $18,500. The limit may be higher for employees eligible for age-based catch-up contributions.

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

***See Page 2 for Instructions and Important Information***

**1.** 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)*** ____________________

**2. 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) ____________________ ____________________

**3.**

## Medical Coverage

| REQUEST | SELECT ONE PLAN | SELECT ONE COVERAGE |
|---|---|---|
| ◯ Enroll | ◯ Kaiser Permanente HMO | ◯ Employee Only |
| ◯ Change | ◯ Cigna Open Access LOW Option | ◯ Employee + Spouse |
| ◯ Cancel | ◯ Cigna Open Access HIGH Option | ◯ Employee + Child(ren) |
| ◯ Waive | | ◯ Family |

## Dental Coverage (with Delta Dental)

| REQUEST | SELECT ONE COVERAGE |
|---|---|
| ◯ Enroll | ◯ Employee Only |
| ◯ Change | ◯ Employee + Spouse |
| ◯ Cancel | ◯ Employee + Child(ren) |
| ◯ Waive | ◯ Family |

## Vision Coverage (with VSP)

| REQUEST | SELECT ONE COVERAGE |
|---|---|
| ◯ Enroll | ◯ Employee Only |
| ◯ Change | ◯ Employee + Spouse |
| ◯ Cancel | ◯ Employee + Child(ren) |
| ◯ Waive | ◯ Family |

## Voluntary Disability Buy-Up**

REQUEST
- ◯ Enroll
- ◯ Cancel
- ◯ Waive

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

## Flexible Spending Accounts

**Flexible Spending Accounts, also known as FSAs, are funded 100% by the employee with pre-tax dollars. Go to www.apsva.us/benefits to learn more about the IRS rules that govern FSA plans.**

### 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**: **$2,650** (2018 limit)

REQUEST
- ◯ Enroll
- ◯ Change
- ◯ Cancel
- ◯ Waive

$ ____________ Plan Year Election Amount

### 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** (2018 limit)

REQUEST
- ◯ Enroll
- ◯ Change
- ◯ Cancel
- ◯ Waive

$ ____________ Plan Year Election Amount

### Parking FSA / Transit FSA

Your enrollment, cancellation, or deduction change will be effective the pay period following receipt of your enrollment or change request.

**Parking FSA** — REQUEST
- ◯ Enroll
- ◯ Change
- ◯ Cancel
- ◯ Waive

$ ____________ Monthly Election Amount **$260 maximum** (2018 limit)

**Transit FSA** — REQUEST
- ◯ Enroll
- ◯ Change
- ◯ Cancel
- ◯ Waive

$ ____________ Monthly Election Amount **$260 maximum** (2018 limit)

**4. 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) | Vision (Yes / No) | Add / Drop |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

**5.** 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 form and applicable documents to the Human Resources Department.**

APS Human Resources Department ◆ 1426 N. Quincy St., Arlington, VA 22207 ◆ Fax: 703-841-2138 ◆ E-Mail: benefits@apsva.us

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

# APS Benefits Enrollment and Change Form

## Instructions and Important Reminders:

Complete the "**APS Benefits Enrollment and Change Form**" indicating your coverage elections and/or waivers and return your completed form to the Human Resources Department. (*see contact information at bottom of form*)

### Electing Medical, Dental, Vision, Voluntary Disability Buy-Up *(if eligible)*, Health Care FSA, and Dependent Care FSA

**NEW Employee**: Coverage will begin the on the 1st day of the month following 30-days of employment. You have 31-days from your first day of employment to elect coverage.

**NEWLY-Eligible Employee**: Coverage will begin on the 1st day of the month following the effective date of your new, benefits-eligible position. You have 31-days from your new, benefits-eligible position to elect coverage.

**Electing Parking FSA and Transit FSA** You can enroll or change your Parking and Transit FSA elections at any time during the year. Elections are effective the pay period following your election or change request.

**Waiving Coverage** If you decide not to enroll in coverage, you must complete the "**APS Benefits Enrollment and Change Form.**" Select the "Waive" boxes and return your completed form to Human Resources.

## Electing Coverage for Eligible Dependents:

**Your eligible dependents can also participate in the plans in which you are enrolled:**

**Your lawful spouse:** your spouse is eligible to participate in the plan if he or she is an individual who is recognized as your husband or wife under the laws of the state where you live. *(Common-law spouses are not eligible.)*

***If covering a spouse, you will need to provide a copy of your marriage certificate***.

**Your child(ren):** including your biological child, legally-adopted child (or child placed for adoption), stepchild, foster child, child for whom you are the legal guardian and child you are required to cover under the terms of a qualified medical child support order, to age 26.

***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.***

If you are enrolling your eligible family members for benefits, you will need to provide your dependent's full name, date of birth, gender, and Social Security number.

# 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<br>**40106 / 55506** |

## PART A. MEMBER/RETIREE INFORMATION

| **3. Name** (First, Middle Initial, Last) | **4. Are you retired?**<br>❑ 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:**

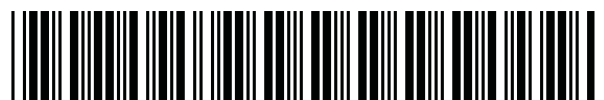
❑ **I revoke any previous designations and elect payment of VRS basic and optional group life insurance benefits to be made by order of precedence established by law.** If you check this box, **do not** complete the beneficiary information below. Continue to Part C. (Order of precedence is explained 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)<br>❑ 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)<br>❑ 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)<br>❑ Primary ❑ Contingent | **Share %** | **Relationship** | **Birth Date** |
| **Name of Trust Organization** | | | **Date of Trust** |
| **Address** (Street, City, State and Zip+4) | | | |
| **Beneficiary Type** (Check one)<br>❑ Primary ❑ Contingent | **Share %** | **Trustee or Organization Executive Officer** | |

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





## PART C. BENEFICIARIES FOR VRS DEFINED BENEFIT MEMBER ACCOUNT RETIREMENT CONTRIBUTION/ BENEFITS

**Check ONE:**

- ❑ **I revoke any previous designations and elect payment of VRS defined benefit 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 defined benefit 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 defined benefit 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.

**Defined Benefit 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 defined benefit 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 defined benefit 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 is *not* used to designate a beneficiary for any defined contribution account funds that you may have as a part of your covered employment. You must contact your defined contribution plan provider directly to designate beneficiaries.
2. 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.
3. 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.
4. To be valid, this form must be filled out completely using given names such as "Mary L. Doe" rather than "Mrs. John Doe."
5. 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.
6. 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.
7. 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.
8. 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.
9. *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 Defined Benefit 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.

# Enrollment Application for VRS Optional Group Life Insurance

**VRS-39**

**MINNESOTA LIFE**

**Minnesota Life Insurance Company** - A Securian Company
Richmond Branch Office • P.O. Box 1193 • Richmond, VA 23218-1193 • Phone 1-800-441-2258

| Employer code (5 digits) | Employer name | Employee's annual salary<br>$ |
|---|---|---|

## 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.)

| Option | OPTIONAL INSURANCE AMOUNTS | | |
|---|---|---|---|
| | 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 $375,000 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 $750,000 for an employee and $375,000 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 name, middle initial, last) | Relationship | Sex | Social Security number | Date of Birth (mo/day/yr) |
|---|---|---|---|---|
| | Your Spouse | ☐ Male ☐ Female | | |
| | Youngest Child | ☐ Male ☐ Female | | |

## 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<br>X | Date signed |
|---|---|

## 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<br>X | Date signed |
|---|---|

## 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<br>X | Title | Date signed |
|---|---|---|

## 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.

# Arlington Public Schools


Anna M Samayoa – Payroll Administrator

*1426 North Quincy Street, Arlington, VA 22207 703-228-6099 Phone 703-807-0146 Facsimile*


## REQUEST TO TRANSFER UNUSED SICK LEAVE TO ARLINGTON COUNTY PUBLIC SCHOOLS FROM OTHER DISTRICT

To Human Resources/Payroll Manager:

School Division Name: ________________________________________

School Division Representative: __________________________________

The individual listed below was previously employed by your School District and has requested to transfer his/her unused sick leave to our district.

---

According to the provisions of the State Sick Leave Plan of Virginia, Employees with experience in another Virginia public school division may transfer up to NINETY (90) days of accumulated sick leave from their former Virginia school division within one year of their departure, as certified by the previous school division.
Employees have one year from resignation/retirement date to complete this form to have sick days transferred to Arlington Public Schools.

Employee SSN

| | | | - | | | - | | | | |
|---|---|---|---|---|---|---|---|---|---|---|

Employee Name______________________________ ________________________________________

Employee's Signature

Transfer ☐ Entire Balance ☐ Partial Balance Amount of hours/days______________________

_______________________________________________________________________________

Employee's Termination/Retirement Date: ________________

School Division Representative:

Signature: _________________________________

Title: _______________________ Contact Number: _________________

Please send form to:
1426 North Quincy Street
Arlington, VA 22207

Attention: Anna Samayoa

Or Fax to: 703-807-0146

Or e-mail: anna.samayoa@apsva.us

# Model General Notice Of COBRA Continuation Coverage Rights

## ** Continuation Coverage Rights Under COBRA**

### Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more 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.

**You may have other options available to you when you lose group health coverage.** For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

### What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called 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're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- 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 of the following qualifying events:

- 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 becomes entitled to Medicare benefits (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."

To Retirees:

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 Schools, 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. 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 continuation 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. The employer must notify the Plan Administrator of the following qualifying events:

- 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).

**For all 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:**

**COBRA Administration**
**APS Human Resources / Benefits Department**
**1426 N. Quincy St., 4th Fl**
**Arlington, VA 22207**
**Phone: 703-228-6105**

**How is COBRA continuation 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 that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

***Disability extension of 18-month period of COBRA continuation coverage***

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a 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 COBRA continuation coverage. You must provide notification to:

**COBRA Administration**
**APS Human Resources / Benefits Department**
**1426 N. Quincy St., 4th Fl**
**Arlington, VA 22207**
**Phone: 703-228-6105**

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

If your family experiences another qualifying event during the 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 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the

spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

**Are there other coverage options besides COBRA Continuation Coverage?**

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

**If you have questions**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

**Keep your Plan informed of address changes**

To protect your family's rights, let the Plan Administrator know about any changes in the 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**

**COBRA Administration**
**APS Human Resources / Benefits Department**
**1426 N. Quincy St., 4th Fl**
**Arlington, VA 22207**
**Phone: 703-228-6105**

# New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

## 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 Floor | | 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? $ 59.63 for 2017 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 2018

☐ 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? $ 58.26 for 2018 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**
Human Resources Department

## LICENSURE CHECKLIST

Teachers, principals, guidance counselors, school psychologists, school social workers, school managers, vocational evaluators, and superintendents are required to hold a valid by the Virginia Department of Education. **Licensure documents for all personnel are due to Adora Aldana within 30 days from 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:** The VDOE does not accept photocopies, PDFs, eSCRIP-SAFE transcripts. Transcripts by third-party vendors like Parchment and Transcripts Network must arrive in a sealed envelope.
- ☐ **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 "CWSE 5691Child Abuse and Neglect: Recognizing, Reporting, & Responding (for educators) (Web page).
- ☐ **REQUIRED Emergency First Aid, CPR, and Use of AEDs**: Evidence of the certification or training in emergency first aid, cardiopulmonary resuscitation, and the use of automated external defibrillators shall include hands-on practice of the skills necessary to perform cardiopulmonary resuscitation.
- ☐ **REQUIRED Dyslexia Awareness training**: Submit a copy of your certificate from the free module available at: http://www.doe.virginia.gov/teaching/licensure/dyslexia-module/story.html.

**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.
**School Counselor Training (if applicable):** Persons seeking initial licensure or renewal of a license with an endorsement as a school counselor must complete training in the recognition of mental health disorder and behavioral distress, including depression, trauma, violence, youth suicide, and substance abuse. Additional information on how to meet the requirement will be provided soon. Use the link to access the license application below for updates.
**Out-of-State Teaching Licenses* (if applicable):** If you have a valid out-of-state teaching licenses, submit a copy.
**Test scores (if applicable)**: We can apply for the license without your test scores. 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*.
**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.

## USE THIS LINK TO ACCESS THE LICENSE APPLICATION

**http://www.doe.virginia.gov/teaching/licensure/application-license.pdf**

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

# ATTENTION Title I teachers, be advised of the following:

Under the guidance of *Every Student Succeeds Act of 2015 (ESSA)* and §22.1-298.1 of the Code of Virginia, school divisions are being required to send notifications to parents in Title I schools if their children are taught four or more weeks by a teacher who is not properly licensed and endorsed in Virginia to teach the class to which the students are assigned.

If you are working at any of the following locations:

**APS Title I Schools**

Abingdon Elementary School
Barcroft Elementary School
K.W. Barrett Elementary School
Campbell Elementary School
Carlin Springs Elementary School
Drew Model Elementary School
Hoffman-Boston Elementary School
Randolph Elementary School

Your initial license application packet or Virginia teaching license must be received in the HR Department within thirty days. Otherwise, the parents of your Title I students will be notified you are not properly licensed and endorsed to teach the class to which the students are assigned.

# 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:*** ____________________________________________

Updated 07/27/05

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.*