

FRESNO STATE PROGRAMS FOR CHILDREN, INC.

STUDENT/PART-TIME/TEMPORARY EMPLOYEE INFORMATION SHEET

PLEASE CHECK THE CORRECT BOX(ES):

<input type="checkbox"/> NEW HIRE	<input type="checkbox"/> PART-TIME <input type="checkbox"/> Fresno State Faculty <input type="checkbox"/> Fresno State Staff <input type="checkbox"/> Non-Fresno State Employee	<input type="checkbox"/> STUDENT AT FRESNO STATE _____ #of units enrolled for: <input type="checkbox"/> Fall <input type="checkbox"/> Spring <input type="checkbox"/> Summer	<input type="checkbox"/> CHANGE <input type="checkbox"/> Address <input type="checkbox"/> Cost Center <input type="checkbox"/> Pay Increase <input type="checkbox"/> Other: _____
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TO BE COMPLETED BY EMPLOYEE

Name: _____		Social Security Number: - -	
Mailing Address: _____ Street Apt. # City State Zip Code			Phone Number: () _____
Fresno State Email Address: _____@mail.fresnostate.edu			
<input type="checkbox"/> Married	<input type="checkbox"/> Single	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Date of Birth: _____			
Have you worked or are you currently working for the Association, Foundation, Ag Foundation or Fresno State?			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, Last Day Worked: _____ Department: _____	

EMERGENCY CONTACT INFORMATION

In case of emergency, notify:		
Name: _____	Relationship: _____	Phone: _____

ACKNOWLEDGEMENTS

I have received and acknowledge the following forms as part of the new hire packet:

<input type="checkbox"/> Nature of Employment Agreement	<input type="checkbox"/> Injury and Illness Prevention Program
<input type="checkbox"/> Interim Vaccine Policy	<input type="checkbox"/> Employee Handbook (available on www.Auxiliary.FresnoState.edu)
<input type="checkbox"/> AB 469 Rate and Payday Notification	<input type="checkbox"/> W4 Form and State DE 4
<input type="checkbox"/> Drug Free Workplace Policy	<input type="checkbox"/> I-9 Employment Eligibility Form

Dated: _____ Employee Signature: _____

TO BE COMPLETED BY SUPERVISOR

Cost Center/Obj. Code/Subsidiary:	Date of Hire or Re-hire:	Mail Stop:
Pay Rate: \$	Position Title:	Kronos Supervisor:
Is it likely that this position would have contact with minors (individuals under the age of 18)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Confidential Data Access? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is driving a requirement for this position? <input type="checkbox"/> Yes <input type="checkbox"/> No	Supervisory Responsibility? <input type="checkbox"/> Yes <input type="checkbox"/> No

Neptism: "Related employees are not permitted to work in job positions in which a conflict of interest could arise or in a direct supervisory relationship." To my knowledge, this hire does not violate the Association Neptism policy. _____ **Employee Initials** _____ **Supervisor Initials**

PAY INCREASE *Please attach justification and AB 469

Reason for Increase: _____

Current Hourly Rate:	New Hourly Rate:	Effective Date:
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AUTHORIZATION REQUIRED

Employee Signature	Date
Supervisor Signature	Date
Approving Manager Signature	Date

OFFICE USE ONLY

Aux ID:	Date:	Entered by:	Paid Sick Leave:	Date:	Reviewed by:	Date:
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FRESNO STATE PROGRAMS FOR CHILDREN, INC.

Hiring Checklist

Name: _____ Date of Hire: _____

Dept./Project: _____ Cost Center: _____

To be returned to Human Resources:

- Employee Information Sheet
- Application
- Nature of Employment Acknowledgment
- AB 469 Rate and Payday Notification
- Child Abuse and Neglect Reporting Act (CANRA) Acknowledgment
- Employee Handbook Acknowledgment
- Drug Free Workplace Acknowledgment
- Injury and Illness Prevention Program Acknowledgement
- Federal W-4 and State DE 4
- I-9 Employment Eligibility Form & Appropriate Identification*

Additional Forms Available to Employees by Request:

- Employee Handbook
- Sexual Harassment Brochure
- Employee Assistance & Development Brochure (EAP)
- Workers' Compensation Informational Brochures
- Workplace Violence Guide
- State Disability Insurance Brochure
- Paid Family Leave Insurance Brochure

Employee Signature

Date

Supervisor's Signature

Date

*Employee **CAN NOT** begin work until I-9 form has been verified by HR personnel.



California State University, Fresno Auxiliary Corporations

2771 E. Shaw Avenue, Fresno, CA 93710 · www.auxiliary.com · Fax: (559) 278-0988 · HRAUX@LISTSERV.csufresno.edu

EMPLOYMENT APPLICATION FOR STUDENT/PART-TIME/TEMPORARY POSITIONS

Please Print

Date: _____

Name: _____

(Last) (First) (MI)

Address: _____

(Number & Street) (City) (State) (Zip)

Telephone: (_____) _____
(Home)

(_____) _____
(Work)

(_____) _____
(Cell Phone)

Email: _____

Employment Desired

Position applying for: _____ Department: _____

What days and hours are you available for work? _____

Are you available for work on weekends? Yes No

Would you be available for overtime, if necessary? Yes No

If hired, on what day can you start work? ___/___/___

Education, Training and Experience

School	Name and Address	No. of years Completed	Did you Graduate?	Degree Or Diploma
High School	Name		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Address			
	City State Zip			
College/ University	Name		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Address			
	City State Zip			
Vocational/ Business	Name		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Address			
	City State Zip			
Other	Name		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Address			
	City State Zip			

Please provide the following information and indicate the skills you possess **only** if they are a requirement of the position for which you are applying:

Driver's License Number: _____ State: _____ Class: _____

Languages you speak, read or write fluently in addition to English: _____

Do you have any other experience, training, qualifications or skills which you feel make you especially suited for work at California State University, Fresno Auxiliary Corporations? Yes No

If so, please explain: _____

Employment History

List below all present and past employment starting with your most recent employer. Account for all periods of unemployment. You must complete this section even if attaching a resume.

<i>Name of Employer</i>	<i>Dates of Employment:</i> _____ <i>From</i> _____ <i>To</i>
<i>Type of Business</i>	<i>Your Supervisor's Name</i> ()
<i>Street Address</i>	<i>Telephone No.</i>
<i>City</i> _____ <i>State</i> _____ <i>Zip</i> _____	<i>Your Reason for Leaving:</i>
<i>Your Position and Duties:</i> _____	
	<i>May we contact this employer for a reference?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No

<i>Name of Employer</i>	<i>Dates of Employment:</i> _____ <i>From</i> _____ <i>To</i>
<i>Type of Business</i>	<i>Your Supervisor's Name</i> ()
<i>Street Address</i>	<i>Telephone No.</i>
<i>City</i> _____ <i>State</i> _____ <i>Zip</i> _____	<i>Your Reason for Leaving:</i>
<i>Your Position and Duties:</i> _____	
	<i>May we contact this employer for a reference?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No

<i>Name of Employer</i>	<i>Dates of Employment:</i> _____ <i>From</i> _____ <i>To</i>
<i>Type of Business</i>	<i>Your Supervisor's Name</i> ()
<i>Street Address</i>	<i>Telephone No.</i>
<i>City</i> _____ <i>State</i> _____ <i>Zip</i> _____	<i>Your Reason for Leaving:</i>
<i>Your Position and Duties:</i> _____	
	<i>May we contact this employer for a reference?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No

<i>Name of Employer</i>	<i>Dates of Employment:</i> _____ <i>From</i> _____ <i>To</i>
<i>Type of Business</i>	<i>Your Supervisor's Name</i> ()
<i>Street Address</i>	<i>Telephone No.</i>
<i>City</i> _____ <i>State</i> _____ <i>Zip</i> _____	<i>Your Reason for Leaving:</i>
<i>Your Position and Duties:</i> _____	
	<i>May we contact this employer for a reference?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No

Personal Information

Have you ever applied to or worked for California State University, Fresno Auxiliary Corporations (which include the Association, the Agricultural Foundation, and the Foundation) before? Yes No
If yes, for which corporation and when? _____

Do you have friends or relatives working for California State University, Fresno Auxiliary Corporations? Yes No
If yes, state name, relationship and organization:

Name	Relationship	Organization
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If hired, would you have a reliable means of transportation to and from work?..... Yes No

If hired, can you provide evidence of your legal right to work in the United States? Yes No

Are you able to perform the essential functions of the job for which you are applying, either with or without reasonable accommodation? Yes No

If no, describe the functions that cannot be performed: _____

(Note: We comply with the ADA and consider reasonable accommodation measures that may be necessary for eligible applicants/employees to perform essential functions. Hire may be subject to passing a medical examination, and to skill and agility tests.)

Are you currently employed? Yes No

If so, may we contact your current employer? Yes No

Please Read Carefully, Initial Each Paragraph and Sign Below

_____ I hereby certify that I have not knowingly withheld any information that might adversely affect my chances for employment and that the answers given by me are true and correct to the best of my knowledge. I further certify that I, the undersigned applicant, have personally completed this application. I understand that any omission or misstatement of material fact on this application or on any document used to secure employment shall be grounds for rejection of this application or for immediate discharge if I am employed, regardless of the time elapsed before discovery.

_____ I hereby authorize the company to thoroughly investigate my references, work record, education and other matters related to my suitability for employment and, further, authorize the references I have listed to disclose to the company any and all letters, reports and other information related to my work records, without giving me prior notice of such disclosure. In addition, I hereby release the company, my former employers and all other persons, corporations, partnerships and associations from any and all claims, demands or liabilities arising out of or in any way related to such investigation or disclosure.

_____ I understand that nothing contained in the application, or conveyed during any interview which may be granted or during my employment, if hired, is intended to create an employment contract between me and the company. In addition, I understand and agree that if I am employed, my employment is for no definite or determinable period and may be terminated at any time, with or without prior notice, at the option of either myself or the company, and that no promises or representations contrary to the foregoing are binding on the company unless made in writing and signed by me and the company's designated representative.

_____ Date

_____ Applicant's Signature

FRESNO STATE

Auxiliary Services

STUDENT CLASS SCHEDULE

Name: _____

Address: _____

Cell Phone: _____

Home Phone: _____

Email Address: _____

Please place an "X" in each box during the time of your class.

Semester: _____

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
8:00 a.m.							
9:00 a.m.							
10:00 a.m.							
11:00 a.m.							
12:00 p.m.							
1:00 p.m.							
2:00 p.m.							
3:00 p.m.							
4:00 p.m.							
5:00 p.m.							
6:00 p.m.							
7:00 p.m.							
8:00 p.m.							
9:00 p.m.							

Equal Employment Opportunity Data

To be completed by applicant:

_____ *Application Date*

Completion of this form is entirely voluntary, and all information will remain confidential and will not affect your application for employment. We are required by law to collect this information for equal opportunity employment purposes, and it will not become part of your personnel record if you are hired by this company.

Name: _____

Position Applied for: _____

Department: _____

Gender: Male Female

Race/Ethnicity: American Indian/Alaskan Native
 Asian/Pacific Islander
 Black
 Hispanic
 White

Method of referral for employment at California State University, Fresno Auxiliary Corporations:

<input type="checkbox"/> Fresno State employee	<input type="checkbox"/> Fresno State Auxiliary Corporations employee
<input type="checkbox"/> Newspaper advertisement	<input type="checkbox"/> Auxiliary Job Announcement
<input type="checkbox"/> Internet	<input type="checkbox"/> Employment Agency
<input type="checkbox"/> Friend/Relative	<input type="checkbox"/> Other: _____

Government contractors must take affirmative action to employ and advance certain qualified individuals subject to the Rehabilitation Act of 1973 and the Vietnam Era Veterans Readjustment Act of 1974. Completion of the following information is voluntary, and will assist us in proper placement and reasonable accommodation. If you wish to be identified as qualifying for such placement or accommodation, please check where applicable:

<input type="checkbox"/> Vietnam Era Veteran	<input type="checkbox"/> Other Veteran
<input type="checkbox"/> Disabled Veteran	<input type="checkbox"/> Individual with a Disability

To be completed by employer:

EEO-1 Category: 1. Officials and managers 6. Crafts – skilled
 2. Professionals 7. Operatives – semi-skilled
 3. Technicians 8. Laborers – unskilled
 4. Sales 9. Service workers
 5. Office and clerical

Employer information completed by:

Name

Date

FRESNO STATE PROGRAMS FOR CHILDREN, INC.

NATURE OF EMPLOYMENT

The relationship between employees and Fresno State Programs for Children, Inc. (PFC) is for an unspecified term and is considered employment at-will. No supervisor or employee of PFC has the authority to enter into any agreement for employment for any specified period of time or to make any agreement for employment other than at-will. Only the Executive Director in consultation with the Program Director has the authority to make any such agreement and then only in writing, signed by the Executive Director and indicating it is intended as a modification of a particular employee's at-will status. Consequently, the employment relationship with any employee can be terminated at will, either by the employee or PFC, with or without cause or advance notice. PFC can also demote and change pay and duties of any employee at-will.

All employees should be aware that PFC is not governed by collective bargaining. Although some benefits and policies may be the same or similar to those of the University, PFC has developed its own policies and procedures under California law, including the California Code of Regulations, the Education Code, the California Department of Education, Child Development Division-Funding Terms and Conditions, the California Department of Social Services-Community Care Licensing and under directives and policies by the Trustees and the Chancellor of The California State University system. PFC is a private employer under the Internal Revenue Code and is not a State agency.

All student employees should be aware that employment with the Programs for Children is for a maximum of twenty (20) hours per week during the academic year. If a Programs for Children student employee were to be concurrently employed through California State University, Fresno, the employee will work a maximum of twenty (20) hours per week, combined.

Any questions should be addressed to the PFC Center Supervisor, Program Director, Executive Director or the Human Resources Department for clarification. University employees may not be familiar with the policies and procedures of PFC and may not be able to provide accurate information.

Acknowledgment:

I have entered into my employment relationship with PFC voluntarily and acknowledge that there is no specified length of employment. I understand that I or PFC can terminate the relationship at-will, with or without notice or cause, at any time.

Employee's Name (Printed)

Employee's Signature

Date

**Notice and Acknowledgement of Pay Rate and Payday
Under Section 2810.5 of the California Labor Code
Notice for Hourly Rate Non-Exempt Employees**

Employee Information	
Name:	Start Date:

Employee Rate of Pay Per Hour		
Straight Time Rate:	Time & One Half Rate:	Double Time Rate:

Employer & Worker's Compensation Information	
Employer: Fresno State Programs for Children, Inc. 2771 E. Shaw Avenue Fresno, CA 93710 Phone: (559) 278-0865 Mailing Address (if different): N/A Doing Business As (DBA) Name(s): N/A	Workers' Compensation Insurance Carrier (name, address, phone): Security National Insurance Company / AmTrust P.O. Box 6939 Cleveland, OH 44101 Phone: (866) 272-9267 Fax: (877) 669-9140

Wage Information	
Notice Given: <input checked="" type="checkbox"/> At hiring <input type="checkbox"/> Before a change in pay rate(s), allowances claimed or payday Allowances taken: <input checked="" type="checkbox"/> None	Pay is: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input checked="" type="checkbox"/> Semi-monthly <input type="checkbox"/> Other Regular Pay Dates: <u>7th</u> and <u>22nd</u>

Paid Sick Leave
Unless exempt, the employee identified on this notice is entitled to minimum requirements for paid sick leave under state law which provides that an employee: <ol style="list-style-type: none"> a. May accrue paid sick leave and may request and use up to 3 days or 24 hours of accrued paid sick leave per year; b. May not be terminated or retaliated against for using or requesting the use of accrued paid sick leave; and c. Has the right to file a complaint against an employer who retaliates or discriminates against an employee for: <ol style="list-style-type: none"> 1. Requesting or using accrued sick days; 2. Attempting to exercise the right to use accrued paid sick days; 3. Filing a complaint or alleging a violation of Article 1.5 section 245 et seq. of the California Labor Code; 4. Cooperating in an investigation or prosecution of an alleged violation of this Article or opposing any policy or practice or act that is prohibited by Article 1.5 section 245 et seq. of the California Labor Code.
<p style="text-align: center;">The following applies to the employee identified on this notice: (Check one box)</p> <input type="checkbox"/> 1. Accrues paid sick leave only pursuant to the minimum requirements stated in Labor Code §245 et seq. with no other employer policy providing additional or different terms for accrual and use of paid sick leave. <input type="checkbox"/> 2. Accrues paid sick leave pursuant to the employer's policy which satisfies or exceeds the accrual, carryover, and use requirements of Labor Code §246. <input checked="" type="checkbox"/> 3. Employer provides no less than 24 hours (or 3 days) of paid sick leave at the beginning of each 12-month period. <input type="checkbox"/> 4. The employee is exempt from paid sick leave protection by Labor Code §245.5. (State exemption and specific subsection for exemption)

Employee Acknowledgment	
On this day I have been notified of my pay rate, overtime rate, allowances, designated pay day, and my employer's information on the date given below.	
_____ Employee Name (Printed)	_____ Date
_____ Employee Signature	_____ Preparer's Name and Title

Employee Emergency Contact Information

Please complete the following information (please print):

Employee Name: _____ Contact Number: _____

Full Address: _____

In case of emergency, notify the following:

Name: _____ Relationship: _____

Full Address: _____

Contact Number: _____ Additional # (if applicable): _____

Pre-Designation of Physician for Work-Related Injury

Please read carefully: This information pertains to work-related injury or illness only:

You are entitled to be treated by your own personal physician if the pre-designation form is completed and returned to the Auxiliary Human Resources Office prior to any work-related injury. If you do not pre-designate a physician and need medical treatment for a work-related injury or illness, you will be referred to the organization's approved physician.

Please complete below:

I elect to be treated by the organizations' approved work physician

I elect to be treated by my own physician (Please list physician information below)

Physician Name

Phone

Address

Employee Signature: _____ Date: _____

STATEMENT ACKNOWLEDGING REQUIREMENT
TO REPORT CHILD ABUSE AND NEGLECT
[USE FOR GENERAL REPORTERS ONLY]

INSTRUCTION FOR HUMAN RESOURCES: Provide this form, as well as Attachments A and B of Executive Order 1083 Revised July 21, 2017, to employees who are identified as General Reporters*. Retain the completed form in the employee's official personnel file.

***Exception:** Non-Management Personnel Plan employees hired prior to January 1, 1985

California law **requires** certain people, known as "Mandated Reporters," to report known or suspected child abuse or neglect. You have been identified as a Mandated Reporter (General Reporter). As a General Reporter, you are required by the law to sign this statement acknowledging your legal reporting obligations.

A copy of the relevant provisions of the law explaining the definition of "Mandated Reporter" (Penal Code § 11165.7), the reporting obligations (Penal Code § 11166), penalty for failure to report abuse or impeding report (Penal Code § 11166.01), the contents of the reports, and the confidentiality of the Mandated Reporter's identity (Penal Code § 11167) is attached.

Online training is available to you at <https://ds.calstate.edu/?svc=skillsoft> (under keyword search "Mandated Reporter").

While it is not required, we strongly encourage you to take the training.

WHEN REPORTING ABUSE IS REQUIRED

As a Mandated Reporter (General Reporter), whenever in your professional capacity or within the scope of your employment you have knowledge of or observe a person under the age of 18 years whom you know or reasonably suspect has been the victim of child abuse or neglect, you must report the suspected incident, ***no matter where it occurred*** (Penal Code §§ 11166(a)).

PROCEDURE FOR REPORTING

To make a report, you **must** do the following:

- ***Immediately, or as soon as practically possible***, contact by phone one of the following: police or sheriff's department (including campus police, but not including a school district police or security department); a county probation department (if designated by the county to receive mandated reports); or the county welfare department (Child Protective Services or CPS).
- ***Within 36 hours of receiving the information concerning the incident***: complete Form SS 8572 (available online at http://ag.ca.gov/childabuse/pdf/ss_8572.pdf) per the instructions (available online at http://ag.ca.gov/childabuse/pdf/8572_instruct.pdf); and send, fax or electronically transmit it to the agency that was contacted by phone (Penal Code § 11166(a)).

Names and contact information for agencies that can accept reports are available online at the following websites:

California State University Police Departments (by campus):

<http://calstate.edu/strategicinitiatives/UPD/contacts.shtml>

Child Protective Services (by county):

http://www.hwcws.cahwnet.gov/countyinfo/county_contacts/hotline_numbers.asp

For Sheriffs' Departments (by county):

<http://www.calsheriffs.org/sheriffs-offices.html>

Note: Reporting to a supervisor, a coworker, or other person is not a substitute for making a mandated report to one of the agencies listed above.

ABUSE AND NEGLECT THAT MUST BE REPORTED

Physical abuse, meaning physical injury other than by accidental means inflicted on a child (Penal Code § 11165.6).

Sexual assault, including sex acts with a child, intentional masturbation in the presence of a child, child molestation, and lewd or lascivious acts with a child under 14 years of age or with a child under 16 years of age if the other person is at least ten years older than the child (Penal Code § 11165.1(a)(b)).

Sexual exploitation, including acts relating to child pornography, child prostitution, or performances involving obscene sexual conduct by a child (Penal Code § 11165.1(c)).

Statutory rape involving sexual intercourse between a child under 16 years of age and a person 21 years of age or older, which is also a form of "sexual assault" (Penal Code § 11165.1(a)).

Neglect, meaning the negligent treatment or maltreatment of a child by a parent, guardian or caretaker under circumstances indicating harm or threatened harm to the child's health or welfare (Penal Code § 11165.2).

Willful harming or injuring or endangering a child meaning a situation in which any person inflicts, or willfully causes or permits a child to suffer unjustifiable physical pain or mental suffering, or causes or permits a child to be placed in a situation in which the child or child's health is endangered (Penal Code § 11165.3).

Unlawful corporal punishment, meaning a situation in which any person willfully inflicts upon a child cruel and inhuman corporal punishment or a physical injury (Penal Code § 11165.4).

WHAT IS NOT CHILD ABUSE OR NEGLECT?

The law does **not** consider the following child abuse or neglect for reporting purposes:

- Injuries caused by two children fighting during a mutual altercation (Penal Code § 11165.6)
- An injury caused by reasonable and necessary force used by a peace officer acting within the course and scope of his or her employment (Penal Code § 11165.6)

- Reasonable and necessary force used by public school officials to quell a disturbance threatening physical injury to person or damage to property, for self-defense, or to obtain possession of weapons or other dangerous objects under a child's control (Penal Code § 11165.4)
- Corporal punishment, unless it is cruel or inhumane or willfully inflicts a physical injury (Penal Code § 11165.4)
- Not receiving medical treatment for religious reasons (Penal Code § 11165.2(b))
- Acts performed for a valid medical purpose (Penal Code § 11165.1(b)(3))
- An informed and appropriate medical decision made by a parent, guardian or caretaker after consultation with a physician who has examined the child (Penal Code § 11165.2(b))

IMMUNITY AND CONFIDENTIALITY OF REPORTER

Mandated Reporters cannot be held civilly or criminally liable for their reports. Instead, they enjoy immunity from prosecution for their reporting of suspected child abuse (Penal Code § 11172(a)). Both the identity of the person who reports and the report itself are confidential and disclosed only among appropriate agencies (Penal Code § 11167(d)).

PENALTY FOR FAILURE TO REPORT ABUSE OR IMPEDING REPORT

A Mandated Reporter who fails to make a required report of abuse, or any administrator or supervisor who impedes or inhibits a report, is guilty of a misdemeanor punishable by up to six months in jail, a fine of \$1,000, or both (Penal Code Section 11166(c) and Section 11166.01(a)). Where the abuse results in death or great bodily injury, the Mandated Reporter who fails to make a required report or administrator or supervisor who impeded or inhibited the report is subject to punishment of up to one year in jail, a fine of \$5,000, or both (Penal Code Section 11166.01(b)).

ACKNOWLEDGMENT

I acknowledge being provided with copies of Penal Code Sections 11165.7, 11166, 11166.01, and 11167. I acknowledge and understand my responsibility and legal obligation to report known or suspected child abuse or neglect in compliance with Penal Code Section 11166.

Employee's Name: _____ Dept.: _____

Signature: _____ Date: _____

**FRESNO STATE PROGRAMS FOR
CHILDREN, INC.**

**INJURY AND ILLNESS
PREVENTION PROGRAM**

INTRODUCTION

FRESNO STATE PROGRAMS FOR CHILDREN, INC. is concerned about the welfare of all of its employees, and is committed to providing a healthful and safe working environment for everyone. In demonstrating our commitment, and to facilitate achievement of our goal, FRESNO STATE PROGRAMS FOR CHILDREN, INC. has implemented a comprehensive safety plan, including important policies and procedures that all employees are required to follow. Safety, though, is a mutual responsibility. Regardless of how detailed our overall safety program is, it cannot cover every possible work situation. By being alert for possible hazards and unsafe conditions or acts, you can help ensure your safety and that of your co-workers.

This Injury Illness Prevention Program document is a summary of our overall safety and health program. It highlights the general areas of our safety and health plan, and identifies responsible parties. Detailed policies, procedures, and safe practices are available covering our entire program. Any questions or concerns should be addressed to the Director of Human Resources for Auxiliary Services. FRESNO STATE PROGRAMS FOR CHILDREN, INC. expects each employee to understand and follow the guidelines printed on the following pages.

APPROVAL

The Executive Director of Auxiliary Services has approved this IIPP dated 11/30/01, which has been written according to Cal/OSHA Standard 8, CCR 3203. This summary and all supporting policies and procedures are effective December 1, 2001 and supersede any other written and verbal safety procedures previously implemented.

RESPONSIBILITY

The Director of Human Resources has the responsibility for administering and maintaining the Injury and Illness Prevention Program (IIPP).

All employees are responsible for reading, understanding and following the IIPP in their work areas. A copy of this IIPP is available from the Human Resources Department.

COMPLIANCE

All employees are responsible for complying with safe and healthful work practices. Our system of ensuring that all employees comply with these practices includes the following:

- Informing employees of the provisions of our IIPP.
- Evaluating the safety performance of all employees.
- Recognizing employees who perform safe and healthful work practices.
- Providing training to employees whose safety performance is deficient.
- Disciplining employees for failure to comply with safe and healthful work practices.

COMMUNICATION

The Director of Human Resources is responsible for communicating with all employees about occupational safety and health in a form readily understandable by all employees. Our communications system encourages all employees to inform their immediate supervisor/manager about workplace hazards without fear of reprisal.

Our communication system includes:

- New employee orientations including a discussion of safety and health policies and procedures.
- Review of our IIPP with all employees.
- Workplace safety and health training.
- Effective communication of safety and health.
- Regularly scheduled safety meetings.
- Posted and distributed safety information.
- A safety suggestion box that allows employees to anonymously inform management about workplace hazards.

HAZARD ASSESSMENT

Periodic inspections to identify and evaluate workplace hazards will be performed by the Associated Students, Inc. Safety Committee. Inspections will occur according to the following schedule:

- Quarterly
- When we initially established our IIPP.
- When new substances, processes, procedures, or equipment, which present potential new hazards are introduced into our workplace.
- When new, previously unidentified hazards are recognized.
- When we hire and/or reassign employees to departments, operations or tasks for which a hazard evaluation has not been previously conducted.
- When occupational injuries and illnesses occur.
- Whenever workplace conditions warrant an inspection.

INVESTIGATIONS OF INJURIES, ILLNESS AND ACCIDENTS

Workplace injuries and illnesses will be investigated to determine if any preventable safety or health hazard contributed to the occurrence. The Department Manager will conduct the investigation in a timely manner after being advised of the incident. If a reportable serious injury or death results, the investigator will ensure that a report is made to Cal/OSHA within eight hours. Any hazardous condition or work practice that contributed to the injury, illness or accident will be abated according to the following Hazard Correction Policy.

HAZARD CORRECTION

Unsafe and unhealthy work-conditions, practices or procedures will be corrected in a timely manner based on the severity of the hazards. Hazards will be corrected according to the following procedures:

- When observed or discovered, hazards that do not pose an imminent danger will be corrected as soon as possible. If the hazard cannot be corrected immediately, a safe practice will be established and employees exposed to the hazard will be trained to avoid any injury. In addition, personal protective equipment will be provided as needed. The hazard will be scheduled for correction.
- When an imminent hazard exists which cannot be immediately corrected without endangering employees and/or property, we will remove all exposed employees from the area except those necessary to correct the existing condition. Employees who are required to correct the hazardous condition will be provided with the necessary protection.

TRAINING AND INSTRUCTION

All employees will have training and instruction on general and job specific safety and health practices. Training and instruction is provided as follows:

- When the IIPP is first established.
- To all new employees.
- To all employees given new job assignments for which training has not previously been provided.
- Whenever new substances, processes, procedures or equipment are introduced to the workplace and represent a new hazard.
- Whenever the Company is made aware of a new or previously unrecognized hazard.
- To supervisors to familiarize them with the safety and health hazards to which employees under their immediate direction and control may be exposed.
- To all employees with respect to hazards specific to each employees job assignment.

General workplace safety and health practices include, but are not limited to the following:

- Explanation of the Company's IIPP, emergency action plan, fire prevention plan, hazard communication program and measures for reporting any unsafe conditions, work practices, injuries and when additional instruction is needed.
- Use of appropriate clothing and any additional personal protective equipment.
- Safe lifting, carrying and bending procedures.
- Use of equipment, machinery as applicable
- Ergonomic safety; prevention of repetitive motion injuries and musculoskeletal disorders
- Information about chemical hazards to which employees could be exposed and other hazard communication program information including proper labeling of containers.
- Provisions for medical services and first aid including emergency procedures.
- Availability of restroom and drinking facilities.

RECORDKEEPING

We have taken the following steps to implement and maintain our IIPP:

- Records of hazard assessment inspections, including the person(s) conducting the inspection, the unsafe conditions and work practices that have been identified and the action taken to correct the identified unsafe conditions and work practices, are recorded on a hazard assessment and correction form.
- Documentation of safety and health training for each employee, including the employee's name, training dates, type(s) of training, and training providers are recorded on an employee training and instruction form.

Inspection records and training documentation will be maintained for three (3) years.

FRESNO STATE PROGRAMS FOR CHILDREN, INC.

**RECEIPT AND ACKNOWLEDGMENT OF
INJURY AND ILLNESS PREVENTION PROGRAM**

FRESNO STATE PROGRAMS FOR CHILDREN'S Injury and Illness Prevention Program has been reviewed with me on this day. I acknowledge that I had the opportunity to review the document myself, that I understand it is my responsibility to understand the requirements of the Program, and to ensure that I follow all related safe practices and procedures. I am aware that the IIPP is available for my review at my work site.

Signature _____

Print Name _____

Date _____

ACKNOWLEDGMENT

This Employee Handbook describes important information about the Fresno State Programs for Children (PFC). I understand that I should consult Auxiliary Human Resources regarding any questions not answered in this Handbook.

I have entered into my employment relationship with PFC voluntarily, and acknowledge there is no specified length of employment. I understand PFC is an at-will employer, which means I can terminate my employment at any time, with or without advance notice, with or without cause, and PFC has similar rights.

No manager, supervisor, or employee of PFC has authority to enter into any agreement for employment, for any specified period of time or to make any agreement for employment other than at-will.

Since the information, policies, and benefits described are subject to change, I acknowledge changes and revisions may occur and that such changes will be communicated through appropriate notices, and that those changes may modify, eliminate, reduce or improve existing policies and benefits.

I agree to read the Employment Handbook, whether in paper form or electronic form, read all changes in a timely manner, and agree to comply with the policies contained in the Handbook and any revisions made to it.

PRINT FULL NAME _____

EMPLOYEE SIGNATURE _____

DATE _____



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
<p>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.</p>		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):				
		<input type="checkbox"/> 1. A citizen of the United States				
		<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)				
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)				
<input type="checkbox"/> 4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any)						
If you check Item Number 4. , enter one of these:						
USCIS A-Number		OR	Form I-94 Admission Number		OR	Foreign Passport Number and Country of Issuance
Signature of Employee					Today's Date (mm/dd/yyyy)	

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

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

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

<p>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.</p>		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
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI 	OR	<ol style="list-style-type: none"> 1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">For persons under age 18 who are unable to present a document listed above: 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record 	AND	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security <p style="margin-left: 20px;">For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/i-9-central.</p> <p style="margin-left: 20px;">The Form I-766, Employment Authorization Document, is a List A, Item Number 4, document, not a List C document.</p>
<p>Acceptable Receipts</p> <p>May be presented in lieu of a document listed above for a temporary period.</p> <p>For receipt validity dates, see the M-274.</p>				
<ul style="list-style-type: none"> • Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee. 	OR	<p>Receipt for a replacement of a lost, stolen, or damaged List B document.</p>	AND	<p>Receipt for a replacement of a lost, stolen, or damaged List C document.</p>

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

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.**

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) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

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 Fresno State Programs for Children 2771 E. Shaw Ave. Fresno, CA 93710	First date of employment	Employer identification number (EIN) 77-0443565
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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	Filing Status
City, State, and ZIP Code	<input type="checkbox"/> SINGLE or MARRIED (with two or more incomes) <input type="checkbox"/> MARRIED (one income) <input type="checkbox"/> 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 2021, 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
Fresno State Programs for Children 2771 E. Shaw Ave.	451-2233-0

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 Personal Income Tax (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.

Dear Employee:

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or Contact Auxiliary Human Resources at (559) 278-0865.

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer Name <i>Fresno State Programs for Children, Inc.</i>	4. Employer Identification Number (EIN) <i>77-0443565</i>	
5. Employer Address <i>2771 E. Shaw Avenue</i>	6. Employer Phone Number <i>(559) 278-0865</i>	
7. City <i>Fresno</i>	8. State <i>CA</i>	9. ZIP Code <i>93710</i>
10. Who can we contact about employee health coverage at this job? <i>Nicole Lane</i>		
11. Phone Number (if different than above)	12. Email address <i>nicolel@csufresno.edu</i>	

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

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

All employees

Some employees. Eligible employees are:

Benefited employees (also called regular or full time employees).

- With respect to dependents:

We do offer coverage. Eligible dependents are:

A spouse, a domestic partner of the same sex as the Employee, or a domestic partner of the opposite sex of the Employee provided the partner is over age 62 and is registered with the California State Registry; and a child, stepchild or other eligible dependent up to age 26.

We do not offer coverage

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

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

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

2024 Semi-Monthly Payroll Schedule

California State University, Fresno Association, Inc.
 California State University, Fresno Athletic Corporation
 California State University, Fresno Foundation
 Agricultural Foundation of California State University, Fresno
 Associated Students Inc. of California State University, Fresno
 Fresno State Programs for Children, Inc.

<u>Pay Period</u>	<u>Time-Sheet Due</u>	<u>Date Paychecks Available</u>
December 16-31	January 2, by 5:00 p.m.	Friday, January 5
January 1-15	January 16, by 5:00 p.m.	Monday, January 22
January 16-31	February 1, by 5:00 p.m.	Wednesday, February 7
February 1-15	February 16, by 5:00 p.m.	Thursday, February 22
February 16-29	March 1, by 5:00 p.m.	Thursday, March 7
March 1-15	March 18, by 5:00 p.m.	Friday, March 22
March 16-31	April 2, by 5:00 p.m.	Friday, April 5
April 1-15	April 16, by 5:00 p.m.	Monday, April 22
April 16-30	May 1, by 5:00 p.m.	Tuesday, May 7
May 1-15	May 16, by 5:00 p.m.	Wednesday, May 22
May 16-31	June 3, by 3:30 p.m.	Friday, June 7
June 1-15	June 17, by 3:30 p.m.	Friday, June 21
June 16-30	July 1, by 3:30 p.m.	Monday, July 8
July 1-15	July 16, by 3:30 p.m.	Monday, July 22
July 16-31	August 1, by 3:30 p.m.	Wednesday, August 7
August 1-15	August 16, by 5:00 p.m.	Thursday, August 22
August 16-31	September 3, by 5:00 p.m.	Friday, September 6
September 1-15	September 16, by 5:00 p.m.	Friday, September 20
September 16-30	October 1, by 5:00 p.m.	Monday, October 7
October 1-15	October 16, by 5:00 p.m.	Tuesday, October 22
October 16-31	November 1, by 5:00 p.m.	Thursday, November 7
November 1-15	November 18, by 5:00 p.m.	Friday, November 22
November 16-30	December 2, by 5:00 p.m.	Friday, December 6
December 1-15	December 16, by 5:00 p.m.	Friday, December 20

ALL PAYROLL CHECKS ARE AVAILABLE
AFTER 1:00 PM ON THE DATE SHOWN ABOVE

FRESNO STATE

Auxiliary Services

Authorization for Direct Deposit of Payroll

Type of Enrollment Action: <input type="checkbox"/> NEW <input type="checkbox"/> CHANGE <input type="checkbox"/> CANCEL	Social Security Number OR Auxiliary ID Number: Name: (First Middle Last)
---	---

To be Completed by Employee if NEW or CHANGE is Checked

Type of Account: <input type="checkbox"/> Checking <input type="checkbox"/> Savings											
Numbers on Form Must Match Supporting Documentation											
Routing Number: <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>											Account Number:
Financial Institution Name:											
Financial Institution Address:											

To be Completed by Employee if NEW or CHANGE is Checked

<input type="checkbox"/> I authorize Auxiliary Services to perform electronic credit entries, and if necessary, and debit entries that are in error to my account, to the financial institution account named above. This authority will remain in force until I have given written notification to terminate it.	
Signature	Date

To be Completed by Employee if CANCEL is Checked

<input type="checkbox"/> I authorize Auxiliary Services to cancel my Direct Deposit.	
Signature	Date

Please staple a voided check in this area.
If checks not available, please attach official bank documentation.