NEW WALK-ON COACH

Please bring the following to your fingerprint appointment:

- ◻ **State-issued driver's license or identification card** (Must be unexpired)
- ◻ A **money order** for $79.00 payable to HLPUSD (for DOJ & FBI LiveScan) (No cash, checks, or cards accepted)
- ◻ The **completed coaching packet** (please do not include handouts – for your reference only)
- ◻ Verification of completed COVID-19 vaccination
    - Per HLPUSD Board of Education, it is a condition of employment to be fully vaccinated against COVID-19, no exemptions accepted
- ◻ If available, most recent **TB test results** (If new to HLPUSD, must be within 60 days of start date)

Verify that the following items are up-to-date and valid for entire school year:

- ◻ **Original** CPR Card or Certificate (Must include hands-on training, valid for 2 years)
- ◻ **Original** First Aid Card or Certificate (Must include hands-on training, valid for 2 years)
- ◻ Concussion in Sports certificate (Renewal is tied to CPR/First Aid renewal date)
- ◻ Sudden Cardiac Arrest certificate (Renewal is tied to CPR/First Aid renewal date)
- ◻ Heat Illness Prevention certificate (Renewal is tied to CPR/First Aid renewal date)
- ◻ Fundamentals of Coaching certificate (Does not apply to elementary coaches and Dance, Drill Team, Band, or Badminton)
- ◻ Keenan Trainings
- ◻ **Cheer/Pep Coaches: USA Cheer Spirit Safety Certification (previously known as AACCA National Safety Certification)
- ◻ **Water Polo/Swimming Coaches: Basic Water Rescue, Safety Training for Swim Coaches, or Lifeguarding certification from American Red Cross (must include in-water training)

High School Coaches – Please contact your Athletic Director for any questions regarding your application or certifications.
Elementary and Middle Coaches - Please contact the principal for any questions regarding your application or certifications.

Human Resources will contact you if any additional information is required.

REMINDER: If you change your name, move, or change any of your contact information from this point on, please visit Human Resources as soon as possible to request a change of information form. This request must be submitted in person with a valid photo ID in order to update your information in our database.

PRINT THIS PAGE

HACIENDA LA PUENTE UNIFIED SCHOOL DISTRICT

Human Resources Department

EXTRA DUTY ASSIGNMENTS/COACHES - NEW WALK-ON COACH

School Site: ____ School Year: ____________________

Print Name: ____

Note: Please print and complete the **bold** items along with this form and submit them to authorized school personnel or Human Resources.

Initials	Form Name	Initials	Form Name
	Application		**Form W-4 - Withholding Allowance**
	Important Form		**Oath of Allegiance (Form #1001)**
	Required Certifications/Coaching ID Badges Handout		**HLPUSD Warrant Recipient Designation (Form #1048)**
	Employee/Student Interaction Notice		**CALPERS Form (EAMD-801)**
	No Drive Notification Letter		**Annual Employee Reminders (Form #1870)**
	Emergency Contact Information		Health Information Privacy Practices
	Mandated Reporting Requirement for Coaches		Worker's Compensation Information
	HLPNet Membership Application		Employee Assistance Program - REEP
	Global Positioning System (GPS) Device - Fact Sheet ***(one-time requirement only)***		Payroll Schedule
	Retirement Questionnaire		Child Abuse and Neglect Staff Handbook
	Form I-9 - Employment Eligibility Verification		

As a condition of employment, I acknowledge that I have received, read, completed and understand all of the above information.

____ ____

Signature Date

HUMAN RESOURCES DEPARTMENT ONLY

Assignment(s): ____

❑ Certificated ______________________________ ❑ Stipend

❑ Classified ______________________________ ❑ Site-Funded

❑ Walk-on ❑ Volunteer

APPLICATION FOR EMPLOYMENT
NON-CERTIFICATED TEMPORARY ATHLETIC TEAM COACH

Hacienda La Puente Unified School District
15959 E. Gale Ave, City of Industry, CA 91745
AFFIRMATIVE ACTION AND EQUAL OPPORTUNITY EMPLOYER

Activity/Sport: ____________________
School/Site: ____________________
PRINT CLEARLY Please answer all questions --- Type or print, using only ink. Date Filed: ____________________

ANY FALSIFICATION IS SUBJECT TO IMMEDIATE TERMINATION.

LEGAL NAME: ____
LAST FIRST MIDDLE

Other Legal Names: ________________________________ Date of Birth: ______________

PRESENT ADDRESS: ____
NUMBER STREET APT./SUITE (If applicable)

____ EMAIL____________________
CITY STATE ZIP CODE

HOME PHONE ______________ CELL PHONE ______________ WORK PHONE ______________

If you are not a citizen of the United States, have you the right to work in the United States? Yes ☐ No ☐
If “No”, attach an explanation.

Are you currently employed by the Hacienda La Puente Unified School District? Yes ☐ No ☐

If yes, give position held:____

Have you previously been employed by the Hacienda La Puente Unified School District? Yes ☐ No ☐

If yes, give date left:______________________ and position held:______________________

HAVE YOU EVER COACHED AT A CIF MEMBER SCHOOL IN THE PAST? Yes ☐ No ☐
If yes, please complete: (Attach additional sheets if necessary)

School name: ______________________ Date(s) of service: ______________________

Have you ever held a position where you had supervisory authority over students? Yes ☐ No ☐

If yes, please elaborate:____

Do you have any physical condition that may limit your ability to perform the job for which you are applying? Yes ☐ No ☐

If yes, please state condition: ____

What can be done to accommodate your limitation? ____

AGE REQUIREMENT:
(Employment is subject to verification that applicant meets legal age requirements for the position applied.)
Are you over eighteen (18) years of age? Yes ☐ No ☐

If under eighteen (18), can you, after employment, submit a work permit? Yes ☐ No ☐

IF YOU ARE PRESENTLY EMPLOYED, MAY WE CONTACT YOUR EMPLOYER FOR A REFERENCE?
Yes ☐ No ☐ Presently Unemployed ☐

References must be from an employer (supervisor) or school/program administrator from your current or most recent place of employment or service. A minimum of one reference is required. (Attach additional sheets if necessary)

Your Current/Most Recent Job Title: ______________________ Organization/Company: ______________________

Reference Name:______________________ Reference Title:______________________

Phone Number: ______________________ Email: ______________________

APPLICATION FOR EMPLOYMENT
NON-CERTIFICATED TEMPORARY ATHLETIC TEAM COACH

HAVE YOU EVER BEEN DISCHARGED OR FORCED TO RESIGN FROM ANY POSITION? Yes ☐ No ☐
If yes, please complete: (Attach additional sheets if necessary)

Employer Name: ____

Employer Address: ____

Date of Termination: ___________________ Reason for Termination: ______________________________

NOTE: A "YES" answer does not automatically eliminate you from consideration for a position. Failure to admit is cause for termination.

MUST READ! If you have ***ever*** plead guilty, been convicted, fined, imprisoned, placed on probation, or given a suspended sentence by a civilian or military court for ***any crime*** (other than minor traffic violations) you are required to provide detailed information regarding the offense(s) prior to your employment. **Applicants selected for employment will be fingerprinted and a criminal record check will be made.**

Have you, as a juvenile or adult, ever been convicted, fined, imprisoned, placed on probation or sentenced in any civil, criminal, or military court, or have you ever forfeited bail? Yes ☐ No ☐

If you answered YES, please list ANY misdemeanor and/or felony offenses, including driving under the influence (DUI), set asides and expungements for which you have been convicted or received a withheld judgment within your lifetime. You must include minor traffic violations if they resulted in the issuance of a warrant, drunk driving convictions and convictions dismissed following probation. Some juvenile offenses for which an individual is charged as an adult (tobacco, alcohol, and drug charges) and traffic citations or moving violations such as inattentive driving may fall into this category. **It is the applicant's responsibility to verify the accuracy of the information contained within the record.**

Offense & Date	City, State	Sentence or Fine

Any convictions not declared will be cause for disqualification. In addition, we cannot employ or retain in employment, any person convicted of *any sex offense* as defined in Education Code Section 44010 or *any controlled substance offense* as defined in Education Code Section 44011.

NOTE: The existence of a criminal record does not automatically bar you from employment. Failure to admit is cause for termination.

HIGH SCHOOL GRADUATION:
Did you graduate from high school? Yes ☐ No ☐ If not, have you passed a GED test? Yes ☐ No ☐

Name of High School: ____________________________ Date GED completed:______________________________

Location of High School:___________________________

ADDITIONAL REMARKS: (Include anything you believe pertinent to the position for which you are applying. List any licenses, registration and certificates of professional or vocational competence you may have obtained.)

____

____

____

CERTIFICATE OF APPLICANT: I certify that all statements made on this application are true and complete to the best of my knowledge. I understand that any false statement will subject me to dismissal and that I will be required by law to be fingerprinted, Mantoux tested (or chest X-rayed as required), and to sign a loyalty oath.

SIGNATURE:____ DATE:_______________________

PRINT THIS PAGE

HACIENDA LA PUENTE UNIFIED SCHOOL DISTRICT

I M P O R T A N T For Walk-On Coaches

FOR OFF-SEASON VOLUNTEER COACHING, PLEASE COMPLETE PAGE 2

Name: ______________________________

COACHES MUST COMPLETE THE FOLLOWING MANDATORY REQUIREMENTS:

(Initials required on #7b, #12a & #13. Signature required on page 2)

1. Structured interview with school site administrator and completion of reference check (New candidates only)
2. Employment paperwork should be uploaded to Home Campus (Coaches Clearance) for High School coaches. Elementary and Middle School coaches should submit employment paperwork to site administrator.
   a. For returning coaches, has your employment changed recently? ❑ Yes ❑ No
   If yes, please provide reference information below. (Note: References must be from an employer (supervisor) or school/program administrator from your current or most recent place of employment or service.)

Your Current/Most Recent Job Title:	Organization/Company:
Reference Name:	Phone Number:
Reference Title:	E-Mail:

3. Fingerprint processing and clearance by the Department of Justice (DOJ) – AB 1610 Ed Code 45125c and FBI – AB 346. A **money order** in the amount of $79 payable to HLPUSD, which is required for LiveScan. (New candidates only)
4. Original documentation to show identity and authorization to work (New candidates only)
   (Note: List of acceptable documents are included with Form I-9; all documents must be unexpired).
5. Verification of a mantoux (TB) test for tuberculosis or TB Risk Assessment (valid for four (4) years).
   Initial results must be within the past 60 days.
6. Verification of completed COVID-19 vaccination. All coaches must be fully vaccinated against COVID-19. Full vaccination consists of 2 doses of either Pfizer or Moderna vaccines or a single dose Johnson & Johnson vaccine.
7. Completion of First Aid and CPR certification (must be valid for entire assignment). If certification expires within coaching season, it must be renewed BEFORE the start of the coaching assignment.
   a. Elementary/Middle Schools: **Child and Adult CPR** are required. High Schools: **Adult CPR** is required.
   b. ***All First Aid and CPR certification must include hands-on training*. Acceptable agencies include*: American Red Cross, American Heart Association, American Safety & Health Institute, American CPR Training, EMS Safety, and CPR & More.*** _____ **(initials)**
8. Have you ever coached in a CIF member school in the past?
   (Does not apply to elementary coaches and Dance, Drill Team, or Band)
   ☐ Yes – You must complete the **CIF Fundamentals of Coaching** program (www.NFHSlearn.com).
   ☐ No – A one-time waiver of this requirement may be granted for the first sports season and will expire upon the completion of that sports season.
9. Completion of the following certifications on **www.NFHSLearn.com**:
   (Renewals are directly tied to the renewal date of the First Aid and CPR certification – every two (2) years)
   - **Concussion in Sports – What You Need to Know**
     Also acceptable from www.cdc.gov (**Heads Up: Concussion in High School Sports**)
   - **Sudden Cardiac Arrest**
   - **Heat Illness Prevention**
10. Completion of **Keenan SafeSchools** trainings (required annually)
11. Cheer/Pep Coaches: Completion of **Cheer and Dance Safety Certification**, previously known as AACCA National Safety Certification Program (Stunt Certificate). Also required for Dance coaching with stunts. Valid for four (4) years, must renew before expiration date.
12. Water Sports Coaches: Completion of water safety certification.
    a. ***We will only accept one of the following through American Red Cross:* Basic Water Rescue, Safety Training for Swim Coaches *or* Lifeguarding*. Courses must include in-water training*.** _____ **(initials)**
13. Coaches will be tasked with supervising students while on campus, bus and/or various other venues. It is essential to follow all guidelines and to use effective supervisory strategies, such as maintaining visual contact with all students, setting clear boundaries, and proactively addressing any behavioral issues that may arise. _____ **(initials)**
14. Coaches will not be considered cleared and approved to coach until they have been issued a current photo badge for the school year. Coaching badges **must be worn at all times** while on school premises. _____ **(initials)**

*****(Signature required on page 2)*****

ORIGINAL - HUMAN RESOURCES
☐ COPY PROVIDED TO EMPLOYEE

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HACIENDA LA PUENTE UNIFIED SCHOOL DISTRICT

I M P O R T A N T For Walk-On Coaches

FOR OFF-SEASON VOLUNTEER COACHING, PLEASE COMPLETE PAGE 2

SIGNATURE REQUIRED FOR ALL WALK-ON COACHES

COACHES WHO FAIL TO HAVE THE ABOVE-LISTED REQUIREMENTS COMPLETED PRIOR TO HAVING A COACHING ASSIGNMENT ARE NOT AUTHORIZED TO WORK WITH STUDENTS & WILL *NOT* BE PAID!! By signing below, I acknowledge that I must complete all mandatory requirements, receive authorization from Human Resources and site administration, and receive approval from the Board of Education before I can begin any paid coaching assignments.

Printed Name ______________________ Signature ______________________ Date ______________

Site ______________________ Assignment ______________________ Additional Assignment ______________

HIGH SCHOOLS ONLY

OFF-SEASON COACHING ASSIGNMENTS

Indicate off-season assignments and effective dates below (site administrator must sign for approval):

ASSIGNMENT	START DATE	END DATE	SITE ADMIN APPROVAL

By signing below, I acknowledge that I must complete all mandatory requirements and receive authorization from Human Resources and site administration before I can begin any off-season coaching assignments. I understand that I will not be receiving payment or any other form of compensation from HLPUSD or any third parties during the off-season dates indicated above.

Name ______________________ Signature ______________________ Date ______________

COMPLETED BY HUMAN RESOURCES ONLY – INDICATE WALK-ON ASSIGNMENT(S) AND PAID EFFECTIVE DATES

❑ FALL ASSIGNMENT: ______________________ START DATE: __________ END DATE: __________

❑ WINTER ASSIGNMENT: ______________________ START DATE: __________ END DATE: __________

❑ SPRING ASSIGNMENT: ______________________ START DATE: __________ END DATE: __________

❑ SUMMER ASSIGNMENT: ______________________ START DATE: __________ END DATE: __________

ORIGINAL - HUMAN RESOURCES

☐ COPY PROVIDED TO EMPLOYEE

REQUIRED CERTIFICATIONS

We accept CPR & First Aid certification from the following agencies only (<u>must include hands-on training - no exceptions</u>, typically renewed every two (2) years):

American Red Cross
American Heart Association
American Safety & Health Institute
American CPR Training
EMS Safety (www.emssafetyservices.com)
CPR & More (www.cprnmore.com)

Campus Locations that offer CPR & First Aid Classes:

<u>Willow Adult (American Heart Association)</u>
14101 E. Nelson Ave
La Puente, CA 91744
(626) 934-2801 or 2808

CIF: Fundamentals of Coaching – One time only, no renewal needed.
Course is available on **www.NFHSLearn.com**
(Required for HS Cheer/Pep; not required for elementary coaches and Dance, Drill Team, Band, or Badminton)

The following certifications must be completed together with CPR/First Aid:
Free courses are available on **www.NFHSLearn.com**

- **Concussion in Sports** (Also acceptable from www.cdc.gov – <u>Heads Up: Concussion in High School Sports</u>)
- **Sudden Cardiac Arrest**
- **Heat Illness Prevention**

(Note: Renewals for the above certifications are tied directly to CPR & First Aid renewal date)

Keenan trainings must be completed annually at hlpusd.keenan.safeschools.com.
(Note: Keenan trainings must be assigned by school administrator)

Water Safety Certification – Coaches involved in Aquatics (Swimming, Water Polo) must complete water safety certification from **American Red Cross**; **<u>courses must include in-water training</u>**, renewed every two (2) years.

We accept the following certifications only (no exceptions):

- <u>Basic Water Rescue</u>
- <u>Safety Training for Swim Coaches</u>
- <u>Lifeguarding</u>

USA Cheer Spirit Safety Certification (Previously known as AACCA National Safety Certification Program) Stunt certification for Cheer/Pep coaches only (also required for Dance coaching that involves stunts). Course is available on **www.NFHSLearn.com** - One time only, no renewal needed

HACIENDA LA PUENTE UNIFIED SCHOOL DISTRICT
HUMAN RESOURCES DEPARTMENT
15959 E. GALE AVE.
CITY OF INDUSTRY, CA 91745-0002

Coaching ID Badges

Coaches will not be considered cleared and approved to coach until they have been issued a current photo badge for the school year. Coaching badges must be worn at all times while on school premises.

1. New Coaches:
    - A photo will be taken during your fingerprinting appointment. After fingerprints have cleared and all necessary documents are completed and have been received you will be placed on the School Board Agenda for approval.
    - Once approved, a badge will be issued by HR.

2. Returning Coaches:
    - Returning coaches cannot coach until they have been cleared by HR. Paid coaches must also be Board approved prior to starting assignment.
    - A new badge indicating the current school year will be issued by HR.
    - Badges from previous years must be returned before a new one will be issued.

3. Replacement Badge:
    - $10.00 First Replacement Fee – paid to HR
    - $25.00 Second Replacement Fee – paid to HR
    - If a third replacement is necessary, Principal, Assistant Principal, & Athletic Director will be notified. HR will wait for instructions from the site.

4. Temporary Badge:
    - Coaches who have forgotten or misplaced their coaching badges may be issued a temporary badge by the Principal/Assistant Principal at site.
    - These badges are issued on a temporary basis only and shall not be used on a regular basis.

HACIENDA LA PUENTE UNIFIED SCHOOL DISTRICT
OFFICE OF HUMAN RESOURCES
15959 E. GALE AVE. • CITY OF INDUSTRY, CA 91745 • (626) 933-3837 • FAX(626) 855-3594

Employee/Student Interaction Notice

All District employees should read and understand this notice and behave in a manner to avoid even the appearance of misconduct. A District employee who violates this notice will be subject to appropriate disciplinary action.

Under California law, it is a crime for an adult to have any sexual relationship with a minor. In addition, California law and Board Policy require "mandated reporters" to report to child protective services or to law enforcement any suspected sexual assault or sexual exploitation of a minor. This includes any suspected sexual relationship between an adult and a minor. Any District employee who reasonably suspects that an adult is having a sexual relationship with a student must report the suspicion to child protective services or law enforcement immediately. Immediate reporting is crucial for the protection of the student(s) and the community as a whole.

Purpose

The Hacienda La Puente Unified School District expects all its employees to conduct themselves at all times in a manner that reflects standards consistent with the law and with the Board Policies, Board Goals, and Guiding Principles of the District. It is the purpose of this notice to make sure all District employees understand and demonstrate proper judgment in observing the prohibitions which must govern their conduct and recognize their responsibility to respond appropriately to unacceptable behavior by co-workers and/or students. This notice specifies boundaries related to potentially sexual situations and conduct which is contrary to accepted behavior and in conflict with the duties and responsibilities of District employees. In addition, this notice alerts all District employees about problematic matters involved in employee/student relationships, provides guidance for employees in conducting themselves in a manner that reflects high standards of professionalism, and provides notice that potential improper action may have significant consequences. This notice establishes guidelines to be followed by all District employees when interacting with a student.

1. School instruction, counseling and other administrative tasks which require the presence of students should be accomplished on school premises within the normal school day.

2. Whenever it becomes necessary for a District employee to meet with a student/students outside of the normal school day or to conduct instruction or participate in school-related extracurricular activities outside of the school premises, such activities should be accompanied with the written approval of the school principal and of the parent/guardian of the student(s).

3. District employees should only be alone with a single student when it is educationally necessary or is a requirement of that employee's position and has been authorized by the employee's administrator.

4. In the event a school activity requires traveling and the District employee is called upon to drive or otherwise provide transportation, the activity and transportation must be approved in writing by the site principal and by the parent/guardian prior to the required travel (see District AR 3541.1).

5. District employees never should travel alone with a single student without having acquired written permission from the principal and from the parent/guardian District (See District AR 3541.1).

This notice prohibits any type of sexual relationship, sexual contact, or sexually-nuanced behavior between a District employee and a student without regard to the student's age. This prohibition applies to students of the same or opposite gender of the District employee. It also applies regardless of whether the student or the school employee initiated the sexual behavior, and whether or not the student welcomes the sexual behavior and/or reciprocates the attention. This prohibition includes sexually–nuanced communication via internet chat rooms, social networking web sites, cell phones, or any other form of electronic communication or other types of communication.

Examples of Inappropriate/Unacceptable Behavior

These examples establish general knowledge among all District employees that trespassing beyond the acceptable boundaries for an employee/student relationship is deemed an abuse of power and a betrayal of public trust. While some situations may seem innocent, from a student or parent/guardian point of view, they can be perceived as flirtation or as being sexual in nature.

The following illustrative examples of inappropriate behavior are intended as guidance for preventing relationships that could lead to, or may be perceived as, sexual misconduct. While, by their very nature, examples are not the sum total of all possible inappropriate behaviors, they will assist in future decision-making.

1. Making, or participating in, sexually inappropriate comments or actions.

A. Sexual jokes, or jokes/comments with sexual double-entendre;
B. Kissing of any kind;
C. Listening to or telling stories that are sexually oriented;
D. Inappropriate physical contact;
E. Remarks about the physical attributes or physiological development of anyone;
F. Sending a student/students inappropriate email, text messages, or communication via a social networking website (e.g., MySpace, Facebook).

2. Becoming involved with a student so that a reasonable person may suspect inappropriate behavior.

A. Intentionally being alone with a student at or away from the site;
B. Except for extremely rare emergency situations, giving a student a ride to/from school or school activities without written approval from the principal and from the parent/guardian (see District AR 3541.1);
C. Giving gifts of a personal and/or intimate nature to an individual student;
D. Seeking emotional involvement (which can include intimate attachment) with a student beyond

the normative care and concern expected of an educator;

E. Being alone in a room with a student on District property with the door closed unless it is educationally necessary or is a requirement of the employee's position or is authorized by the employee's administrator;
F. Excessive, non-educational attention toward a particular student;
G. Allowing students in your home without written approval from the principal and from the parent/guardian and without a parent/guardian or other responsible adult present;

Consequences of Inappropriate Behavior

A District employee's sexual misconduct with a student harms the student victim. It also disrupts the education of other students, hinders the instructional focus of the District, and harms the reputation of the District. Therefore, a District employee who is accused of sexual misconduct with a student becomes at risk for disciplinary action, for loss of job as well as for criminal and/or civil legal actions.

Acknowledgement of Receipt
This notice will be presented to and signed by all District employees as part of their initial employment and as part of on-going training.

Legal Reference
<u>United States Code</u>
Title IX, Education Act Amendments, 1972; 20 U.S.C §1681

My signature acknowledges I have received, read and understand the *Employee/Student Interaction Notice.*

<u>Employee</u>

____________________	______________________________	
Print Name	Signature	Date

<u>Witness</u>

____________________	______________________________	
Print Name	Signature	Date

PRINT THIS PAGE

HACIENDA LA PUENTE UNIFIED SCHOOL DISTRICT
HUMAN RESOURCES DEPARTMENT

15959 E. GALE AVENUE • CITY OF INDUSTRY, CA 91745 • (626) 933-3830 • (626) 855-3594

Congratulations on your selection as a Coach for our district. We appreciate your willingness to work with our students. Please be reminded that under no circumstances are you to drive or operate a district vehicle including utility and golf carts unless expressly authorized and trained by the Transportation Department.

In addition, at no time are you permitted to drive district students in your own vehicle, nor are you authorized to coach any of our students privately in your home or any other off -site facility without the expressed written permission of the district. Failure to adhere to these directives will result in automatic termination.

If you have any questions or concerns, please do not hesitate to call.

Sincerely,

Dr. John Lovato
Assistant Superintendent
Human Resources

My signature acknowledges I have received, read and agree to the terms in the information stated above.

______________________________ ______________________________________

Print Name Signature Date

Vision Statement:

The Hacienda La Puente Unified School District is a community committed to developing lifelong learners who value themselves and the diversity of all people; apply decision-making skills leading to responsible actions; and use creativity, critical thinking, and problem solving in meeting the challenges of a changing society.

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HACIENDA LA PUENTE UNIFIED SCHOOL DISTRICT
OFFICE OF HUMAN RESOURCES
15959 E. GALE AVENUE • CITY OF INDUSTRY • CA • 91745 • (626) 933-3840 • FAX (626) 855-3594

EMPLOYMENT EMERGENCY CONTACT INFORMATION

MUST PRINT OR TYPE THE INFORMATION ON THIS FORM

Date: ______________________

Last Name: ___________________________ First Name: ______________________

☐ Male ☐ Female Work Location: _____________________________________

Address: ____
Street City Zip Code

Phone: (Home) __________________________ (Cell) _____________________________

Last Four of Social Security # ____

Supervisor's Name: ____

Job Title: **Walk-on Coach** ________________ ☐ Certificated ☐ Classified

---

In case of an emergency please contact the following: (Please try and give three contacts)

Name ______________________________ Cell ______________________________
______________________________ Home ______________________________
Relationship Work ______________________________

Name ______________________________ Cell ______________________________
______________________________ Home ______________________________
Relationship Work ______________________________

Name ______________________________ Cell ______________________________
______________________________ Home ______________________________
Relationship Work ______________________________

Personal email address: ______________________________

PRINT THIS PAGE

Section 1233 of the California Government Code permits school districts to solicit from employees a voluntary declaration of their racial/ethnic group membership. Check only one applicable category below. If more than one applies, choose one category which best identifies your racial/ethnic background. (Married women are to indicate their own ancestry, rather than that of their husband).

A ☐	AMERICAN INDIAN OR ALASKA NATIVE A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.	D ☐	HISPANIC A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
E ☐	ASIAN A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.	I ☐	NATIVE HAWAIIAN OR PACIFIC ISLANDER A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
B ☐	BLACK OR AFRICAN-AMERICAN A person having origins in any of the Black racial groups of Africa.	C ☐	WHITE A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Language Ability	Fluent in:
Other than English	Can use in conversation:
Specify	Can read with understanding:
	Can write:

I certify that all statements made on this form are true and complete to the best of my knowledge.

Signature: ______________________________ Date: ____________________

HACIENDA LA PUENTE UNIFIED SCHOOL DISTRICT
OFFICE OF HUMAN RESOURCES
15959 E. GALE AVE. • HACIENDA HEIGHTS, CA 91745 • (626) 933-3840 • FAX (626) 855-3594

Mandatory Employee Training Requirements

Mandated Reporter Training:

AB 1432 requires mandated reporter training on all school districts, county offices of education (COEs), state special schools and diagnostic centers operated by the California Department of Education (CDE), and charter schools and their school personnel in California. Agencies are required to do all of the following:

- Annually train employees and persons working on their behalf who are mandated reporters under the Child Abuse and Neglect Reporting Act (CANRA) on their abuse and neglect reporting requirements.
- Train new employees and persons working on their behalf who are mandated reporters within six (6) weeks of each person's employment.
- Develop a process for all persons required to receive training under the law to provide proof of completing this training within the first six (6) weeks of each school year or within six (6) weeks of that person's employment.

AB 1207 **(Child Development only)** requires a person who becomes an administrator or employee of a licensed child day care facility to complete the mandated reporter training specific to child day care personnel. Agencies are required to do all of the following:

- Provide training within the first 90 days that he or she is employed at the facility.
- Shall provide mandated reporter training every two (2) years following the date on which he or she completed the initial mandated reporter training.

Required Trainings:

Classification	Training	Requirement
All Employees	Mandated Reporter: Child Abuse and Neglect	Annually
All Employees	Sexual Harassment: Policy and Prevention (SB 1343)	Annually
All Employees	Active and Effective Supervision	Annually
All Employees	Active Assailant Preparedness	Annually
All Employees	Youth Suicide: Awareness, Prevention, and Postvention	Annually
For Child Development Staff only	Child Care Mandated Reporter: AB 1207	Every two years

Email address: ____

The training will be sent to the email address provided above. When completed, Human Resources will print the certificate of completion and place it in your personnel file.

Please select one:

☐ I have access to a computer.

☐ I do not have access to a computer. I will reach out to Human Resources for accommodations.

Please initial the following:

☐ **DISTRICT POLICY for AB 1432 and AB 1207:** ***I understand I must complete all required training modules prior to my start date. If not, my start date will be delayed pending completion of all training modules.***

☐ **DISTRICT POLICY for AB 1432 and AB 1207:** ***I understand that this is a condition of employment and I am required to complete all required training modules and will not receive additional compensation for the time spent to complete these training modules.***

Print Name: ______________________________ Signature: ______________________________

Witness: ______________________________ Date: ______________________________

Vision Statement:

The Hacienda La Puente Unified School District is a community committed to developing lifelong learners who value themselves and the diversity of all people; apply decision-making skills leading to responsible actions; and use creativity, critical thinking, and problem solving in meeting the challenges of a changing society.

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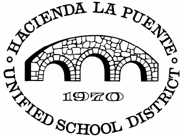

HACIENDA LA PUENTE UNIFIED SCHOOL DISTRICT

HLPnet Membership Application

Member Information:

This is an application for a (check one):
❒ Student ❒ Employee ❒ Other (Please specify ________________________)

Name (full name - no aliases) ____

Street Address____ City__________________________

State___________ Zip___________ Birth date________/________/________

Phone Numbers (Home)___________________________ (Work)___________________________

Alternate E-Mail Address_______________________________ Occupation_______________________

❒ If you are a **student**, check here if you wish to use the alternate e-mail address listed above as your default e-mail address when using inSTiLE for school-related purposes. By checking this box, teachers may communicate with you through the e-mail address listed above for school-related purposes.

If you are a student or employee, at which school or site?______________________________________

Computer being used___N/A___ Operating System___N/A___ Version___N/A___

Special access requests/requirements (check one):
❒ Dial-Up ❒ VPN ❒ Other (Please specify ___N/A___)

Please read the following VERY carefully and follow the instructions EXACTLY or your application cannot be processed!

Login Name:

Your account will be identified by your login name. Your login name cannot contain a space and must be at least 6 characters long and no more than 20 characters total. You must use all lower case letters. Please list three possible login names in order of preference.
Examples: susieq, johndoe

First request for login name (ALL LOWER CASE LETTERS!) ___N/A___

Second request for login name (ALL LOWER CASE LETTERS!)___N/A___

Third request for login name (ALL LOWER CASE LETTERS!)___N/A___

Your electronic mail address will be your login name followed by: @hlpusd.k12.ca.us (for employees) or @hlpnet.net (for students and the community).

Please complete both sides of this application!
NOTE: Accounts that are inactive for more than 30 days may be closed!

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Password:

Your password to access the System should be known to you and no one else. You are responsible for all activity related to this login account and your password is there for your protection and protection of the System. You must provide a password on this application. We recommend that you change your password the first time you log in to the System and periodically thereafter. Should you lose or forget your password, you will need to contact the Account Manager to request assistance. There may be a service charge if the account manager must reset your password due to it being lost or forgotten. If you feel that someone else has learned your password, change it immediately and notify a system administrator. *Allowing another individual to use your password is strictly forbidden by the Terms and Conditions as such actions pose security and legal problems and may result in cancellation of your account.*

Passwords must be at least 6 characters long and no more than 32 characters total. At least 4 characters must be from the alphabet and at least 2 nonalphabetic characters. It cannot contain spaces. Your password must be entered exactly, including the correct upper and lower case letters. *Examples: d34xcl$*

Request for password **(Please write CLEARLY!)**____________N/A____________

Carefully distinguish upper case from lower case, I's from 1's (ones) and O's from 0's (zeros)!

Security Questions:

If it becomes necessary to reset your password, the Networks and Computer Services Department may ask you any of the following questions. Please be prepared to provide this information if you must reset your password.

What is your Mother's maiden name? _____N/A_____ What is your pet's name?_____N/A_____

What is your favorite TV Show?_____N/A_____ What is your favorite food? _____N/A_____

Please note: If you are a student or employee, other basic information that is in your student or employee file may be used for identification purposes.

Signatures:

Please be sure to sign and date this application. By signing this application, you acknowledge that you have received and read the Terms and Conditions for the use of HLPnet. As a member of the System, you understand that changes are made occasionally to the Terms and Conditions document and agree to abide by the current version of the Terms and Conditions document as posted electronically on the System. Any questions related to the Terms and Conditions should be directed to a system administrator. As a member of the System, you agree that should you ever be unwilling to comply with any provision in the current Terms and Conditions document that you will immediately cease using the System and contact the Account Manager to request that this login account be closed. Any violation of the Terms and Conditions may result in the loss of System access privileges and/or legal action against the individual(s).

Member Signature____________________ Date______/______/______

Parent Signature __________N/A__________ Date______/______/______
(required if Member is under 18)

NCS Specialist or Department Head Signature_____-----_____ Date______/______/______

(DO NOT WRITE IN THIS SECTION – SYSTEM ADMINISTRATION USE ONLY)

Account name___-----___ **Opened**___-----___ **Closed**___-----___ **Host**___-----___

Return completed application to the District Office for signature, processing and forwarding to Networks and Computer Services (NCS). Applications will be processed on receipt by

Hacienda La Puente Unified School District
Networks and Computer Services
15959 East Gale Avenue
City of Industry, California 91745-0002

Help Desk: (626) 933-1111, help@hlpusd.k12.ca.us

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<u>Global Positioning System (GPS) Device – Fact Sheet</u>

All vehicles operated by Hacienda La Puente Unified School District (HLPUSD) are equipped with Global Positioning System (GPS) Devices.

The GPS device tracks the following data:

- Geographical Location of the Vehicle
- Speed of the Vehicle
- Mileage driven
- Distance traveled
- Start, Stops and Idle times
- Engine Emergency Codes

HLPUSD vehicles are affixed with a sticker to indicate that the vehicle is equipped with a GPS tracking device.

The GPS data is usually stored for a period of 12 months. Superintendent or designee can extend the storage period for specific cases/incidents.

Only designated staff or authorized vendors are allowed to install, service, repair, remove, reposition, or alter GPS hardware or software. Intentional damage, tampering and/or disabling of vehicle GPS equipment, defacing, or removing the sticker without approval is prohibited and may result in disciplinary action.

The GPS data is considered "Public Records" as defined under California Public Records Act. (Government Code 6250 et al.)

Employees are required to adhere with all policies, procedures, applicable laws, and regulations when driving and operating a District vehicle.

****

I certify that I understand the GPS Device - Fact Sheet and agree to adhere to the policies when driving a HLPUSD vehicle.

Printed Name: ____

Signature:______________________________ Date: ______________________________

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Employment Eligibility Verification

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

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

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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

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

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

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

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

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

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

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

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card **2.** Permanent Resident Card or Alien Registration Receipt Card (Form I-551) **3.** Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa **4.** Employment Authorization Document that contains a photograph (Form I-766) **5.** For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. **6.** Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address **2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address **3.** School ID card with a photograph **4.** Voter's registration card **5.** U.S. Military card or draft record **6.** Military dependent's ID card **7.** U.S. Coast Guard Merchant Mariner Card **8.** Native American tribal document **9.** Driver's license issued by a Canadian government authority **For persons under age 18 who are unable to present a document listed above:** **10.** School record or report card **11.** Clinic, doctor, or hospital record **12.** Day-care or nursery school record		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION **2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) **3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal **4.** Native American tribal document **5.** U.S. Citizen ID Card (Form I-197) **6.** Identification Card for Use of Resident Citizen in the United States (Form I-179) **7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.

For receipt validity dates, see the M-274.

	OR			
• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.		Receipt for a replacement of a lost, stolen, or damaged List B document.		Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

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

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

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

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

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

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

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

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

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

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

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

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

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

PRINT THIS PAGE

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

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

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

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

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

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

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

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ ______

Multiply the number of other dependents by $500 . . . . . $ ______

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2024 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing “Exempt” on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2025.

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

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

1. Expect to work only part of the year;

2. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

3. Prefer the most accurate withholding for multiple job situations.

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

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

Specific Instructions

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

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

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

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

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

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

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2024 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

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

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

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . **1** $ ______

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . **2a** $ ______

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . **2b** $ ______

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . **2c** $ ______

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. . . . . . . **3** ______

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . **4** $ ______

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

1 Enter an estimate of your 2024 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . **1** $ ______

2 Enter:
- $29,200 if you're married filing jointly or a qualifying surviving spouse
- $21,900 if you're head of household
- $14,600 if you're single or married filing separately

. . . . . . **2** $ ______

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . **3** $ ______

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . **4** $ ______

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . **5** $ ______

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$780	$850	$940	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,370
$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$240	$870	$1,020	$1,020	$1,020	$1,540	$1,870	$1,870	$1,870	$1,870	$1,910	$2,040
$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$510	$850	$1,020	$1,020	$1,020	$1,020	$1,220	$1,870	$1,870	$1,870	$1,960
$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230

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Employee's Withholding Allowance Certificate

Complete this form so that your employer can withhold the correct California state income tax from your paycheck.

Enter Personal Information	
First, Middle, Last Name	Social Security Number
Address City State ZIP Code	Filing Status Single or Married (with two or more incomes) Married (one income) Head of Household

1. Use Worksheet A for Regular Withholding allowances. Use other worksheets on the following pages as applicable.
   - 1a. Number of Regular Withholding Allowances (Worksheet A)
   - 1b. Number of allowances from the Estimated Deductions (Worksheet B, if applicable.)
   - 1c. Total Number of Allowances you are claiming
2. Additional amount, if any, you want withheld each pay period (if employer agrees), **(Worksheet C)**
   OR

Exemption from Withholding

3. I claim exemption from withholding for 2023, and I certify I meet both of the conditions for exemption. (Check box here)
   OR
4. I certify under penalty of perjury that I am **not subject** to California withholding. I meet the conditions set forth under the Service Member Civil Relief Act, as amended by the Military Spouses Residency Relief Act and the Veterans Benefits and Transition Act of 2018. (Check box here)

Under the penalties of perjury, I certify that the number of withholding allowances claimed on this certificate does not exceed the number to which I am entitled or, if claiming exemption from withholding, that I am entitled to claim the exempt status.

Employee's Signature ______________________________ Date ____________

Employer's Section: Employer's Name and Address	California Employer Payroll Tax Account Number

Purpose: This certificate, DE 4, is for **California Personal Income Tax (PIT)** withholding purposes only. The DE 4 is used to compute the amount of taxes to be withheld from your wages, by your employer, to accurately reflect your state tax withholding obligation.

Beginning January 1, 2020, *Employee's Withholding Allowance Certificate* (Form W-4) from the Internal Revenue Service (IRS) will be used for federal income tax withholding **only**. You must file the state form *Employee's Withholding Allowance Certificate* (DE 4) to determine the appropriate California PIT withholding.

If you do not provide your employer with a withholding certificate, the employer must use Single with Zero withholding allowance.

Check Your Withholding: After your DE 4 takes effect, compare the state income tax withheld with your estimated total annual tax. For state withholding, use the worksheets on this form.

Exemption From Withholding: If you wish to claim exempt, complete the federal Form W-4 and the state DE 4. You may claim exempt from withholding California income tax if you meet both of the following conditions for exemption:

1. You did not owe any federal/state income tax last year, and
2. You do not expect to owe any federal/state income tax this year. The exemption is good for one year.

If you continue to qualify for the exempt filing status, a new DE 4 designating **exempt** must be submitted by February 15 each year to continue your exemption. If you are not having federal/state income tax withheld this year but expect to have a tax liability next year, you are required to give your employer a new DE 4 by December 1.

Member Service Civil Relief Act: Under this act, as provided by the Military Spouses Residency Relief Act and the Veterans Benefits and Transition Act of 2018, you may be exempt from California income tax withholding on your wages if

(i) Your spouse is a member of the armed forces present in California in compliance with military orders;

(ii) You are present in California solely to be with your spouse; and

(iii) You maintain your domicile in another state.

If you claim exemption under **this** act, **check the box on Line 4**. You may be required to provide proof of exemption upon request.

The *California Employer's Guide* (DE 44) (edd.ca.gov/pdf_pub_ctr/de44.pdf) provides the income tax withholding tables. This publication may be found by visiting Payroll Taxes - Forms and Publications (edd.ca.gov/Payroll_Taxes/Forms_and_Publications.htm). To assist you in calculating your tax liability, please visit the Franchise Tax Board (FTB) (ftb.ca.gov).

If you need information on your last *California Resident Income Tax Return* (FTB Form 540), visit the FTB (ftb.ca.gov).

Notification: The burden of proof rests with the employee to show the correct California income tax withholding. Pursuant to section 4340-1(e) of Title 22, California Code of Regulations (CCR) (govt.westlaw.com/calregs/Search/Index), the FTB or the EDD may, by special direction in writing, require an employer to submit a Form W-4 or DE 4 when such forms are necessary for the administration of the withholding tax programs.

Penalty: You may be fined $500 if you file, with no reasonable basis, a DE 4 that results in less tax being withheld than is properly allowable. In addition, criminal penalties apply for willfully supplying false or fraudulent information or failing to supply information requiring an increase in withholding. This is provided by section 13101 of the California Unemployment Insurance Code (leginfo.legislature.ca.gov/faces/codes.xhtml) and section 19176 of the Revenue and Taxation Code (leginfo.legislature.ca.gov/faces/codes).xhtml).

Instructions — 1 — Allowances*

When determining your withholding allowances, you must consider your personal situation:
— Do you claim allowances for dependents or blindness?
— Will you itemize your deductions?
— Do you have more than one income coming into the household?

Two-Earners/Multiple Incomes: When earnings are derived from more than one source, under-withholding may occur. If you have a working spouse or more than one job, it is best to check the box "SINGLE or MARRIED (with two or more incomes)." Figure the total number of allowances you are entitled to claim on all jobs using only one DE 4 form. Claim allowances with **one** employer.

Do **not** claim the same allowances with more than one employer. Your withholding will usually be most accurate when all allowances are claimed on the DE 4 filed for the highest paying job and zero allowances are claimed for the others.

Married But Not Living With Your Spouse: You may check the "Head of Household" marital status box if you meet all of the following tests:
(1) Your spouse will not live with you **at any time** during the year;
(2) You will furnish over half of the cost of maintaining a home for the entire year for yourself and your child or stepchild who qualifies as your dependent; **and**
(3) You will file a separate return for the year.

Head of Household: To qualify, you must be unmarried or legally separated from your spouse and pay more than 50% of the costs of maintaining a home for the **entire** year for yourself and your dependent(s) or other qualifying individuals. Cost of maintaining the home includes such items as rent, property insurance, property taxes, mortgage interest, repairs, utilities, and cost of food. It does not include the individual's personal expenses or any amount which represents value of services performed by a member of the household of the taxpayer.

Worksheet A — **Regular Withholding Allowances**

(A)	Allowance for yourself — enter 1	(A)
(B)	Allowance for your spouse (if not separately claimed by your spouse) — enter 1	(B)
(C)	Allowance for blindness — yourself — enter 1	(C)
(D)	Allowance for blindness — your spouse (if not separately claimed by your spouse) — enter 1	(D)
(E)	Allowance(s) for dependent(s) — do not include yourself or your spouse	(E)
(F)	Total — add lines (A) through (E) above and enter on line 1a of the DE 4	(F)

Instructions — 2 — (Optional) Additional Withholding Allowances

If you expect to itemize deductions on your California income tax return, you can claim additional withholding allowances. Use Worksheet B to determine whether your expected estimated deductions may entitle you to claim **one or more additional** withholding allowances. Use last year's FTB Form 540 as a model to calculate this year's withholding amounts.

Do not include deferred compensation, qualified pension payments, or flexible benefits, etc., that are deducted from your gross pay but are not taxed on this worksheet.

You may reduce the amount of tax withheld from your wages by claiming one additional withholding allowance for each $1,000, or fraction of $1,000, by which you expect your estimated deductions for the year to exceed your allowable standard deduction.

Worksheet B — **Estimated Deductions**

Use this worksheet **only** if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income not subject to withholding.

1.	Enter an estimate of your itemized deductions for California taxes for this tax year as listed in the schedules in the FTB Form 540		1.
2.	Enter $10,404 if married filing joint with two or more allowances, unmarried head of household, or qualifying widow(er) with dependent(s) or $5,202 if single or married filing separately, dual income married, or married with multiple employers	–	2.
3.	Subtract line 2 from line 1, enter difference	=	3.
4.	Enter an estimate of your adjustments to income (alimony payments, IRA deposits)	+	4.
5.	Add line 4 to line 3, enter sum	=	5.
6.	Enter an estimate of your nonwage income (dividends, interest income, alimony receipts)	–	6.
7.	If line 5 is greater than line 6 (if less, see below [go to line 9]); Subtract line 6 from line 5, enter difference	=	7.
8.	Divide the amount on line 7 by $1,000, round any fraction to the nearest whole number enter this number on line 1b of the DE 4. Complete Worksheet C, if needed, otherwise **stop here**.		8.
9.	If line 6 is greater than line 5; Enter amount from line 6 (nonwage income)		9.
10.	Enter amount from line 5 (deductions)		10.
11.	Subtract line 10 from line 9, enter difference. Then, complete Worksheet C.		11.

*Wages paid to registered domestic partners will be treated the same for state income tax purposes as wages paid to spouses for California PIT withholding and PIT wages. This law does not impact federal income tax law. A registered domestic partner means an individual partner in a domestic partner relationship within the meaning of section 297 of the Family Code. For more information, please call our Taxpayer Assistance Center at 1-888-745-3886.

Worksheet C **Additional Tax Withholding and Estimated Tax**

1.	Enter estimate of total wages for tax year 2023.	1.
2.	Enter estimate of nonwage income (line 6 of Worksheet B).	2.
3.	Add line 1 and line 2. Enter sum.	3.
4.	Enter itemized deductions or standard deduction (line 1 or 2 of Worksheet B, whichever is largest).	4.
5.	Enter adjustments to income (line 4 of Worksheet B).	5.
6.	Add line 4 and line 5. Enter sum.	6.
7.	Subtract line 6 from line 3. Enter difference.	7.
8.	Figure your tax liability for the amount on line 7 by using the 2023 tax rate schedules below.	8.
9.	Enter personal exemptions (line F of Worksheet A x $154.00).	9.
10.	Subtract line 9 from line 8. Enter difference.	10.
11.	Enter any tax credits. (See FTB Form 540).	11.
12.	Subtract line 11 from line 10. Enter difference. This is your total tax liability.	12.
13.	Calculate the tax withheld and estimated to be withheld during 2023. Contact your employer to request the amount that will be withheld on your wages based on the marital status and number of withholding allowances you will claim for 2023. Multiply the estimated amount to be withheld by the number of pay periods left in the year. Add the total to the amount already withheld for 2023.	13.
14.	Subtract line 13 from line 12. Enter difference. If this is less than zero, you do not need to have additional taxes withheld.	14.
15.	Divide line 14 by the number of pay periods remaining in the year. Enter this figure on line 2 of the DE 4.	15.

Note: Your employer is not required to withhold the additional amount requested on line 2 of your DE 4. If your employer does not agree to withhold the additional amount, you may increase your withholdings as much as possible by using the “single” status with “zero” allowances. If the amount withheld still results in an underpayment of state income taxes, you may need to file quarterly estimates on Form 540-ES with the FTB to avoid a penalty.

These Tables Are for Calculating Worksheet C and for 2023 Only

Single Persons, Dual Income Married or Married With Multiple Employers

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...		PLUS
$0	$10,099	1.100%	$0	$0.00
$10,099	$23,942	2.200%	$10,099	$111.09
$23,942	$37,788	4.400%	$23,942	$415.64
$37,788	$52,455	6.600%	$37,788	$1,024.86
$52,455	$66,295	8.800%	$52,455	$1,992.88
$66,295	$338,639	10.230%	$66,295	$3,210.80
$338,639	$406,364	11.330%	$338,639	$31,071.59
$406,364	$677,275	12.430%	$406,364	$38,744.83
$677,275	$1,000,000	13.530%	$677,275	$72,419.07
$1,000,000	and over	14.630%	$1,000,000	$117,556.49

Married Persons

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...		PLUS
$0	$20,198	1.100%	$0	$0.00
$20,198	$47,884	2.200%	$20,198	$222.18
$47,884	$75,576	4.400%	$47,884	$831.27
$75,576	$104,910	6.600%	$75,576	$2,049.72
$104,910	$132,590	8.800%	$104,910	$3,985.76
$132,590	$677,278	10.230%	$132,590	$6,421.60
$677,278	$812,728	11.330%	$677,278	$62,143.18
$812,728	$1,000,000	12.430%	$812,728	$77,489.67
$1,000,000	$1,354,550	13.530%	$1,000,000	$100,767.58
$1,354,550	and over	14.630%	$1,354,550	$148,738.20

Unmarried Head of Household

IF THE TAXABLE INCOME IS		COMPUTED TAX IS		
OVER	BUT NOT OVER	OF AMOUNT OVER...		PLUS
$0	$20,212	1.100%	$0	$0.00
$20,212	$47,887	2.200%	$20,212	$222.33
$47,887	$61,730	4.400%	$47,887	$831.18
$61,730	$76,397	6.600%	$61,730	$1,440.27
$76,397	$90,240	8.800%	$76,397	$2,408.29
$90,240	$460,547	10.230%	$90,240	$3,626.47
$460,547	$552,658	11.330%	$460,547	$41,508.88
$552,658	$921,095	12.430%	$552,658	$51,945.06
$921,095	$1,000,000	13.530%	$921,095	$97,741.78
$1,000,000	and over	14.630%	$1,000,000	$108,417.63

If you need information on your last California Resident Income Tax Return, FTB Form 540, visit (FTB) (ftb.ca.gov).

The DE 4 information is collected for purposes of administering the PIT law and under the authority of Title 22, CCR, section 4340-1, and the California Revenue and Taxation Code, including section 18624. The Information Practices Act of 1977 requires that individuals be notified of how information they provide may be used. Further information is contained in the instructions that came with your last California resident income tax return.

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HACIENDA LA PUENTE UNIFIED SCHOOL DISTRICT

OATH OF ALLEGIANCE FOR PUBLIC EMPLOYEES OR OFFICERS

FILL OUT AND FILE WITH OFFICIAL IN CHARGE OF OFFICE
OR SCHOOL IN WHICH YOU ARE EMPLOYED

In accordance with the adoption of Proposition 6 on the November 1952 General Election ballot and effective November 5, 1952, as amended by the Supreme Court decision effective January 20, 1968, each employee or officer is required to take and subscribe to the Oath of Allegiance as required by said Proposition. No compensation for services nor reimbursement for expense incurred shall be paid unless the employee or officer has taken and subscribed to this Oath.

OATH OF ALLEGIANCE

"I ____, do solemnly swear (or affirm) that I will support and defend the CONSTITUTION OF THE UNITED STATES AND THE CONSTITUTION OF THE STATE OF CALIFORNIA against all enemies, foreign and domestic; that I will bear true fair and allegiance to the CONSTITUTION OF THE UNITED STATES AND THE CONSTITUTION OF THE STATE OF CALIFORNA; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties of the office of _
Walk-On Coach______________________ upon which I am about to enter."
(Name of Office)

____
SIGNATURE OF EMPLOYEE

____
BIRTHDATE

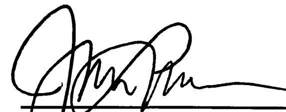
____
TELEPHONE NUMBER

____
ZIP CODE

(DO NOT WRITE BELOW THIS LINE)

Subscribed and affirmed to before me this ____________________day

Of____________________, 2024.



____
ASSISTANT SUPERINTENDENT
HUMAN RESOURCES

SEAL

The Oath of Allegiance may be subscribed to before any notary public or any member of a board of education or board of trustees, superintendent, associate or assistant superintendent, junior college director or president, high school or elementary school principal, (Education Code Section 61) or other legally authorized official.

Form #1001 (Rev. 1/24)

HACIENDA LA PUENTE UNIFIED SCHOOL DISTRICT

15959 GALE AVE. • CITY OF INDUSTRY, CA 91745 • (626) 933-3870 • (626) 333-6313

WARRANT(S) RECIPIENT DESIGNATION

Under the provisions of Section 53245 of the California Government Code, in the event of my death I hereby designate the following named person to be entitled to receive all warrants payable to me by the Hacienda La Puente Unified School District had I survived:

Beneficiary Information

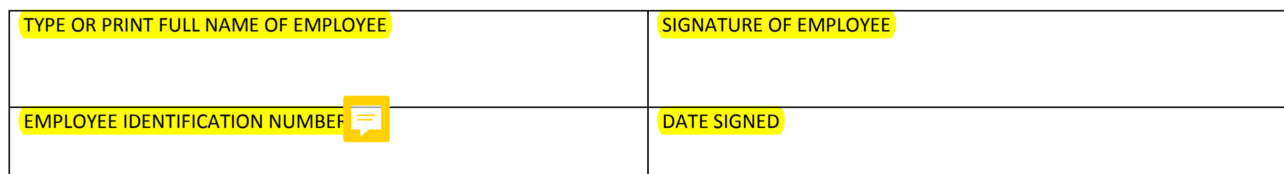
TYPE OR PRINT FULL NAME OF DESIGNEE	RELATIONSHIP TO EMPLOYEE
ADDRESS (NUMBER, STREET, CITY, STATE AND ZIP CODE)	
PHONE NUMBER	SOCIAL SECURITY NUMBER

Contingent Beneficiary Information

IF THE BENEFICIARY NAMED ABOVE IS NOT LIVING THEN PAY:	RELATIONSHIP TO EMPLOYEE
ADDRESS (NUMBER, STREET, CITY, STATE AND ZIP CODE)	
PHONE NUMBER	SOCIAL SECURITY NUMBER

This designation cancels and replaces any previously signed by me for this purpose and shall remain in effect until cancelled in writing by me.

It is expressly understood and agreed that Hacienda La Puente Unified School District is not obligated to deliver said warrants to the person designated hereinabove unless said designated person, within two years after the date of said warrant or warrants, claims said warrants from the Hacienda La Puente Unified School District and provides to said Hacienda La Puente Unified School District sufficient proof of identity pursuant to the provisions of Section 53245 of California Government Code.



TYPE OR PRINT FULL NAME OF EMPLOYEE	SIGNATURE OF EMPLOYEE
EMPLOYEE IDENTIFICATION NUMBER	DATE SIGNED

FORM NO 1048

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CalPERS

State of California
California Public Employees' Retirement System
www.calpers.ca.gov

Reciprocal Self-Certification Form

Complete the following information and return this form to your employer within 10 business days to determine your eligibility for benefits in CalPERS. Only provide details for membership in the retirement systems found on the enclosed ***List of Qualifying Reciprocal Retirement Systems in California*** document.

Section 1: Member Information

Member Name

Date of Birth **CalPERS ID** **Enrollment Date with this Employer**

Are you a member of CalPERS with funds on deposit? ◯ **Yes** ◯ **No**

Are you a member of the defined benefit plan of one of the retirement systems listed on the enclosed List of Qualifying Reciprocal Retirement Systems in California? ◯ **Yes** ◯ **No** If yes, complete Section 2 with membership information for each qualifying reciprocal retirement system. Do not provide CalPERS data on this form. **If no, skip to Section 3.**

Section 2: Qualifying Reciprocal Membership Information

The data you provide must be validated with your reciprocal system. Failure to validate information may result in enrollment errors. Refer to the ***List of Qualifying Reciprocal Retirement Systems in California*** and only include details on this form for membership under the retirement systems listed, not employment covered by CalPERS.

1) Name of most recent reciprocal retirement system:

   Membership date in most recent reciprocal system (MM/DD/YYYY):

   Are you currently active with this reciprocal system? ◯ **Yes** ◯ **No**, provide separation date (or last activity date if a member of CalSTRS (MM/DD/YYYY):

   Did you receive a refund from this reciprocal system? ◯ **Yes** ◯ **No**, provide refund date (MM/DD/YYYY):

   Did you retire from this reciprocal system? ◯ **Yes** ◯ **No**, provide retirement date (MM/DD/YYYY):

   Note: Provide details below for a second reciprocal system or additional membership periods, if applicable. If not, skip to Section 3.

2) Name of reciprocal retirement system:

   Membership date (MM/DD/YYYY):

   Are you currently active with this reciprocal system? ◯ **Yes** ◯ **No**, provide separation date (or last activity date if a member of CalSTRS (MM/DD/YYYY):

   Did you refund from this reciprocal system? ◯ **Yes** ◯ **No**, provide refund date (MM/DD/YYYY):

   Did you retire from this reciprocal system? ◯ **Yes** ◯ **No**, provide retirement date (MM/DD/YYYY):

   Note: If you have additional reciprocal membership, attach a second form. If not, skip to Section 3.

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Section 3: Sign and Certify

I understand that I am subject to the applicable laws and regulations of each system where I have membership. I also understand that completing this form will only determine my enrollment eligibility in CalPERS. It is not a request to establish reciprocity.

I certify that the information on this form has been verified with the qualifying reciprocal retirement system as true and correct and any information found to be incorrect may require corrections to my CalPERS account including, but not limited to, my retirement enrollment level or formula and adjustments to my member contributions. CalPERS may make any necessary corrections to my account to ensure I am properly enrolled and eligible to receive the correct retirement benefits.

Member Signature **Date**

List of Qualifying Reciprocal Retirement Systems in California

Only provide membership information on the ***Reciprocal Self-Certification*** form for membership in the defined benefit plan of the following systems. **CalPERS data should not be included in Section 2 of the form**.

- Alameda County Employees' Retirement Association (ACERA)
- California State Teachers' Retirement System (CalSTRS) – Defined benefit (DB) plan only; cash balance plans not eligible
- City and County of San Francisco Employees' Retirement System (SFERS)
- City of Concord Retirement System*
- City of Costa Mesa Public Retirement System* – Safety only
- City of Delano Retirement System*
- City of Fresno Retirement System (CFRS)
- City of Pasadena Fire and Police Retirement System – Fire and police only
- City of San Clemente* - Miscellaneous only
- City of San Jose Office of Retirement Services – Safety and miscellaneous
- Contra Costa County Employees' Retirement Association (CCCERA)
- Contra Costa Water District (CCWD)
- East Bay Municipal Utility District (EBMUD)
- East Bay Regional Park District – Safety only
- Fresno County Employees' Retirement Association (FCERA)
- Imperial County Employees' Retirement Association (ICERS)
- Judges Retirement System II (JRS II)
- Kern County Employees' Retirement Association (KCERA)
- Legislators' Retirement System (LRS)
- Los Angeles City Employees' Retirement System (LACERS) – Miscellaneous only; L.A. Fire and Police Pension System and L.A. Water and Power Employees' Retirement System not eligible
- Los Angeles County Employees' Retirement Association (LACERA)
- Los Angeles County Metropolitan Transportation Authority* (LACMTA)
- Marin County Employees' Retirement Association (MCERA)
- Mendocino County Employees' Retirement Association (MCERA)
- Merced County Employees' Retirement Association (MCERA)
- Oakland Municipal Employees' Retirement System (City of Oakland)* – Miscellaneous only
- Orange County Employees' Retirement System (OCERS)
- Sacramento City Employees' Retirement System*
- Sacramento County Employees' Retirement System (SCERS) – DB plan only; cash balance plans not eligible
- San Bernardino County Employees' Retirement Association (SBCERA)
- San Diego City Employees' Retirement System (SDCERS) – DB plan only; cash balance plans not eligible
- San Diego County Employees' Retirement Association (SDCERA)
- San Joaquin County Employees' Retirement Association (SJCERA)
- San Luis Obispo County Pension Trust (SLOCPT)
- San Mateo County Employees' Retirement Association (SamCERA)
- Santa Barbara County Employees' Retirement System (SBCERS)
- Sonoma County Employees' Retirement Association (SCERA)
- Stanislaus County Employees' Retirement Association (StanCERA)
- Tulare County Employees' Retirement Association (TCERA)
- University of California Retirement Program (UCRP) – DB plan only; cash balance plans not eligible
- Ventura County Employees' Retirement Association (VCERA)

***CalPERS-covered agency –** *Only include details on this form if you were a member under the reciprocal retirement systems listed and not CalPERS-covered

CalPERS Privacy Notice

The privacy of personal information is of the utmost importance to CalPERS. The following information is provided to you in compliance with the Information Practices Act of 1977 and the Federal Privacy Act of 1974.

Information Purpose
The information requested is collected pursuant to the Government Code (sections 20000 et seq.) and will be used to conduct CalPERS Board of Administration duties under the Public Employees' Retirement Law, the Social Security Act, and/or the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to submit the required information may result in CalPERS being unable to perform its functions regarding your status.

Please do not include information that is not requested.

Social Security Numbers
Social Security numbers are collected either on a mandatory or voluntary basis. If this is CalPERS' first request for disclosure of your Social Security number, then disclosure is mandatory. If your Social Security number has already been provided, disclosure is voluntary. Due to the use of Social Security numbers by other agencies for identification purposes, we may be unable to verify eligibility for benefits without the number.

Social Security numbers are used for the following purposes:
1. Enrollee identification
2. Payroll deduction/state contributions
3. Billing of contracting agencies for employee/employer contributions
4. Reports to CalPERS and other state agencies
5. Coordination of benefits among carriers
6. Resolving member appeals, complaints, or grievances with health plan carriers

Information Disclosure
Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

Your Rights
You have the right to review your membership files maintained by CalPERS. For questions about this notice, our Privacy Policy, or your rights, write to:

CalPERS
CalPERS Privacy Officer
400 Q Street
Sacramento, CA 95811

You may also call us at **888 CalPERS** (or **888**-225-7377).

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HACIENDA LA PUENTE UNIFIED SCHOOL DISTRICT
Office of Human Resources

RETIREMENT QUESTIONNAIRE

1. Are you a member of a Retirement System? Yes No

   If yes, indicate below which one:

   ☐ CalPERs
   ☐ CalSTRs
   ☐ Other- Retirement System Name: ____________________
   Employer: ____________________

2. Were you ever a member of a Retirement System? Yes No

   If yes, indicate below which one:

   ☐ CalPERS
   ☐ CalSTRS
   ☐ Other- Retirement System Name: ____________________
   Employer: ____________________

3. Did you withdraw your funds? Yes No

4. Are you now collecting retirement benefits? Yes No

   If yes, indicate below which one:

   ☐ CalPERS
   ☐ CalSTRS
   ☐ Other- Retirement System Name: ____________________
   Employer: ____________________

5. Are you a full-time employee at another school district? Yes No

   *If yes, name:*____________________

6. Are you a substitute and/or hourly employee at another district? Yes No

   If yes, last school year did you, check all that apply:*

   ☐ Reach 100 days of service, *if CalSTRS*
   ☐ Reach 600 hours of service, *if CalSTRS*
   ☐ Reach combination of both, *if CalSTRS*
   ☐ Reach 1000 hours of service, *if CalPERS*

   **Combined service in all districts is counted toward qualifying retirement.*

By signing below I acknowledge I have provided information to the best of my knowledge and agree to inform Hacienda La Puente Unified School District if or when I reach qualifying retirement service to avoid costly adjustments or possible delays to my payroll check.

____________________ ____________________ __________
Print Name Signature Date

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HACIENDA LA PUENTE UNIFIED SCHOOL DISTRICT

Office of the Assistant Superintendent, Human Resources

To: HLPUSD Employees
From: John Lovato, Ed.D.
Regarding: 2024-2025 Annual Employee Reminders

This is an annual reminder that your supervisor will provide the following information, which you must review.

Department of Fair Employment and Housing-
DFEH EO7 **(Revised) -** California Law Prohibits Workplace Discrimination and Harassment
DFEH 100-21 **(Revised) -** Family Care and Medical Leave and Pregnancy Disability
DFEH 185 **(Revised) -** Sexual Harassment
DFEH EO4 **(Revised)** - Transgender Rights in the Workplace
DFEH E09 **(Revised) -** Your Rights and Obligations as a Pregnant Employee
DFEH E18 **(New)** – Reproductive Loss Leave

Board Policies and Administrative Directives-
Board Policy/Directive - 1113 District and School Web Sites
Board Policy/Directive - 1311 Civility Policy
Board Policy/Directive **(Revised)** - 1312.3 Uniform Complaint Procedure
Board Policy/Directive - 3513.3(a) Tobacco Free School
Board Policy/Directive - 3520 Use of District Computers/Network
Board Policy - 4020 Drug and Alcohol-Free Workplace
Board Policy **(Revised)**/Directive **(Revised)** - 4030 Nondiscrimination in Employment
Directive **(Revised)** - AR 4031 – Complaints Concerning Discrimination in Employment
Board Policy - 4040 - Employee Use of Technology
Board Policy - 4119.21, E 4119.21(a)(b)(c), E 4219.21, E 4319.21 Professional Standards & Code of Ethics
Board Policy - 4119.22, 4219.22, 4319.22 Dress and Grooming
Board Policy - 4131.7, 4231.7, 4331.7 Weapons and Dangerous Instruments
Board Policy/Directive - 4119.11, 4219.11, 4319.11 Sexual Harassment – Employees
Board Policy - 5131.2 Bullying
Board Policy/Directive - 5141.4 - Child Abuse Reporting
Board Policy/Directive - 5141.52 Suicide Prevention
Board Policy/Directive - 5145.7(a) Sexual Harassment – Students
Board Policy/Directive - 5145.13 Response to Immigration Enforcement
Board Policy/Directive - 6163.4(a) Internet Use and Safety

Forms and Policies-
District Form - Employee/Student Interaction Notice *(Employee should have a signed copy in personnel file with H.R.)*
District Policy - Board of Education (Guiding Principles/Vision Statement/Board Goals)
District Policy - Employee Responsibilities/Political Activities
District Policy - Employee Safety & Security/Work Related Injuries
District Policy - Absences (Frontline Absence Management & Lesson Plan)
District Policy - Attendance/Employee Use of Technology/Personal Communication Device Usage
District Form - Unsafe and/or Unhealthful Conditions Notification (Form#1115)

Supervisor: Please review each document to be knowledgeable of the District's position in each area prior to discussing with your employees and reproduce and/or post these publications, policies and directives in a highly visible space at your site.

Please contact me if you have any questions or concerns.

Employee: I have been given, read, understand, and agree to comply with the above policies; including my responsibility as a mandated reporter of child abuse.

____________________	____________________	____________________
Employee Printed Name	Employee Signature	Date

(To order copies of this packet please submit a print shop request and reference Form #1870)

July 1, 2024 – Form #1870

Click here to view full document.

Hacienda La Puente Unified School District
2024 - 2025 PAYROLL SCHEDULE

HOURLY/DAILY EMPLOYEES
(Noon Aides/Other Employees/Clerical Subs/Sub Teachers)

Listed are the payroll timesheet due dates for the 2024/2025 fiscal year for **HOURLY/DAILY** employees. The Payroll Department must meet deadlines required by the Los Angeles County Office of Education (LACOE). It is imperative that all sites/employees adhere to the payroll due dates listed.

EMPLOYEE IS RESPONSIBILE FOR PROVIDING ORIGINAL TIMESHEETS TO PAYROLL

- **PAID ON THE 5TH OF THE MONTH**

Timesheet Check-off List:

- Typed or filled out in Ink, no pencil will be accepted.
- Last Name, First Name
- EID or Social Security
- Employee Signature
- Administrative Signature
- Sacs String and REQ. #
- Total Hours or Total Days added up
- Separate timesheet for each month

***Dates subject to change**

Note: Processing dates are tentative until schedule is published by LACOE. If any changes occur all sites will be notified of change prior to the payroll month.

Timesheets paid on the 5th of the month are ultimately due the 18th of each month. If the 18th falls on a weekend, the timesheets are due the Friday before the 18th.

Timesheets that are not received by the 18th will be paid on the next hourly payroll

Hacienda La Puente Unified School District
2024 - 2025 PAYROLL SCHEDULE

HOURLY/DAILY EMPLOYEES

(Site Supervision Aides/Sub Teachers/Clerical Subs/Other Employees)

- **PAID ON THE 5TH OF THE MONTH**

HOURLY		PAYROLL SCHEDULE	DUE TO PAYROLL	PAYROLL ISSUE DATE
July	2024	07/01/24-07/18/24	07/18/24	08/05/24
August	2024	07/19/24-07/31/24 08/01/24-08/16/24	07/31/24 08/16/24	09/05/24
September	2024	08/17/24-08/31/24 09/01/24-09/18/24	08/30/24 09/18/24	10/04/24
October	2024	09/19/24-09/30/24 10/01/24-10/18/24	09/30/24 10/18/24	11/05/24
November	2024	10/19/24-10/31/24 11/01/24-11/18/24	10/31/24 11/18/24	12/05/24
December*	2024	11/19/24-11/30/24 12/01/24-12/18/24	12/02/24 12/18/24	01/03/25
January*	2025	12/19/24-12/31/24 1/01/25-01/17/25	01/02/25 01/17/25	02/05/25
February	2025	01/18/25-01/31/25 02/01/25-02/16/25	01/31/25 02/16/25	03/05/25
March	2025	02/17/25-02/28/25 03/01/25-03/18/25	02/28/25 03/18/25	04/04/25
April	2025	03/19/25-03/31/25 04/1/25-04/18/25	03/31/25 04/18/25	05/05/25
May	2025	04/19/25-04/30/25 05/01/25-05/23/25	04/30/25 05/23/25	06/05/25
June	2025	05/24/25-05/31/25 06/1/25-06/18/25	06/02/25 06/18/25	07/03/25 *SUMMER PAYROLL
June	2025	06/19/25-06/30/25	06/30/25	07/10/25 *SUMMER PAYROLL

HACIENDA LA PUENTE UNIFIED SCHOOL DISTRICT
RISK MANAGEMENT OFFICE
15959 EAST GALE AVENUE • CITY OF INDUSTRY, CALIFORNIA 91745-0002 PHONE (626) 933-3860
• FAX (626) 933-3863

NOTICE OF HACIENDA LA PUENTE UNIFIED SCHOOL DISTRICT HEALTH INFORMATION PRIVACY PRACTICES

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by employer health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan – whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of these plans: Self-funded Dental, Self-funded Vision, EASE and FSA plans. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan or HMO option, you will receive a notice directly from the Insurer or HMO. It's important to note that these rules apply to the Plan, not *Hacienda La Puente USD* as an employer – that's the way the HIPAA rules work. Different policies may apply to other Hacienda La Puente USD programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- ***Treatment*** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.

- ***Payment*** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing; as well as "behind the scenes" plan functions such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.

- ***Health care operations*** include activities by this Plan (and in limited circumstances other plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes. The Plan may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you, as permitted by law.

How the Plan may share your health information with Hacienda La Puente USD

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to Hacienda La Puente USD for plan administration purposes. Hacienda La Puente USD may need your health information to administer benefits under the Plan. Hacienda La Puente USD agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Risk Management, Human Resources, Payroll, and Legal staff are the only Hacienda La Puente USD employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and Hacienda La Puente USD, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to Hacienda La Puente USD if requested, for purposes of obtaining premium bids to provide coverage under the Plan, or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.

- The Plan, or its insurer or HMO, may disclose to Hacienda La Puente USD information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO medical offered by the Plan.

In addition, you should know that Hacienda La Puente USD cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Hacienda La Puente USD from other sources, for example under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation is *not* protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made – for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify

proceedings	you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use or disclosure of your unsecured health information as required by law.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death – or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing. The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

Effective February 17, 2010, an entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid for the item or service, in full out of pocket.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.
If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible onsite), the Plan will provide you with:

- the access or copies you requested;

- a written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or

- a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage.
If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed of where to direct your request.
Effective February 17, 2010, you may request an electronic copy of your health information if it is maintained in an electronic health record. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. Any charge that is assessed to you for these copies, if any, must be reasonable and based on the Plan's cost.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).
If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will:

- make the amendment as requested;

- provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or

- provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the

disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.
You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made:

- for treatment, payment, or health care operations;
- to you about your own health information;
- incidental to other permitted or required disclosures;
- where authorization was provided;
- to family members or friends involved in your care (where disclosure is permitted without authorization);
- for national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
- as part of a "limited data set" (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official. If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect as of August 1, 2011. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's

privacy policies described in this notice, you will be provided with a revised privacy notice via inter-office memorandum.

Complaints

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, send it in writing (or via email) to the District Office:

Attention: Hal Longan
15959 East Gale Avenue
City of Industry, CA 91745

Contact

For more information on the Plan's privacy policies or your rights under HIPAA, contact Hal Longan, Director, Risk Management/Prevention at (626) 933-3860.

HACIENDA LA PUENTE UNIFIED SCHOOL DISTRICT
RISK MANAGEMENT OFFICE

15959 EAST GALE AVENUE • P.O. BOX 60002 • CITY OF INDUSTRY, CALIFORNIA 91716-0002
PHONE (626) 933-3860 • FAX (626) 933-3863

TO: HLPUSD Employees
FROM: Hal Longan, Director of Risk Management d Benefits
RE: Workers' Compensation Pre-Designation Form for the 2024-2025 School Year

Welcome back to another exciting school year! The purpose of this memo is to inform you about your choices in receiving medical treatment if you have a work-related accident. While the District continuously works towards a safe environment, we realize accidents happen. The District has designated Universal Industrial Health Care to treat on-the-job injuries. In the event that you sustain a work-related injury or illness that requires medical attention, you have three options:

Option 1: Go to Universal Industrial Care and be treated for your on-the-job injury.
Option 2: Select a medical provider from our Medical Provider Network (MPN).
Option 3: Pre-designate your personal physician in advance of incurring a work-related injury. To do so, it is required that you **annually** complete the **Pre-Designated Physician Form.**

Your personal physician must complete and sign Section 2 of the Pre-Designation form, thereby agreeing to treat you under workers' compensation guidelines. If your personal physician does not complete and sign Section 2, you will not be able to treat with your physician for any work related injury.

If you want your primary care physician to treat your industrial injury or occupational illness, you must complete Section 1 and have your personal physician complete and sign Section 2.

If you are pre-designating Kaiser, your primary care physician does not have to complete Section 2. Check "Kaiser" in the box provided. Employees who designate Kaiser on their Pre-Designation form will go to Kaiser Occupational Medicine Clinic for treatment.

The pre-designation form must be on file with the Risk Management Office by Friday, August 30, 2024. This pre-designation form is effective from 8/01/2024 through 08/31/2025.

Please contact the Risk Management Office at (626) 933-3860, (626) 933-3861 or (626) 933-3862 if you have questions or need additional information.

RISK MANAGEMENT OFFICE

As a District employee and pursuant to Labor Code Section 4600(d) (1), you may pre-designate your personal physician to treat on-the-job injuries during the 2024-2025 school year. If you do not pre-designate, the District will refer you to an appropriate physician. This pre-designation form is effective from 08/01/2024 through 08/31/2025.

REQUIREMENTS For an on-the-job injury, your pre-designated physician must be on file with the District before your date of Injury.

- ❖ Pursuant to Labor Code 4600(d) (2), a personal physician shall meet all of the following conditions:
  - (A) The physician is the employee's regular physician and surgeon, licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.
  - (B) The physician is the employee's primary care physician and has previously directed the medical treatment of the employee, and retains the employee's medical records, including his/her medical history.
  - (C) The physician agrees to be pre-designated.
- ❖ Complete the form below in its entirety, sign and date the form. If you pre-designate Kaiser Permanente, you do not have to complete Section 2 below. If you pre-designate a physician who is **not** a doctor with Kaiser Permanente, you must complete and sign Section 1, and have your physician complete and sign Section 2 below.
- ❖ You must update your pre·designation annually, or if you change primary care physicians. The pre-designated physician must be your primary care physician prior to your date of injury.
- ❖ Submit the completed form to: Hacienda La Puente Unified School District, Risk Management Office; 15959 E. Gale Avenue; City of Industry, CA 91716·0002; Fax (626) 933-3863.

NOTE: Those pre-designating "Kaiser" will be sent to a Kaiser Occupational-Medicine Clinic (Kaiser-On-The-Job)

SECTION 1 (Please print clearly)

Employee Name:______________________Employee SS#:____________Date of Hire: __________

Employee Work Phone: ( )__________________Employee Home Phone: ( ) __________________

Personal Physician Name: ____

Physician named above is my primary care physician under the following health plan provider:

□ Anthem   � Kaiser Permanente   � Other

Employee Declaration:
In the event that I receive an injury on duty, I designate my personal physician (as defined in Labor Code Section 4600(d) (2) identified above as my workers' compensation physician. He/She is my regular and primary care physician, retains my medical records, is willing to complete the required workers' compensation forms, and is willing to keep the Risk Management Office informed of my medical status.

Employee Signature:______________________________Date: ______________

SECTION 2 (Do not complete this section if pre-designating Kaiser Permanente)

Physician Specialty: ____

Physician Address: ____

Physician Phone: ( )____________________Physician Tax I.D. # __________________

Personal Physician declaration:
I am the personal physician (as defined in Labor Code Section 4600(d) (2) for the employee named above.
I am this employee's regular and primary care physician.
I retain this employee's medical records.
I agree to be this employee's pre-designated physician, complete all required workers' compensation forms, and keep the Risk Management Office informed of the employee's status regarding any occupational related treatment.

□ I decline the request of the above named employee, to be named as his/her treating physician for work related injuries.

Physician Signature:______________________________Date: ______________

Risk Management Approval:__________________________Date: ______________

Important Information about Medical Care if you have a Work-Related Injury or Illness

Complete Written Employee Notification regarding Medical Provider Network
(Title 8, California Code of Regulations, Section 9767.12)

California law requires your employer to provide and pay for medical treatment if you are injured at work. Your employer has chosen to provide this medical care by using a Workers' Compensation physician network called a Medical Provider Network (MPN). This MPN is administered by Harbor Health Systems.

This notification tells you what you need to know about the MPN program and describes your rights in choosing medical care for work-related injuries and illnesses.

- **What happens if I get injured at work?**

  In case of an emergency, you should call 911 or go to the closest emergency room.

  If you are injured at work, notify your employer as soon as possible. Your employer will provide you with a claim form. When you notify your employer that you have had a work-related injury, your employer or insurer will make an initial appointment with a doctor in the MPN.

- **What is an MPN?**

  A Medical Provider Network (MPN) is a group of health care providers (physicians and other medical providers) used by YOUR EMPLOYER to treat workers injured on the job. MPNs must allow employees to have a choice of provider(s). Each MPN must include a mix of doctors specializing in work-related injuries and doctors with expertise in general areas of medicine.

- **What MPN is used by my employer?**

  Your employer is using the PRIME PLUS MPN Powered by Harbor Health Systems MPN with the identification number 2357. You must refer to the MPN name and the MPN identification number whenever you have questions or requests about the MPN.

- **Who can I contact if I have questions about my MPN?**

  The MPN Contact listed in this notification will be able to answer your questions about the use of the MPN and will address any complaints regarding the MPN.

  The contact for your MPN is:

  Name: Harbor Health Systems MPN Contact
  Title: MPN Contact
  Address: P.O. Box 11779, Newport Beach, CA 92658-5041
  Telephone Number: (888) 626-1737
  Email address: MPNcontact@harborsys.com

  General information regarding the MPN can also be found at the following website:
  www.harborsys.com/KeenanPlus.

- **What if I need help finding and making an appointment with a doctor?**

  The MPN's Medical Access Assistant will help you find available MPN physicians of your choice and can assist you with scheduling and confirming physician appointments. The Medical Access Assistant is available to assist you Monday through Saturday from 7am-8pm (Pacific) and schedule medical appointments during doctors' normal business hours. Assistance is available in English and in Spanish.

  The contact information for the Medical Access Assistant is:

  Toll Free Telephone Number: (855) 521-7080
  Fax Number: (703) 673-0181
  Email Address: MPNMAA@harborsys.com

- **How do I find out which doctors are in my MPN?**

  You can get a regional list of all MPN providers in your area by calling the MPN Contact or by going to our website at: www.harborsys.com/KeenanPlus. At minimum, the regional list must include a list of all MPN providers within 15 miles of your workplace and/or residence or a list of all MPN providers within the county where you live and/or work. You may choose which list you wish to receive. You also have the right to obtain a list of all the MPN providers upon request.

  You can access the roster of all treating physicians in the MPN by going to the website: www.harborsys.com/KeenanPlus.

- **How do I choose a provider?**

  Your employer or the insurer for your employer will arrange the initial medical evaluation with an MPN physician. After the first medical visit, you may continue to be treated by that doctor, or you may choose another doctor from the MPN. You may continue to choose doctors within the MPN for all of your medical care for this injury.

  If appropriate, you may choose a specialist or ask your treating doctor for a referral to a specialist. Some specialists will only accept appointments with a referral from the treating doctor. Such specialist might be listed as "by referral only" in your MPN directory.

  If you need help in finding a doctor or scheduling a medical appointment, you may call the Medical Access Assistant.

- **Can I change providers?**

  Yes. You can change providers within the MPN for any reason, but the providers you choose should be appropriate to treat your injury. Contact the MPN Contact or your claims adjuster if you want to change your treating physician.

- **What standards does the MPN have to meet?**

  The MPN has providers for the entire State of California.

  The MPN must give you access to a regional list of providers that includes at least three physicians in each specialty commonly used to treat work injuries/illnesses in your industry. The MPN must provide access to primary treating physicians within 30 minutes or 15 miles and specialists within 60 minutes or 30 miles of where you work or live.

  If you live in a rural area or an area where there is a health care shortage, there may be a different standard.

  After you have notified your employer of your injury, the MPN must provide initial treatment within 3 business days. If treatment with a specialist has been authorized, the appointment with the specialist must be provided to you within 20 business days of your request.

  If you have trouble getting an appointment with a provider in the MPN, contact the Medical Access Assistant.

If there are no MPN providers in the appropriate specialty available to treat your injury within the distance and timeframe requirements, then you will be allowed to seek the necessary treatment outside of the MPN.

- **What if there are no MPN providers where I am located?**

If you are a current employee living in a rural area or temporarily working or living outside the MPN service area, or you are a former employee permanently living outside the MPN service area, the MPN or your treating doctor will give you a list of at least three physicians who can treat you. The MPN may also allow you to choose your own doctor outside of the MPN network. Contact your MPN Contact for assistance in finding a physician or for additional information.

- **What if I need a specialist that is not available in the MPN?**

If you need to see a type of specialist that is not available in the MPN, you have the right to see a specialist outside of the MPN.

- **What if I disagree with my doctor about medical treatment?**

If you disagree with your doctor or wish to change your doctor for any reason, you may choose another doctor within the MPN.

If you disagree with either the diagnosis or treatment prescribed by your doctor, you may ask for a second opinion from another doctor within the MPN. If you want a second opinion, you must contact the MPN contact or your claims adjuster and tell them you want a second opinion. The MPN should give you at least a regional or full MPN provider list from which you can choose a second opinion doctor. To get a second opinion, you must choose a doctor from the MPN list and make an appointment within 60 days. You must tell the MPN Contact of your appointment date, and the MPN will send the doctor a copy of your medical records. You can request a copy of your medical records that will be sent to the doctor.

If you do not make an appointment within 60 days of receiving the regional provider list, you will not be allowed to have a second or third opinion with regard to this disputed diagnosis or treatment of this treating physician.

If the second opinion doctor feels that your injury is outside of the type of injury he or she normally treats, the doctor's office will notify your employer or insurer and you. You will get another list of MPN doctors or specialists so you can make another selection.

If you disagree with the second opinion, you may ask for a third opinion. If you request a third opinion, you will go through the same process you went through for the second opinion.

Remember that if you do not make an appointment within 60 days of obtaining another MPN provider list, then you will not be allowed to have a third opinion with regard to this disputed diagnosis or treatment of this treating physician.

If you disagree with the third-opinion doctor, you may ask for an MPN Independent Medical Review (IMR). Your employer or MPN Contact will give you information on requesting an Independent Medical Review and a form at the time you select a third-opinion physician.

If either the second or third-opinion doctor or Independent Medical Reviewer agrees with your need for a treatment or test, you may be allowed to receive that medical service from a provider within the MPN, or if the MPN does not contain a physician who can provide the recommended treatment, you may choose a physician outside the MPN within a reasonable geographic area.

- **What if I am already being treated for a work-related injury before the MPN begins?**

Your employer or insurer has a "*Transfer of Care*" policy which will determine if you can continue being temporarily treated for an existing work-related injury by a physician outside of the MPN before your care is transferred into the MPN.

If your current doctor is not or does not become a member of the MPN, then you may be required to see a MPN physician. However, if you have properly predesignated a primary treating physician, you cannot be transferred into the MPN. (If you have questions about predesignation, ask your supervisor.)

If your employer decides to transfer you into the MPN, you and your primary treating physician must receive a letter notifying you of the transfer.

If you meet certain conditions, you may qualify to continue treating with a non-MPN physician for up to a year before you are transferred into the MPN. The qualifying conditions to postpone the transfer of your care into the MPN are set forth in the box below.

Can I Continue Being Treated By My Doctor?

You may qualify for continuing treatment with your non-MPN provider (through transfer of care or continuity of care) for up to a year if your injury or illness meets any of the following conditions:

- **(Acute)** The treatment for your injury or illness will be completed in less than 90 days;
- **(Serious or Chronic)** Your injury or illness is one that is serious and continues for at least 90 days without full cure or worsens and requires ongoing treatment. You may be allowed to be treated by your current treating doctor for up to one year, until a safe transfer of care can be made.
- **(Terminal)** You have an incurable illness or irreversible condition that is likely to cause death within one year or less.
- **(Pending Surgery)** You already have a surgery or other procedure that has been authorized by your employer or insurer that will occur within 180 days of the MPN effective date, or the termination of contract date between the MPN and your doctor.

You can disagree with your employer's decision to transfer your care into the MPN. If you don't want to be transferred into the MPN, ask your primary treating physician for a medical report on whether you have one of the four conditions stated above to qualify for a postponement of your transfer into the MPN.

Your primary treating physician has 20 days from the date of your request to give you a copy of his/her report on your condition. If your primary treating physician does not give you the report within 20 days of your request, the employer can transfer your care into the MPN and you will be required to use an MPN physician.

You will need to give a copy of the report to your employer if you wish to postpone the transfer of your care. If you or your employer disagrees with your doctor's report on your condition, you or your employer can dispute it. See the complete Transfer of Care policy for more details on the dispute resolution process.

For a copy of the Transfer of Care policy, in English or Spanish, ask your MPN Contact.

- **What if I am being treated by a MPN doctor who decides to leave the MPN?**

Your employer or insurer has a written "*Continuity of Care"* policy that will determine whether you can temporarily continue treatment for an existing work injury with your doctor if your doctor is no longer participating in the MPN.

If your employer decides that you do not qualify to continue your care with the non-MPN provider, you and your primary treating physician must receive a letter notifying you of this decision.

If you meet certain conditions, you may qualify to continue treating with this doctor for up to a year before you must choose a MPN physician. These conditions are set forth in the, ***"Can I Continue Being Treated By My Doctor?"*** box above.

You can disagree with your employer's decision to deny you Continuity of Care with the terminated MPN provider. If you want to continue treating with the terminated doctor, ask your primary treating physician for a medical report on whether you have one of the four conditions stated in the box above to see if you qualify to continue treating with your current doctor temporarily.

Your primary treating physician has 20 days from the date of your request to give you a copy of his/her medical report on your condition. If your primary treating physician does not give you the report within 20 days of your request, your employer's decision to deny you Continuity of Care with your doctor who is no longer participating in the MPN will apply, and you will be required to choose a MPN physician.

You will need to give a copy of the report to your employer if you wish to postpone the selection of an MPN doctor treatment. If you or your employer disagrees with your doctor's report on your condition, you or your employer can dispute it. See the complete Continuity of Care policy for more details on the dispute resolution process.

For a copy of the Continuity of Care policy, in English or Spanish, ask your MPN Contact.

- **What if I have questions or need help?**

  – **MPN Contact:** You may always contact the MPN Contact if you have questions about the use of the MPN and to address any complaints regarding the MPN.

  – **Medical Access Assistants:** You can contact the Medical Access Assistant if you need help finding MPN physicians and scheduling and confirming appointments.

  – **Division of Workers' Compensation (DWC):** If you have concerns, complaints or questions regarding the MPN, the notification process, or your medical treatment after a work-related injury or illness, you can call the DWC's Information and Assistance office at 1-800-736-7401. You can also go to the DWC's website at www.dir.ca.gov/dwc and click on "medical provider networks" for more information about MPNs.

  – **Independent Medical Review:** If you have questions about the MPN Independent Medical Review process contact the Division of Workers' Compensation's Medical Unit at:

    DWC Medical Unit
    PO Box 71010
    Oakland, CA 94612
    (510) 286-3700 or (800) 794-6900

Keep this information in case you have a work-related injury or illness.

Workers' Compensation Temporary Prescription ID Card

myMatrixx
An Express Scripts Company

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved workers' compensation prescriptions (based on the guidelines established by your employer).

Questions or need assistance locating a participating retail network pharmacy? Call the Express Scripts Patient Care Contact Center at 877.595.3665.

Atención Trabajador Lesionado:

En su primera visita, por favor entregue esta notificación a cualquier farmacia enumerada al reverso para acelerar el procesamiento de sus recetas aprobadas de compensación para trabajadores (según las pautas establecidas por su empleador).

Si tiene cualquier duda o necesita ayuda para localizar una farmacia de venta al por menor participante de la red, por favor llame al Centro de Contacto para Atención a Clientes de Express Scripts, al 877.595.3665.

To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 14-day supply or a cost of $500. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call Express Scripts at 877.595.3665.

Pharmacy Processing Steps

Step 1: Enter bin number 003858

Step 2: Enter processor control WC

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury

Express Scripts

ID#: ______________________________

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____/______/_____
MM/DD/YYYY

Group #: KEENAN1

Employee Date of Birth: ______/______/_____

Please Note: Call Express Scripts with questions at 877.595.3665

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

To the Supervisor: Please fill in the information requested for the injured worker.

Employee Information

First ______ M ______ Last ______

Street Address or PO Box ______

City ______ State ______ ZIP ______

Employer Name

____

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A & P
Acme Pharmacy
Albertson's
Albertson's/Acme
Albertson's/Osco
Albertson's/Sav-On
Amerisource Bergen
Anchor Pharmacies
Arrow
Aurora
Bartell Drugs
Bigg's
Bi-Lo
Bi-Mart
BJ's Wholesale Club
Brooks
Brookshire Brothers
Brookshire Grocery
Bruno
Carrs
Cash Wise
Coborn's
Costco
Cub
CVS
D&W
Dahl's
Dierbergs
Discount Drugmart
Doc's Drugs
Dominicks
Drug Emporium
Drug Fair
Drug Town
Drug World
Eckerd
Econofoods
EPIC Pharmacy
Network
FamilyMeds
Farm Fresh
Farmer Jack
Food City
Food Lion
Fred's
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
Harris Teeter
H-E-B
Hi-School Pharmacy
Hy-Vee
Jewel/Osco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
Kroger
LeaderNet (PSAO)
Longs Drug Store
Major Value
Marsh Drugs Medic
Discount Medicap
Medistat
Meijer
Minyard
MemorialCare
NCS HealthCare
Neighborcare
Network
Pharmaceuticals
Northeast Pharmacy
Services Osco
P & C Food Markets
Pamida
Park Nicollet
Pathmark Pavilions
Price Chopper Publix
Quality Markets
Raley's
Randalls
Rite Aid
Rosauers
Rx Express
RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's
Shop 'N Save
Shopko
ShopRite
Snyder
Stop & Shop
Sun Mart
Super Fresh
Super Rx
Target
Texas Oncology Srvs
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United Supermarkets
Vons
Waldbaums
Walgreens
Wal-Mart
Wegmans
Weis
Winn Dixie

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HACIENDA LA PUENTE UNIFIED SCHOOL DISTRICT
RISK MANAGEMENT OFFICE
15959 EAST GALE AVENUE • P.O. BOX 60002 • CITY OF INDUSTRY, CALIFORNIA 91716-0002
PHONE (626) 933-3860 • FAX (626) 933-3863

NOTICE OF HACIENDA LA PUENTE UNIFIED SCHOOL DISTRICT HEALTH INFORMATION PRIVACY PRACTICES

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by employer health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan – whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of these plans: Self-funded Dental, Self-funded Vision, EASE and FSA plans. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan or HMO option, you will receive a notice directly from the Insurer or HMO. It's important to note that these rules apply to the Plan, not *Hacienda La Puente USD* as an employer – that's the way the HIPAA rules work. Different policies may apply to other Hacienda La Puente USD programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- ***Treatment*** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.

- ***Payment*** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing; as well as "behind the scenes" plan functions such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.

- ***Health care operations*** include activities by this Plan (and in limited circumstances other plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes. The Plan may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you, as permitted by law.

How the Plan may share your health information with Hacienda La Puente USD

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to Hacienda La Puente USD for plan administration purposes. Hacienda La Puente USD may need your health information to administer benefits under the Plan. Hacienda La Puente USD agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Risk Management, Human Resources, Payroll, and Legal staff are the only Hacienda La Puente USD employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and Hacienda La Puente USD, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to Hacienda La Puente USD if requested, for purposes of obtaining premium bids to provide coverage under the Plan, or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.

- The Plan, or its insurer or HMO, may disclose to Hacienda La Puente USD information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO medical offered by the Plan.

In addition, you should know that Hacienda La Puente USD cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Hacienda La Puente USD from other sources, for example under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation is *not* protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made – for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify

proceedings	you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use or disclosure of your unsecured health information as required by law.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death – or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing. The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

Effective February 17, 2010, an entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid for the item or service, in full out of pocket.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.
If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible onsite), the Plan will provide you with:

- the access or copies you requested;
- a written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or
- a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage.
If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed of where to direct your request.
Effective February 17, 2010, you may request an electronic copy of your health information if it is maintained in an electronic health record. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. Any charge that is assessed to you for these copies, if any, must be reasonable and based on the Plan's cost.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).
If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will:

- make the amendment as requested;
- provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or
- provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the

disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.
You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made:

- for treatment, payment, or health care operations;
- to you about your own health information;
- incidental to other permitted or required disclosures;
- where authorization was provided;
- to family members or friends involved in your care (where disclosure is permitted without authorization);
- for national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
- as part of a "limited data set" (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official. If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect as of August 1, 2011. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's

privacy policies described in this notice, you will be provided with a revised privacy notice via inter-office memorandum.

Complaints

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, send it in writing (or via email) to the District Office:

Attention: Hal Longan
15959 East Gale Avenue
City of Industry, CA 91745

Contact

For more information on the Plan's privacy policies or your rights under HIPAA, contact Hal Longan, Director, Risk Management/Prevention at (626) 933-3860.

Your Anthem Employee Assistance Program

AnthemEAP

Your Employee Assistance Program

- The Employee Assistance Program (EAP) is designed to help with any issues that impact your life or ability to perform your job.
- The EAP is a free, confidential service that provides help for personal and work-related issues through a team of licensed mental health professionals and work/life specialists.
- All employees and their household members are eligible for EAP services.
- Anthem EAP Representatives are available 24 hours a day, 7 days a week.

Anthem EAP

Emotional Wellbeing

Callers are provided referrals to licensed mental health professionals either immediately on their call or by email if preferred.

- Up to 5 no cost counseling sessions
- Sessions are available per situation
- Private and Confidential
- In-Person, Virtual, and Telephonic Sessions
- Digital Resources

AnthemEAP

Legal Services

Need Legal Advice? Anthem EAP can help.

- Get a referral to an Advice Attorney for a no cost 30-minute consultation.
- Advice Attorneys are available nationwide
- Anthem EAP can provide a referral for that too.
- Discounts on Attorney fees

Don't forget the legal resources available on the EAP website - Estate Planning, Wills, Power of Attorney and more.

Anthem EAP

Financial Resources

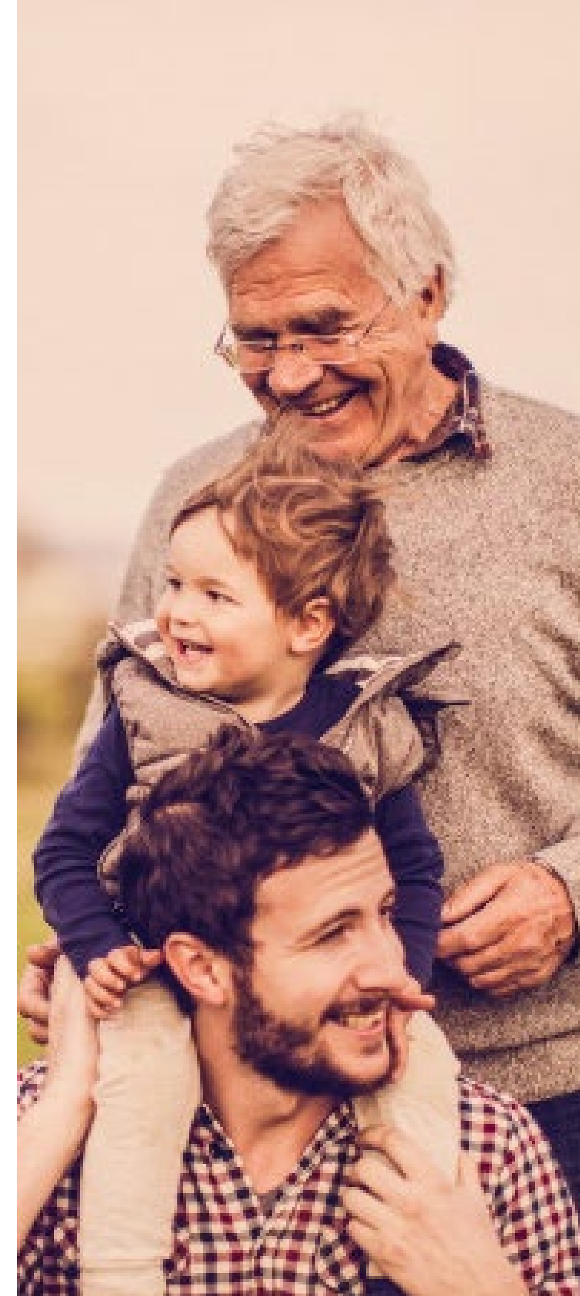
Unlimited access to financial consultants knowledgeable in a wide range of financial topics. Financial consultants can provide direction and additional resources on many topics including:

- Bankruptcy prevention
- Comprehensive financial fitness
- Debt reduction and management
- Financial planning
- Housing education and purchasing
- Budgeting
- Estate planning
- Identity Protection and Recovery

Child & Elder Care Resources

Anthem EAP can help by providing consultation and referrals for any dependent care need. Resources include:

- Day Care Centers
- Family Day Care Homes
- Back-Up Care
- Public & Private Schools
- Nanny Agencies
- Summer Camps
- Retirement Communities
- Elder Hostels
- Senior Centers
- Assisted Living Facilities
- Nursing Homes
- Caregiver Support



Daily Living Assistance

Anthe EAP can help by providing consultation and referrals for a number of daily living needs such as:

- Transportation Resources
- Hardship Assistance
- Emergency Shelter & Food Banks
- Housing & Moving Needs
- Consumer Information
- Travel Information
- Wedding Planners
- Landscaping
- Home Repair & Modification
- Pet Care

Anthem EAP

AnthemEAP.com

- Private and secure
- Company Specific Login
- Live Connect
- 1000s of articles
- Monthly Features
- Self-assessments & Quizzes
- Financial Calculators
- Self-Search Options
- The "News for You" tab
- Free webinars
- Let's Talk Depression - a multi-resource toolkit to support and educate members about depression.
- COVID-19 Specific Resources

Anthem REEP

Welcome Regional Employer/Employee Partnership

Phone : 800-999-7222

Coronavirus (COVID-19) Resources

LIVECONNECT ONLINE

About Your Services | EAP Orientation | Feedback | Email the Expert

Choose Language Go | Search Go | Advanced Search

Homepage | Parenting | Aging | Balancing | Thriving | Working | Living | International

RESOURCE CENTER

Your self-service area to:
- Search for EAP counselors
- Confirm your first appointment
- Send messages to your EAP

Read More: Resource Center

FIND RESOURCES NEAR YOU

Your self-service area to find:
- Child Care
- Adult Services
- Pet Sitter
- Elder Care

Use our handy search tool

Read More: Find Resources Near You

FINANCIAL AND LEGAL ASSISTANCE

- Quicken WillMaker & Trust
- Financial management tools
- Legal assistance

Read More: Financial and Legal Assistance

- Let's Talk Depression +
- Domestic Violence +
- Critical Event Support +
- Addiction and Recovery +
- Monthly Promotion +
- ID Monitoring +
- Legal/Financial +
- myStrength.com +
- Live Tobacco Free +
- Savings Center +
- Relocation Center +
- NEW Podcasts +

News For You

September

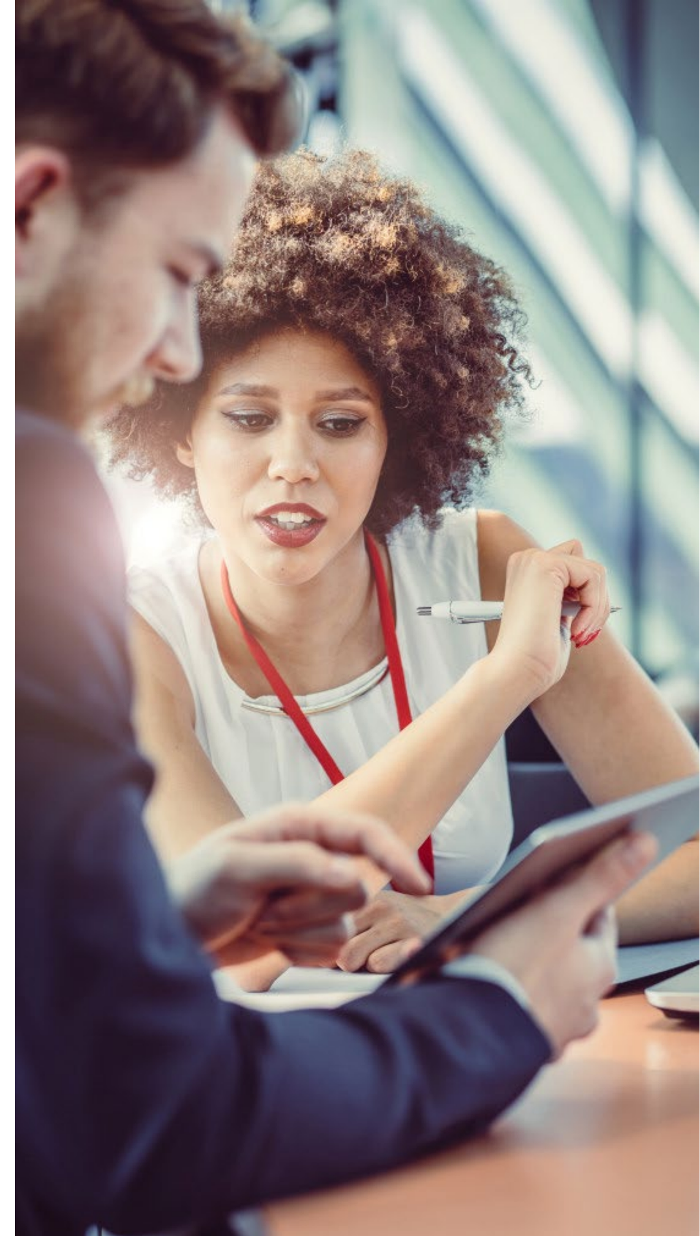
Every September is World Alzheimer's Month.

Consulting With The EAP

The EAP has a dedicated team of consultants trained to provide consultations to managers and HR. Our goal is to assist you, as a leader, to determine what services your employees could most benefit from.

You might seek consultation for:

- Personal issues impacting attendance
- A specific concern for an employee
- Interpersonal conflicts
- General support
- Critical Incident Support & Management



EAP Trainings

Anthem EAP offers training for your employees. Training and wellness seminars are available on-site and via webinar. The EAP offers a complete catalog of training and wellness seminars on a wide variety of topics such as:

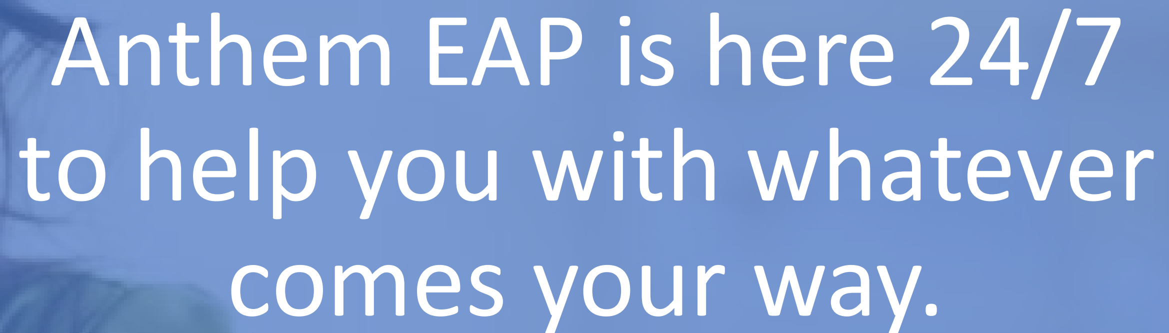
- EAP orientation
- Risk management
- Leadership Skill Building
- Work Life Balance
- Time Management
- Parenting
- Personal growth
- Financial Management
- Health and wellness

Resolving Issues

If there are ever any concerns regarding a EAP service, including scheduling a timely appointment with a provider, unhelpful resources, or being billed for no-cost services, we want resolve these issues immediately.

Please encourage employees to contact the EAP for a prompt resolution.

Anthem EAP



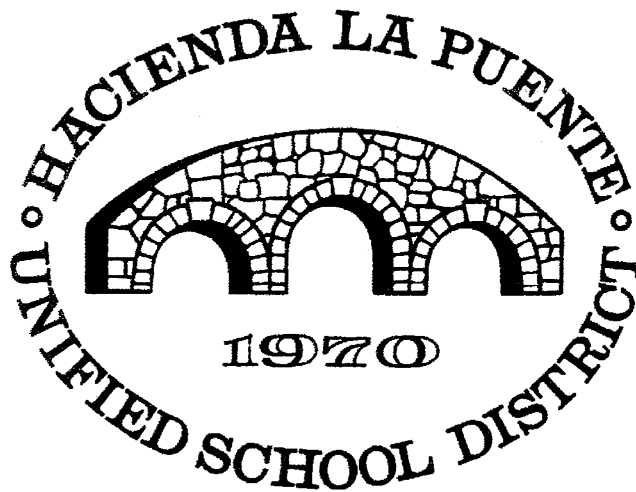
Toll-Free: (800) 999-7222

Or go to AnthemEAP.com
and enter your company code: REEP

Anthem EAP

CHILD ABUSE AND NEGLECT:

YOUR RESPONSIBILITIES



Staff Handbook
Identification and Reporting Procedures

-Revised-
October
2017

Hacienda La Puente Unified School District

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Introduction

Tragically, it is estimated that three children die each day in this nation as a result of child abuse and neglect. Every day, thousands of children are abused, often by a member of their own family, an unmarried parent's partner, or a caregiver.

Each incident of child abuse is a national tragedy. No civilized society can overlook the maltreatment of children. Identification of abuse is the first step to strengthening our efforts in prevention and early intervention with children, youth and troubled families. Citizens and professionals who deal with children play a critical role in protecting innocent victims who suffer from abuse.

Under California state law, specific professional groups, including educators, are mandated to report known or suspected child abuse. Knowledge or reasonable suspicion of child abuse is not privileged information and must be reported. This information may be the only way a child receives help.

As an educator, you are in a unique position to help abused and neglected children escape pain, suffering, and even death. This handbook is designed to assist you in identifying the symptoms of child abuse and understanding your reporting responsibilities. Together, we can stop the abuse and give our children a chance at a safe, happy, and productive life.

From *Child Abuse Educator's Responsibilities*
Crime and Violence Prevention Center
California Attorney General's Office
Revised January 2007

What is Child Abuse?

"Child abuse or neglect" includes physical injury or death inflicted by other than accidental means upon a child by another person, sexual abuse, the willful harming or injuring of a child, or the endangering of the person or health of a child, and unlawful corporal punishment or injury (Penal Code §11165.6).

The law defines child abuse as:

- Physical Abuse
- Physical Neglect
- Sexual Abuse
- Emotional Abuse

Physical Abuse

- The abuser willfully inflicts upon a child any cruel or inhuman corporal punishment or injury resulting in a traumatic condition (P.C. 11165.4).
- Most often a result of severe corporal punishment.
- Usually happens when a caretaker is frustrated or angry.

Physical Indicators of Physical Abuse

- Unexplained bruises (in various stages of healing)
- Unexplained burns, especially cigarette burns or immersion burns
- Unexplained fractures, lacerations or abrasions
- Swollen areas
- Evidence of delayed or inappropriate treatment for injuries

Behavioral Indicators of Physical Abuse

- Self destructive
- Withdrawn and/or aggressive -behavioral extremes
- Arrives at school early or stays late as if afraid to be at home

- Chronic runaway (adolescents)
- Complains of soreness or moves uncomfortably
- Wears clothing inappropriate to weather, to cover body
- Bizarre explanation of injuries
- Wary of adult contact

Physical Neglect

- Neglect is the negligent treatment or maltreatment of a child by a parent or caretaker under circumstances indicating harm or threatened harm to the child's health or welfare.
- It includes both acts of commission and omission on the part of the responsible person.

General Neglect

- General neglect means the negligent failure of a caretaker to provide adequate food, clothing, shelter, medical care or supervision where no physical injury to the child has occurred.

Severe Neglect

- Severe neglect means the negligent failure of a caretaker to protect the child from severe malnutrition or medically diagnosed failure to thrive. (PC1116.5)

Physical Indicators of Physical Neglect

- Abandonment
- Unattended medical needs
- Consistent lack of supervision

- Consistent hunger, in appropriate dress, poor hygiene
- Lice, distended stomach, emaciated
- Inadequate nutrition

Behavioral Indicators of Physical Neglect

- Regularly displays fatigue or listlessness, falls asleep in class
- Steals food, begs from classmates
- Reports that no caretaker is at home
- Frequently absent or tardy
- Self destructive
- School dropout (adolescents)
- Extreme loneliness and need for affection

Sexual Abuse

- Sexual abuse means acts of sexual assault or sexual exploitation of a minor.
- It encompasses a broad spectrum of behavior and may consist of many acts over a long period of time or a single incident.
- Sexual abuse may be non-touching (obscene language, pornography, exposure) or it may involve touching (fondling, molesting, oral sex, intercourse). (PC11165.1)

Sexual Exploitation

- Means conduct or activities related to pornography depicting minors and promoting prostitution by minors.

Physical Indicators of Sexual Abuse

- Tom, stained or bloody underclothing
- Pain, swelling or itching in genital area
- Difficulty walking or sitting
- Bruises or bleeding in genital area
- Venereal disease
- Frequent urinary or yeast infection

Behavioral indicators of Sexual Abuse

- Excessive seductiveness
- Role reversal, overly concerned for siblings
- Massive weight change
- Suicide attempts (especially adolescents)
- Inappropriate sex play or premature understanding of sex

- Threatened by physical contact, closeness

Emotional Abuse

- "Act or omissions by the parents or other caregivers that have caused, or could cause, serious behavioral, cognitive, emotional, or mental disorders." (Penal Code §11165.6).
- Pattern of behavior that impairs a child's emotional development or sense of self-worth
- Is often difficult to prove
- Emotional abuse is almost always present when other forms of abuse have been identified.

Physical Indicators of Emotional Abuse

Emotional abuse may be name-calling, insults, put-downs, etc., or it may be terrorization, isolation, humiliation, rejection, corruption, ignoring

- Speech disorders
- Delayed physical development
- Substance abuse
- Ulcers, asthma, severe allergies

Behavioral Indicators of Emotional Abuse

- Habit disorder (sucking, rocking, and biting)
- Antisocial, destruction
- Neurotic traits (sleep disorders, inhibition of play)
- Passive and aggressive – behavioral extremes
- Delinquent behavior (especially adolescents)
- Developmentally delayed

What is NOT Child Abuse?

- Injuries caused by two children fighting during mutual altercation.
- Injury caused by reasonable and necessary force used by a peace officer acting within the course and scope of his or her employment as a peace officer.
- Voluntary sexual conduct between minors who are both under the age of 14, and who are of similar age and sophistication.
- Pregnancy of a minor, regardless of her age, does not in and of itself, constitute the basis of reasonable suspicion of sexual abuse.

What are the Educator's Responsibilities?

- Teachers, school personnel, nurses, counselors, principals, supervisors or child welfare and attendance, and all classified school personnel are mandated to report.
- Symptoms or signs of abuse and neglect are often first seen by school personnel.
- Immediate investigation by DCFS may save a child from repeated abuse so school personnel should not hesitate to report suspicious injuries or behavior.
- Your duty is to report, NOT INVESTIGATE.

Legal Requirements

- Any child care custodian, health practitioner, employee of a child protective agency, child visitation monitor, firefighter, animal control officer or humane society officer who has knowledge of or observes a child, in his or her professional capacity or within the scope of his or her employment, who he or she knows or reasonably suspects has been the victim of child abuse, shall report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and **shall prepare and send a written report thereof within 36 hours or receiving the information concerning the incident…**
- For the purpose of this article, "reasonable suspicion" means that it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position,

drawing when appropriate on his or her training and experience, to suspect child abuse.

Are volunteers mandated reporters?

- *No,* unless otherwise specified in the law. However, volunteers of public or private organizations whose duties require direct contact and supervision of children are encouraged to obtain training in the identification and reporting of child abuse and are further encouraged to report known or suspected instances of child abuse and neglect to an agency specified in 11165.9(Pen Code, § 11165.7(b)). Public and private organizations are encouraged to provide their volunteers with training on identification and reporting of child abuse and neglect. (Pen Code, §11165.7(f).)

Immunity from Civil or Criminal Liability for Mandate Reporters

- Mandated reporters are provided immunity from civil or criminal liability as a result of making a required or authorized report of known or suspected child abuse.

Can a Mandated Reporter be sued for reporting Child Abuse?

- Yes, BUT- If a civil action is brought against a mandated reporter for filing a mandated or authorized report, the reporter can submit a claim to the State Board of Control for reasonable attorney's fees incurred in the action if he or she prevails (Penal Code, § 11172. (c).

Employers' Responsibilities

- Any person who enters into employment on or after January 1, 1985, "as a child care custodian, health practitioner…" shall sign a statement on a form provided by his employer to the effect that he or she has knowledge of the provisions of Section 11166 and will comply with those provisions. This statement must be signed prior to commencing employment. (Penal Code §11166.5, subd. (a).)

If you FAIL to Report

- Failure to report is a misdemeanor (Penal Code, § 11172, subd. (a).).
- Educators and health practitioners who fail to report may risk loss of their license or credential (Ed. Code, § 44421).
- Failure to report may result in personal civil liability (Landeros v. Flood (1975) 17 Cal. 3d 399).

Special Reporting for Schools

- Reporting is individual responsibility.
- No supervisor or administrator may interfere with the individual reporting responsibility. (PC11166 (F).)
- No mandated reporter may be absolved of responsibility by relying on a supervisor or administrator to meet his or her individual reporting responsibility.
- A mandated reporter may report without fear about any sanction for making the report.

- The supervisor or administrator CAN ask the employee to notify them or reports being made to a child protective agency.
- A reporter cannot be prohibited or impeded from making a report directly to a child protective agency.

How to Report

Step One:

Call the Child Abuse Hot Line by dialing 1(800) 540-4000. This is a 24-hour toll-free number. The staff will evaluate the situation and if other agencies are to be called.

Step Two:

All mandated reporters are required to follow-up the telephone report with a written report on Suspected Child Abuse Report-Form.; .SS'8572· (revised 12/02) as required by Penal Code sections 11166 and 11169. Forms are available at school sites or you may complete an online report by going to https://mandreptla.org/on-lineRep.htm

If your verbal report was made to the Hotline, you may complete the on-line written report and it will not be necessary for you to mail a report to the Hotline.

The written report must be filed within 36 hours of the telephone report.

If not filed online, mail the report to:
Department of Child and Family Services
1933 S. Broadway,
5th Floor
Los Angeles, CA 90007

The Department of Children and Family Services staff will forward a copy of the written report to the Sheriff's Department.

Step Three:

Employees reporting child abuse or neglect to the appropriate agency shall notify the site administrator or designee as soon as possible after the initial telephone report is made.

Step Four:

File a photocopy of report at school (not in student's CUM file).

Step Five:
Send a photocopy of Suspected Child Abuse Report to the District Office Chief of Police.

What Happens to Your Report?
- Reports are investigated by the local law enforcement agency and/or by DCFS
- Sometimes these agencies cross-report with one another.
- Reporting does not always mean that a civil or criminal proceeding will be initiated against the suspected abuser.
- If an investigation does not reveal evidence of child abuse but suggests other family problems or a potential abuse situation, DCFS may intervene and offer appropriate services to prevent abuse before it happens.

Is Your Report Confidential?
- Mandated Reporters ARE REQUIRED to give their names when a report is made (Penal Code,§ 11167, subd. (a).)
- Name is kept confidential and may be disclosed to DCFS, to the district attorney investigating or prosecuting the case, court order, or if confidentiality is waived.
- The parent, guardian or out of home caretaker SHALL NOT be informed as to whom made the report.

Child Abuse Interviews at School
- Children MAY be interviewed on school grounds during an officer's investigation of child abuse.
- The child has the right to be interviewed in private, or
- The child can select any member of the school staff to be present during the interview
- The purpose of having a staff member at the interview is to lend support to the child and help the child feel as comfortable as possible.
- The staff member CANNOT PARTICIPATE in the interview or discuss the facts or circumstances of the case with the child and is subject to confidentiality requirements of Penal Code§ 11167.5
- A staff member selected by the child MAY DECLINE the request to be present at the interview.

Child Abuse Reporting Summary

- School employees are mandated reporters.
- Report all cases of suspected child abuse and neglect immediately.
- Report via telephone to the Department of Children & Family Services (DCFS) Child Abuse Hotline (800) 540-4000 and local law enforcement.
- File a report within 36 hours (Department of Justice (DOJ) Form SS 8572).

Resources

Child Abuse: Educator's Responsibilities, Crime and Violence Prevention Center, California Attorney General's Office, revised January 2007, retrieved from http://www.safestate.org/shop/index.cfm?cat=2&navid=107&action=list

Los Angeles County Child Abuse and Neglect Protocol, Los Angeles County Child Abuse and Neglect Task Force, revised 2004, retrieved from http://www.ican-ncfr.org/tmCANprotocol.asp

CATS On-Line Training Modules, Self-Guided Mandated Reporter ln service Program, Northridge Hospital Medical Center, 2005, retrieved from http://www.abuse-assaultservices.org/training.html

You Can Make a Difference in My Life

SUSPECTED CHILD ABUSE REPORT

Insert new form

To Be Completed by **Mandated Child Abuse Reporters**

Pursuant to Penal Code Section 11166

CASE NAME: ____________________

PLEASE PRINT OR TYPE

CASE NUMBER:

NAME OF MANDATED REPORTER | TITLE | MANDATED REPORTER CATEGORY

REPORTER'S BUSINESS/AGENCY NAME AND ADDRESS Street City Zip | DID MANDATED REPORTER WITNESS THE INCIDENT? ☐ YES ☐ NO

REPORTER'S TELEPHONE (DAYTIME) ( ) | SIGNATURE | TODAY'S DATE

☐ LAW ENFORCEMENT ☐ COUNTY PROBATION ☐ AGENCY

☐ COUNTY WELFARE / CPS (Child Protective Services)

ADDRESS Street City Zip | DATE/TIME OF PHONE CALL

OFFICIAL CONTACTED - TITLE | TELEPHONE ( )

NAME (LAST, FIRST, MIDDLE) | BIRTHDATE OR APPROX. AGE | SEX | ETHNICITY

ADDRESS Street City Zip | TELEPHONE ( )

PRESENT LOCATION OF VICTIM | SCHOOL | CLASS | GRADE

PHYSICALLY DISABLED? ☐ YES ☐ NO | DEVELOPMENTALLY DISABLED? ☐ YES ☐ NO | OTHER DISABILITY (SPECIFY) | PRIMARY LANGUAGE SPOKEN IN HOME

IN FOSTER CARE? ☐ YES ☐ NO | IF VICTIM WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE: ☐ DAY CARE ☐ CHILD CARE CENTER ☐ FOSTER FAMILY HOME ☐ FAMILY FRIEND ☐ GROUP HOME OR INSTITUTION ☐ RELATIVE'S HOME | TYPE OF ABUSE (*CHECK ONE OR MORE*) ☐ PHYSICAL ☐ MENTAL ☐ SEXUAL ☐ NEGLECT ☐ OTHER (SPECIFY)

RELATIONSHIP TO SUSPECT | PHOTOS TAKEN? ☐ YES ☐ NO | DID THE INCIDENT RESULT IN THIS VICTIM'S DEATH? ☐ YES ☐ NO ☐ UNK

	NAME	BIRTHDATE	SEX	ETHNICITY		NAME	BIRTHDATE	SEX	ETHNICITY
1.					3.				
2.					4.				

NAME (LAST, FIRST, MIDDLE) | BIRTHDATE OR APPROX. AGE | SEX | ETHNICITY

ADDRESS Street City Zip | HOME PHONE ( ) | BUSINESS PHONE ( )

NAME (LAST, FIRST, MIDDLE) | BIRTHDATE OR APPROX AGE | SEX | ETHNICITY

ADDRESS Street City Zip | HOME PHONE ( ) | BUSINESS PHONE ( )

SUSPECT'S NAME (LAST, FIRST, MIDDLE) | BIRTHDATE OR APPROX AGE | SEX | ETHNICITY

ADDRESS Street City Zip | HOME PHONE ( ) | BUSINESS PHONE ( )

OTHER RELEVANT INFORMATION

IF NECESSARY, ATTACH EXTRA SHEET(S) OR OTHER FORM(S) AND CHECK THIS BOX ☐ *IF MULTIPLE VICTIMS, INDICATE NUMBER:*

DATE/TIME OF INCIDENT | PLACE OF INCIDENT

NARRATIVE DESCRIPTION (What victim(s) said/what the mandated reporter observed/what person accompanying the victim(s) said/similar or past incidents involving the victim(s) or suspect)

SS 8572 (Rev. 12/02) *DEFINITIONS AND INSTRUCTIONS ON REVERSE*

DO NOT submit a copy of this form to the Department of Justice (DOJ). The investigating agency is required under Penal Code Section 11169 to submit to DOJ a Child Abuse Investigation Report Form SS 8583 if (1) an active investigation was conducted and (2) the incident was determined not to be unfounded.

WHITE COPY-Police or Sheriffs Department; BLUE COPY-County Welfare or Probation Department; GREEN COPY-District Attorney's Office; YELLOW COPY-Reporting Party

DEFINITIONS AND GENERAL INSTRUCTIONS FOR COMPLETION OF FORM SS·SS72

All Periai CQae (PC).teferens are located in Article 2.5 of the PC. This article is known as the Child Abuse and Neglect Reporting Act (CANRA). The·provisions ofCANRA may be viewed at httr;://www.leginfo.ca.gov/calaw.html (specify "Penal Code" and search for Sections 111{14..f1T74.3). A mandated reporter must comolete and submit the form SS 8572 even if some of the requested information is not knOwti. (PC Section·11167(a).)

I. MANDATED CHILD ABUSE REPORTERS

Mandated child abuse reporters include all those individuals. and entities listed in PC Section 11165.7:

II. TO WHOM REPORTS ARE TO BE MADE ("DESIGNATED AGENCIES")

Reports of suspected child abuse or neglect shall be made by mandated reporters ltP any police department or sheriff's department (not including a school district police ot"Security department), the county probation department (if designated ·by the county to reeeive mandated reports), or the county welfdepartment. (PC Section 11165,9.)

Ill. REPORTING RESPONSIBILITIES

- 'Anymandated reporter who has knowledge of or observes-a child, in his or her profesSional c"apacity or within the scope of his or her employment, whom:he·or she knows or .reasonably suspects has ooen the victftn of child abuse or neglect shall report such suspected fucidelit of abpse or neglect to a designated agency immediately or as soon as practically possible by telephone and shall prepare and send a written report thereof *within 36 houn* of receiving the information conceriliilg the incident. (PC Section li166_(a).)

  No mandated reporter who reports a suspected incident of child abuse or neglect shall be held civilly or criminally liable for any report required or authorized by CANRA. Any other person reporting a known or swipected incident of child abuse or neglect shall not incur civil or criminal liabilitY as a result of any report a:uthonzed by CANRA unless it can be proven the report was false and the person knew it was false or made the·report with reckless disregard of its truth or · falsity. (PC Section 11172(a).)

IV: INSTRUCTIONS

- SECTION A- REPORTING-PARTY: Enter the mandated reporter's n;un, title;category (from PC Section 11165.7), business/agency name and address; daytime telephone. · numb r.and today's date. Check yes-no whether the mandated reporter witnessed the incident. The signature area is for either the mandated reporter·or, if the report is .telephoned in by the mandated reporter, the person taking the telephoned report..

IV. INSTRUCTIONS (Continued)

- SECTION B- REPORT NOTIFICATION: Complete the name and address of the designated agency notified, the date/ time of the phone call, and the name, title, and telephone number of the official contactecl
- SECJ'ION C -VICTIM (One Report per Victim): Enter the victim's name, address, telephone number, birth date or approximate age, sex, ethnicity, present location, and, where applicable, enter the school, class (indicate the. teacher's name or room number), and grade. Lj,st the primary . language spoken iil the victim's home. Check the appropriate yes-no box to indicate whether the:Vicfuo may have a developmental disability or physic3.I disability and Specify IUIY other apparent disability. Check the appropnate yes-no box to indicate·whether the victim is in foster care, and check the appropriate bOx to'indicate the type Of care ifffie victim. was in out-of-home care. Check the appropriate box to indicate the type ofabuse. List the victim's relationship to the suspeet. .Check the appropriate yes-no box to indicate whether photos of the injuries were taken. Check the appropriate box tO indicate whether the incident resulted in the victim'sdeath.
- SECTION D- INVOLVED PARTIES: Enter the requested information foVictim'Siblings, Victim's Parents/ Guardians, and SuSpect. Attach extra sheet(s) if needed (provide the requested information for each individual on the attached sheet(s)).
- SECTION E- INCIDENT INFORMATION: If multiple victims, indicate the number and -submit a form for each victim; Enter date/time and place of.the incident. Provide a . narrative of the incident.· Attach extra sh et(s} if needed.

V. DISTRIBUTION

- Reporting Party: After completing Form SS 8572, retain the yellow copy for your records and submi·t the tQp three · copies to the designated agency.
- Designated Agency: *Within 36 hours* of receipt of Form SS 8572, send white copy to police or'sheriff's department, blue·copy to'county welfare or probation departinent, and green.copy to district attorney's office..

ETHNICJTY CODES ·

I Alaskan Native	6 Can"bbcan	II Guamanian	16 Korean	22 Polynesian	27 White-Armenian
2 AmeriCan Indian	7 Centia! American.	12 Hawaiian·	17 Laotian	23·8amoan	28 White.Ccntral American
3 Asian Indian	8 Chinese	13 Hispanic	18. Mexican	24 South American	29 White-Euroj;ean
4 Black	9 Ethiopian	14 Hmong	19 Other Asian	2S Vietnamese	30 White·Middle Eastern
5 ('.amhodian	10 Filipino	·.IS Japanese.	21 Other Pacific Islander	26 White	31 Whire·Romanian

a OSP 0374570

HOTLINES

Child Abuse Hotlines

Child Abuse Hotline.. (800) 540-4000

California Youth Crisis Line... (800) 843-5200

LA County Safely Surrendered Hotline.................................... (877) 222-9723

Suicide Prevention Hotline... (877) 727-4747

Industry Sheriff's Dept.. .... (626) 369-1713

TDD -Hearing Impaired Line... (800) 272-6699
TRS- Number: 711
Information For Community Services
211LA County 2-1-1

Battering & Rape Hotlines

1736 Family Crisis Center... (323) 737-3900

Center for Pacific Asian Family... (800) 339-3940
24-Hour (Chinese, Japanese, Korean, Filipino, Vietnamese)

Los Angeles Rape and Battering Hotline.................................... (310) 392-8381

Pomona Rape Hot Line (Project Sister)............................ (626) 966-4155

Victims of Crime Resource Center... (800) 842-8467

Women's & Children Crisis Shelter, Inc (Hot Line)......................... (562) 945-3939

National Runaway Hotline.. (800) 621-4000

Counseling
East Valley Community Health Center....................................... (626) 919-5724

La Puente AA Center.. (626) 914-1861

La Puente Mental Health... (626) 961-8971

Pomona Community Crisis Center-Drug Abuse........................... (909) 623-1588

CHILD ABUSE REPORTING

Child Abuse Reporting

The Governing Board recognizes that child abuse has severe consequences and that the district has a responsibility to protect students by facilitating the prompt reporting of known and suspected incidents of child abuse. The Superintendent or designee shall establish procedures for the identification and reporting of such incidents in accordance with law.

(cf 0450- Comprehensive Safety Plan)

Employees who are mandated reporters, as defined by law and administrative regulation, are obligated to report all known of suspected incidents of' child abuse and neglect. Mandated reporters shall not investigate any suspected incidents but rather shall cooperate with agencies responsible for investigating and prosecuting cases of child abuse and neglect.

The Superintendent or designee shall provide training regarding the reporting duties of mandated reporters.

In the event that training is not provided to mandated reporters, the Superintendent or designee shall report to the California Department of Education the reasons that such training is not provided. (Penal Code 11165.7)

Legal Reference:

EDUCATION CODE
32280-32288 Comprehensive school safety plans
33308.I Guidelines on procedure for filing child abuse complaints
44690-4469I Staff development in the detection of child abuse and neglect
44807 Duty concerning conduct of students
48906 Notification when student released to peace officer
48987 Dissemination of reporting guidelines to parents
4900I Prohibition of corporal punishment
51220.5 Parenting skills education
PENAL CODE
152.3 Duty to report murder, rape, or lewd or lascivious act
273a Willful cruelty or unjustifiable punishment of child; endangering life or health
288 Definition of lewd or lascivious act requiring reporting
11164-11174.4 Child Abuse and Neglect Reporting Act
WELFARE AND INSTITUTIONS CODE
15630-15637 Dependent adult abuse reporting
CODE OF REGULATIONS. TITLE 5
4650 Filing complaints with CDE, special education students

Management Resources:

CHILD ABUSE REPORTING

CDELEGALADVISORIES
0514.93 Guidelines for parents to report suspected child abuse
WEB SITES
California Attorney General's Office, Crime and Violence Prevention Center: http://safestate.org
California Department of Education, Safe Schools: http://www.cde.ca.gov/ls/ss
California Department of Social Services, Children and Family Services Division: http://www.childsworld.ca.gov
U.S. Department of Health and Human Services, National Clearinghouse on Child Abuse and Neglect Information: http://nccanch.acfhhs.gov

Policy
Adopted: May 25, 2006

HACIENDA LA PUENTE UNIFIED SCHOOL DISTRICT
City of Industry, California

CHILD ABUSE REPORTING

Definitions

Child abuse or neglect includes the following: (Penal Code 11165.5, 11165.6)

1. A physical injury inflicted by other than accidental means on a child by another person

2. Sexual abuse of a child as defined in Penal Code 11165.1

3. Neglect as defined in Penal Code 11165.2

4. Willful harming or injuring of a child or the endangering of the person or health of a child as defined in Penal Code 11165.3

5. Unlawful corporal punishment or injury as defined in Penal Code 11165.4

Child abuse or neglect does not include:

1. A mutual affray between minors (Penal Code 11165.6)

2. An injury caused by reasonable and necessary force used by a peace officer acting within the course and scope of his/her employment (Penal Code 11165.6)

(cj 3515.3 -District Police/Security Department)

3. An injury resulting from the exercise by a teacher, vice principal, principal, or other certificated employee of the same degree of physical control over a student that a parent/guardian would be privileged to exercise, not exceeding the amount of physical control reasonably necessary to maintain order, protect property, protect the health and safety of students, or maintain proper and appropriate conditions conducive to learning (Education Code 44807)

(cj 5144 - Discipline)

4. An injury caused by a school employee's use of force that is reasonable and necessary to quell a disturbance threatening physical injury to persons or damage to property, to protect himself/herself, or to obtain weapons or other dangerous objects within the control of the student (Education Code 49001)

5. Physical pain or discomfort caused by athletic competition or other such recreational activity voluntarily engaged in by the student (Education Code 49001)

Mandated reporters include but are not limited to teachers; instructional aides; teacher's aides or assistants; classified employees; certificated pupil personnel employees; administrative officers or supervisors of child attendance; administrators and employees of a licensed day care facility; Head Start teachers; district police or security officers; and administrators, presenters, or counselors of a child abuse prevention program. (Penal Code 11165.7)

Reasonable suspicion means that it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing when appropriate on his/her training and experience, to suspect child abuse or neglect. (Penal Code 11166)

Reportable Offenses

A mandated reporter shall make a report using the procedures provided below whenever, in his/her professional capacity or within the scope of his/her employment, he/she has knowledge of or observes a child whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or neglect. (Penal Code 11166)

Any mandated reporter who has knowledge of or who reasonably suspects that a child is suffering serious emotional damage or is at a substantial risk of suffering serious emotional damage based on evidence of severe anxiety, depression, withdrawal, or untoward aggressive behavior toward self or others, may make a report to the appropriate agency. (Penal Code 11166.05)

Any person shall notify a peace officer if he/she reasonably believes that he/she has observed the commission of a murder, rape, or lewd or lascivious act by use of force, violence, duress, menace, or fear of immediate and unlawful bodily injury, where the victim is a child under age 14. (Penal Code 152.3, 288)

Responsibility for Reporting

The reporting duties of mandated reporters are individual and cannot be delegated to another person. (Penal Code 11166)

When two or more mandated reporters jointly have knowledge of a known or suspected instance of child abuse or neglect, and when there is agreement among them, the report may be made by a member of the team selected by mutual agreement and a single report may be made and signed by the selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so shall thereafter make the report. (Penal Code 11166)

No supervisor or administrator shall impede or inhibit a mandated reporter from making a report. (Penal Code 11166)

Any person not identified as a mandated reporter who has knowledge of or observes a child whom he/she knows or reasonably suspects has been a victim of child abuse or neglect may report the known or suspected instance of child abuse or neglect to the appropriate agency. (Penal Code 11166)

Reporting Procedures

1. Initial Telephone Report

   Immediately or as soon as practicably possible after knowing or observing suspected child abuse or neglect, a mandated reporter ·shall make a report by telephone to any police department (excluding a school district police/security department), sheriff's department, county probation department if designated by the county to receive such reports, or county welfare department. Telephone reports may be made to the following child abuse reporting agency. (Penal Code 11166)

   Department of Children and Family Services
   Child Abuse Hotline
   1933 S. Broadway 5th Floor
   Los Angeles, CA 9007
   800-540-4000

   When the telephone report is made, the mandated reporter shall note the name of the official contacted, the date and time contacted, and any instructions or advice received.

2. Written Report

   Within 36 hours of receiving the information concerning the incident, the mandated reporter shall prepare and send to the appropriate agency a written report which includes a completed Department of Justice form. (Penal Code 11166, 11168)

   Record all required information on the Suspected Child Abuse Report Form, SS 8572.

   a. Report information factually and objectively

   b. Avoid allegations regarding any suspected offender other than allegations which are a part of the minor's explanation

   c. Record minor's explanation as nearly verbatim as possible

Mandated reporters may obtain copies of the above form from either the district or the appropriate agency.

Reports of suspected child abuse or neglect shall include, if known: (Penal Code 11167)

a. The name, business address, and telephone number of the person making the report and the capacity that makes the person a mandated reporter

b. The child's name and address, present location and, where applicable, school, grade, and class

c. The names, addresses, and telephone numbers of the child's parents/guardians

d. The information that gave rise to the reasonable suspicion of child abuse or neglect and the source(s) of that information

e. The name, address, telephone number, and other relevant personal information about the person(s) who might have abused or neglected the child

The mandated reporter shall make a report even if some of this information is not known or is uncertain to him/her. (Penal Code 11167)

Disposition of the suspected child abuse report form copies:

a. Mail all copies of the suspected child abuse form to: Child Abuse Hotline, 1933 S. Broadway, 5th Floor, Los Angeles, CA 90007

b. File a photocopy of the suspected child abuse report form at school (not in student's CUM file).

c. Make a notation of the suspected child abuse report in the student's health record under Supplementary Information section 9. Notation should indicate only the Department of Justice, suspected child abuse report form number S.S.8572, the date a suspected child abuse was reported and the agency with which the report was filed. Example: "S.S 8572, 07/07/05, DFCS hotline."

d. Send a photocopy of the suspected child abuse report to the Coordinator of Student and Family Services at the Student Services Center (SSC).

Information relevant to the incident of child abuse or neglect may also be given to an investigator from an agency that is investigating the case. (Penal Code 11167)

3. Internal Reporting

Employees reporting child abuse or neglect to the appropriate agency shall notify the site administrator or designee as soon as possible after the initial telephone report to the appropriate agency. When so notified, the site administrator or designee shall inform the Superintendent or designee.

The site administrator or designee so notified shall provide the mandated reporter with any assistance necessary to ensure that reporting procedures are carried out in accordance with law, Board policy and administrative regulation. At the mandated reporter's request, the site administrator or designee may assist in completing and filing the necessary forms.

The mandated reporter shall not be required to disclose his/her identity to the site administrator or designee. (Penal Code 11166)

He/she may provide or mail a copy of the written report to the site administrator or designee, Superintendent or designee without his/her signature or name.

Reporting the information to an employer, supervisor, school principal, school counselor, co-worker, or other person shall not be a substitute for making a mandated report to the appropriate agency. (Penal Code 11166)

If the site administrator is absent and the situation is such that the minor's person or health is endangered, then the appropriate district administrator shall be contacted as soon as possible.

Training

Training of mandated reporters shall include child abuse identification and reporting. (Penal Code 11165.7)

Training shall also include guidance in the appropriate discipline of students, physical contact with students, and maintenance of ethical relationships with students to avoid actions that may be misinterpreted as child abuse.

(cf 4131 - Staff Development)
(cf 4231- Staff Development)
(cf 4331 -Staff Development)
(cf 5145.7- Sexual Harassment)

Victim Interviews

Whenever a representative of an agency investigating suspected child abuse or neglect deems it necessary, a suspected victim may be interviewed during school hours, on school premises, concerning a report of suspected child abuse or neglect that occurred within the child's home or out-of-home care facility. The child shall be given the choice of being interviewed in private or in the presence of any adult school employee or volunteer aide selected by the child. (Penal Code 11174.3)

A staff member or volunteer aide selected by a child may decline to be present at the interview. If the selected person accepts, the principal or designee shall inform him/her of the following requirements: (Penal Code 11174.3)

1. The purpose of the selected person's presence at the interview is to lend support to the child and enable him/her to be as comfortable as possible.

2. The selected person shall not participate in the interview.

3. The selected person shall not discuss the facts or circumstances of the case with the child.

4. The selected person is subject to the confidentiality requirements of the Child Abuse and Neglect Reporting Act, a violation of which is punishable as specified in Penal Code 11167.5.

If a staff member agrees to be present, the interview shall be held at a time during school hours when it does not involve an expense to the school. (Penal Code 11174.3)

Release of Child to Peace Officer

In cases of child abuse reporting, where it is determined that the minor shall be taken into custody, the site administrator or other district official shall provide the peace officer with the address and telephone number of the minor's parents or guardians.

School officials shall not initiate notification to the parent or guardian that the child has been taken into custody by the peace officer. Such notification shall be the responsibility of the peace officer.

The district form #233, Removal of Student from School during School Hours by a Peace Officer shall be completed and kept on file at the school site office.

Parent/Guardian Complaints

Upon request, the Superintendent or designee shall provide parents/guardians with procedures that describe how to report suspected child abuse occurring at a school site to appropriate agencies. For parents/guardians whose primary language is other than English, such procedures shall be in the primary language of the parent/guardian and, when communicating orally regarding those procedures, an interpreter shall be provided.

To file a complaint against a district employee or other person suspected of child abuse or neglect at a school site, parents/guardians may file a report by telephone, in person or in writing with any appropriate agency identified above under "Reporting Procedures." If a parent/guardian makes a complaint to any district employee, that employee shall notify the parent/guardian of procedures for filing a complaint with the appropriate agency. The employee also is obligated pursuant to Penal Code 11166 to file a report himself/herself using the procedures described above for mandated reporters.

(cf 1312.1- Complaints Concerning District Employees)

In addition, if the child is enrolled in special education, a separate complaint may be filed with the California Department of Education pursuant to 5 CCR 4650.

(cf 1312.3- Uniform Complaint Procedures)

Notifications

The Superintendent or designee shall provide all new employees who are mandated reporters a statement that informs them that they are mandated reporters, of their reporting obligations under Penal Code 11166, and of their confidentiality rights under Penal Code 11167. The district shall also provide these new employees with a copy of Penal Code 11165.7, 11166, and 11167. (Penal Code 11165.7, 11166.5)

Before beginning employment, employees shall sign the statement indicating that they have knowledge of the reporting obligations under Penal Code 11166 and that they will comply with those provisions. The signed statements shall be retained by the Superintendent or designee. (Penal Code 11166.5)

(cf 4112.914212.9/4312.9- Employee Notifications)

Employees who work with dependent adults shall be notified of legal responsibilities and reporting procedures pursuant to Welfare and Institutions Code 15630-15637.

The Superintendent or designee shall also notify all employees that:

1. A mandated reporter who reports a known or suspected instance of child abuse or neglect shall not· be held civilly or criminally liable for making a report and this immunity shall apply even if the mandated reporter acquired the knowledge or reasonable suspicion of child abuse or neglect outside of his/her professional capacity or outside the scope of his/her employment. Any other person making a report shall not incur civil or criminal liability unless it can be proven that he/she knowingly made a false report or made a report with reckless disregard of the truth or falsity of the report. (Penal Code 11172)

2. If a mandated reporter fails to report an incident of known or reasonably suspected child abuse or neglect, he/she may be guilty of a crime punishable by a fine and/or imprisonment. (Penal Code 11166) and/or imprisonment. (Penal Code 11166)

3. No employee shall be subject to any sanction by the district for making a report. (Penal Code 11166)

Regulation
Approved: May 25, 2006

HACIENDA LA PUENTE UNIFIED SCHOOL DISTRICT
City of Industry, California