Welcome to Policies and Forms of

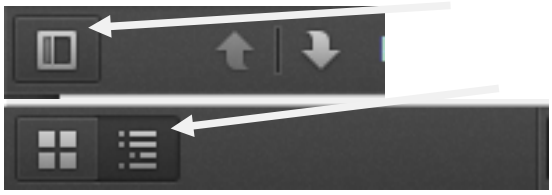
HUMAN TECHNOLOGIES

The Power of People with Purpose

TO NAVIGATE:

- View the table of contents/bookmarks:

Firefox browser:

1. 

2.

Internet Explorer browser:

Click green box →

[green box may only be visible in certain browsers]

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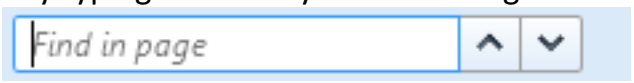
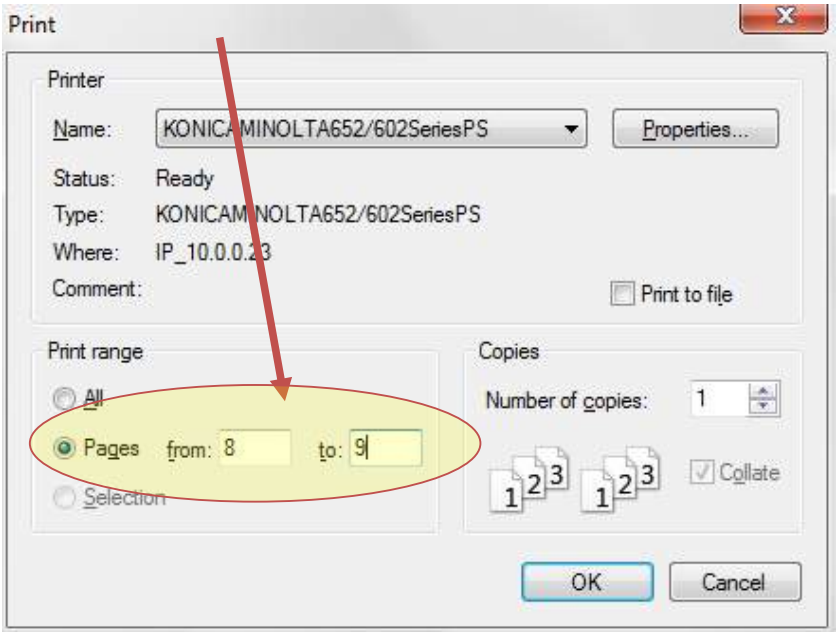
- Press 'Ctrl +F' and a search tool will show up on your screen where you can search the entire document by typing the word you are looking for in the box:



TO PRINT:

In print properties, choose your page range. Otherwise you print the entire document, which would not be very eco friendly.



HUMAN TECHNOLOGIES

The Power of People with Purpose

FORMS

HUMAN TECHNOLOGIES
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INJURY OR ILLNESS REPORT

(For employee to take to physician)

Name of Employee: _____ DOB: _____

Date of Injury/Illness: _____ Time of Injury/Illness: _____

Employee Phone Number: _____

Emergency Contact Person: _____ Phone: _____

Presenting Problem:

_____

_____

First Aid Given:

_____

_____

Medications as stated by patient:

_____

Form Completed by: _____ Date: _____

BILLING INSTRUCTIONS:

In many workplace injuries/illnesses cases, Human Technologies will self-pay medical bills as a First Aid Claim.

Please send medical bills to: Human Technologies
2260 Dwyer Avenue
Utica, NY 13501
315-724-9891 EXT 6915

Please contact the HR Department with any questions.
Phone: 315-724-9891 ext 6915 | Fax: 315-570-6933 | Email: christines@htcorp.net

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RETURN TO WORK INFORMATION

Name of Employee: _____ DOB: _____

Date of Injury/Illness: _____

TO BE COMPLETED BY TREATING PHYSICIAN:

Treating Physician or Clinic: _____

Physician's phone number: _____

Diagnosis: _____

Physical Findings: _____

Return to Work Status:

- ☐ Full Duty Date: _____
- ☐ Limited Duty Until _____
- ☐ Unable to Work Until _____

Capabilities: Employee may do the following activities:

Drive	☐ None	☐ 1 – 4 hours	☐ 4 – 6 hours	☐ 6 or more hours	
Walk	☐ None	☐ 1 – 4 hours	☐ 4 – 6 hours	☐ 6 or more hours	
Stand	☐ None	☐ 1 – 4 hours	☐ 4 – 6 hours	☐ 6 or more hours	
Sit	☐ None	☐ 1 – 4 hours	☐ 4 – 6 hours	☐ 6 or more hours	
Climb	☐ None	☐ 1 – 4 hours	☐ 4 – 6 hours	☐ 6 or more hours	
Lift	☐ None	☐ 0 – 10 lbs.	☐ 10 – 25 lbs.	☐ 25 – 50 lbs.	☐ 50 + lbs.
Push/Pull	☐ None	☐ 0 – 10 lbs.	☐ 10 – 25 lbs.	☐ 25 – 50 lbs.	☐ 50 + lbs.
Right Arm/Hand	☐ Limited Use	☐ No Use			
Left Arm/Hand	☐ Limited Use	☐ No Use			

Follow up medical visit need on: _____

Comments: _____

_____

_____ _____ _____

Examining Physician's Signature Printed Name Date

Please return completed form to the HR Department
by fax at 315-570-6933 or by email to christines@htcorp.net, or by regular mail to:
Human Technologies, 2260 Dwyer Avenue, Utica, NY 13501.

HUMAN TECHNOLOGIES

Authorization to Release and/or Obtain Protected Health Information

Name: _____ Date of Birth: _____

Address: _____

Phone #: _____

I authorize Human Technologies Corporation to:

☐	RELEASE the above named individual's health information to:	☒	OBTAIN the above named individual's health information from:
Name:			
Address:			
City/State/Zip Code:			
Phone #:		Fax #:	

1. Description of information that may be disclosed:
   Ongoing verbal and written communication for care coordination and employment.

   *Specific authorization is required to release the following documentation. If authorizing release, please initial:

   ☐ _____ Substance Abuse Records (Initial) ☐ _____ Psychiatric Records (Initial)

2. The information may be used/disclosed for the following purposes:
   ☐ Continuity/Transfer of Care ☐ Employment ☐ Disability ☐ Legal

3. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information authorized for disclosure in item number (1) above may be re-disclosed and may be no longer protected by these regulations.

4. I understand that by authorizing Human Technologies, to use/disclose the information, that they may receive compensation for reasonable expenses incurred for making photo copies of my records.

5. I understand that I may revoke this authorization in writing at any time by contacting my provider/employer, except to the extent that action has been taken in reliance of this authorization.

6. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my eligibility for employment. However, if applying for a position that requires a person with a disability I must provide required disability documentation.

7. This authorization expires _____ (insert applicable date), or within twelve (12) months of the date of the authorization, whichever is greater.

_____ _____
Signature of Employee Date

_____ _____
Signature of Witness Date

_____
If signed by Legal Representative, relationship to the employee

Bereavement Time Off Request

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You can never be fully compensated for the loss of an immediate family member. In the event of such an occurrence, it is the intent of the Corporation to protect employees from loss of earnings while making necessary arrangements and attending the funeral. Eligible employees can be absent without loss of pay for a period of up to three (3) days with the written approval of the VP of Human Resources for a death of an immediate family member, i.e., spouse, partner, child, parent, brother, sister, in-laws, grandparent, grandchild.

Employee: _____ Date: _____

Number of Days being requested: _____

Relationship (Check one):

- ☐ Spouse
- ☐ Partner
- ☐ Child
- ☐ Parent/In-Law
- ☐ Sister/In-Law
- ☐ Brother/In-Law
- ☐ Grandparent/In-Law
- ☐ Grandchild

Supervisor/Manager Name: _____

Supervisor/Manager Signature: _____ Date: _____

Original: Payroll
Copies: HR Department
Supervisor/Manager
Employee

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Bus Passes Through Payroll Deduction

Employee Name:_____ File # _____

Amount of Deduction:

Centro Bus (Utica) $_____

Birnie Bus Service $_____

TOTAL $_____

I understand that the above amount will be deducted from each of my bi-weekly paychecks until such time that I do not require assistance in transportation. I also agree that upon termination, any balance amount due will be deducted from my final paycheck. If I disagree with the amount deducted from my paycheck, I will notify my immediate supervisor.

Employee Signature: _____

Supervisor Signature: _____

Deduction Start Date: _____

Pay Period: _____

Payroll Staff Signature: _____

**Per Deductions in accordance with Law 195 – 4 authorized deductions for the benefit of the employee*

Original: Payroll

Copy: Requester

Rev: 2/27/14

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
100 BROADWAY-MENANDS
ALBANY, NY 12241
(877) 632-4996

You were injured at work. What now?

The New York State Workers' Compensation Board has received notice you suffered a workplace injury or illness, so we're preparing a workers' compensation case in your name. You may have already received medical treatment. If you haven't, you should seek medical care as soon as possible.

A Worker's Responsibilities

- You must tell your employer, in writing, when, where and how you were injured. Do this within 30 days of injury.
- *Medical reports are necessary for your case.* Advise your doctors that you have a work-related injury, and give the name of your employer. Do not pay for your care yourself or use other health insurance. Tell your doctor to file reports with the Board and with your employer or its insurance carrier. If your case is disputed, the Board needs a medical report on your injury to begin resolving your claim.

Starting a Case

Once your employer knows of your injury, it must notify this Board by filing a C-2 form. *You should file an employee claim (C-3 form) reporting your injury as soon as possible.* (You **must** notify the Board of your injury or illness within two years.) If you injured the same body part before, or had a similar illness, you must also file a Form C-3.3.

If you haven't already filed a C-3 or C-3.3 (if necessary), there are three ways to do it.

- Visit *www.wcb.state.ny.us/content/main/onthejob/howto.jsp* to complete the form.
- Complete the enclosed paper forms, and mail them to the Board.
- Call 1-866-396-8314. A Board employee will complete the form with you.

Health Care Bills

Do not pay your doctor or hospital. Those bills are paid by the insurer unless the Board disallows your case. If your case is disputed, the providers are paid when the Board decides your case. If the Board decides against you, or if *you don't pursue a case, you will have to pay the doctor or hospital.*

Your employer's insurance covers medically necessary drugs and equipment your doctor prescribes. You're also entitled to carfare or necessary expenses incurred when traveling for treatment. (Get receipts for those expenses.)

Generally, you can choose any doctor authorized by the Board. You can also use occupational health clinics. However, if your employer's insurer has a preferred provider organization to provide care for workers' compensation injuries, you must get your initial treatment from those providers. If that insurer also has a pharmacy or diagnostic network, you must get service within these networks. If the carrier uses these networks, it must also tell you its service providers and how to use them.

Benefits for Lost Wages

You are entitled to a portion of your lost wages if your injury affects you in one or more ways:

1. It keeps you from work for more than seven days;
2. Part of your body is permanently disabled;
3. Your pay is reduced because you now work fewer hours or do other work.

An employer or insurer can accept your claim and begin paying your lost wage benefit promptly. Sometimes, employers and carriers dispute a claim. When that occurs, the Board strives to resolve most cases within 90 days.

You may hire an attorney or licensed representative, who can be helpful with complex or disputed claims, but it isn't required. The Board sets their fees and they will be deducted from your lost wages award. You or your family should not pay anything directly to your attorney or licensed representative.

If your case is disputed, you may receive disability benefits while the case is heard. You'd pay them back out of your lost wages award. To get a DB-450 form, visit *www.wcb.state.ny.us/content/main/forms/db450.pdf* or a Board office, or call (800) 353-3092.

Help is Available

People sometimes need help getting back to work. Your employer may have a *return to work* program that can get you back to work in light duty or an alternative position while you heal. An injury can also cause family or financial problems. The Workers' Compensation Board has rehabilitation counselors and social workers to help. Call (877) 632-4996 for more assistance.

What's Next?

Your employer or its insurance carrier will contact you if your claim is accepted. When that happens, your treatment will be paid and lost wage benefits begin. If your case is challenged, the Board will notify you about resolving the case. If more information is necessary, the Board will contact you and tell you how to file it.

Important Contact Information

Workers' Compensation Board	(877)632-4996	General_Information@wcb.state.ny.us
Disability Benefits	(800)353-3092	www.WCB.State.NY.US
NYS Bar Association Lawyer Referral and Information Service	(800)342-3661	lr@nysba.org.

HUMAN TECHNOLOGIES
The Power of People with Purpose

HUMAN TECHNOLOGIES
CONFIDENTIALITY AND NONDISCLOSURE AGREEMENT (EMPLOYEES)

Date: _____

Name (Print): _____

I understand that I may see or otherwise be given access to, confidential information belonging to the Company, or the company's customers and/or suppliers, through my relationship with the Company or as a result of my access to the Company's premises.

I understand and acknowledge that the Company's confidential information and/or trade secrets consist of information and materials that are valuable to the Company and not generally known to the Company's competitors or outsiders. Therefore, I agree to hold in strict confidence:

(i) The names and identities of employees;

(ii) Information concerning the Company's current, future or proposed products, including, but not limited to, computer hardware, software, codes, drawings, specifications, technical notes, computer printouts, and other proprietary technology;

(iii) Information and materials relating to the Company's business contracts, purchasing, accounting and marketing, quality control, inventory and shipping, pricing information and customer lists, and other customer information that is not already publicly known;

(iv) All other types and categories of information not listed whether written, verbal, electronic, or printed.

I also agree to not remove any document, equipment or other materials from the premises without the Company's express permission. I will not photograph or otherwise record information which I may have access to during my employment.

Signature: _____ Date: _____

HUMAN TECHNOLOGIES
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HUMAN TECHNOLOGIES
CONFIDENTIALITY AND NONDISCLOSURE AGREEMENT (VISITORS)

Date: _____

Name (Print): _____

I understand that I may see or otherwise be given access to, confidential information belonging to the Company, or the company's customers and/or suppliers, through my relationship with the Company or as a result of my access to the Company's premises.

I understand and acknowledge that the Company's confidential information and/or trade secrets consist of information and materials that are valuable to the Company and not generally known to the Company's competitors or outsiders, including, but not limited to:

(i) The names and identities of employees and volunteers I may see at the Company premises.

(ii) Information concerning the Company's current, future or proposed products, including, but not limited to, computer hardware, software, codes, drawings, specifications, technical notes, computer printouts, and other proprietary technology.

(iii) Information and materials relating to Company's business contracts, purchasing, accounting and marketing, quality control, inventory and shipping, pricing information and customer lists, and other customer information that is not already publicly known.

(iv) All other types and categories of information not listed whether written, verbal, electronic, or printed.

I will hold in strictest confidence any confidential information that is disclosed to me. I will not remove any document, equipment or other materials from the premises without the Company's express permission. I will not photograph or otherwise record information which I may have access to during my employment.

Signature: _____ Date: _____
(If under 18, parent/legal guardian signature)

DIRECT DEPOSIT OF PAYROLL AUTHORIZATION AGREEMENT

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Company: Human Technologies	Company ID: 15-0571056

I hereby authorize Human Technologies Hereinafter called Company, to make payment of $ _____ for Direct Deposit of Payroll to the Bank indicated below, hereinafter called Bank, and authorize Bank to credit said amount to my:

Name of Bank: _____ ☐ Checking ☐ Savings

Routing Number: _____

Account Number: _____

Authorization for recovery of funds deposited in error:

By signing this form, the employee consents to allow the Company, through the financial institution, to debit the account, upon notice to the account owner, in order to recover any salary to which the employee is not entitled, which was deposited to the account in error or by mistake. This means of recovery shall not prevent the Company from utilizing any other lawful means to retrieve salary payments to which the employee is not entitled. This authorization is to remain in full force and effective until Company has received written notification from me of its termination in such time and manner as to afford the Company and Bank a reasonable opportunity to act on it.

STAPLE

VOIDED CHECK

HERE

Employee Name: _____

Signature: _____ Date: _____

Disciplinary Notice

HUMAN TECHNOLOGIES
The Power of People with Purpose

NAME: _____

DEPARTMENT: _____ DATE OF MEETING: _____

Check all that apply:

☐	Excessive Absenteeism and/or tardiness	☐	Failure to comply with Safety Rules	☐	Unlawful use of drugs or alcohol
☐	Poor Workmanship	☐	Theft	☐	Alleged Harassment/ Sexual Harassment
☐	Insubordination	☐	Failure to follow instructions	☐	Falsifying Time Card or other documents
☐	Fighting	☐	Violation of Corporate Policy	☐	Verbal Abuse
☐	Walking off Job/Abandon Job			☐	Other (specify below)

DESCRIPTION OF EVENT/BEHAVIOR: (FACTUAL INFORMATION ONLY include dates) (Attach extra sheets if needed)

What happened? (Include who, what, where, when)

_____

_____

_____

_____

_____

_____

_____

Has this situation/behavior occurred with this person before? ☐ Yes ☐ No If yes, when and what was the outcome?

_____

_____

_____

Expectations for future performance:

_____

_____

_____

_____

_____

_____

Action to be taken: ☐ Verbal Discipline ☐ Written Discipline ☐ Suspension (Circle One) With Pay / Without Pay

Consequences should incident occur again:

_____

_____

_____

_____

Your signature below indicates your understanding of this discipline and the expectations as outlined above.

_____ _____
Signature of Employee Date

_____ _____
Signature of Supervisor Issuing Discipline Date

_____ _____
Signature of Manager Date

Employee Statement (initial):

_____ I agree with the Employer's Statement

_____ I disagree with the Employer's Statement

Explanation:

_____

_____

_____

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JOB APPLICANT REFERRAL FORM

Instructions: **In order to be eligible to receive incentives for referring applicants for employment with Human Technologies Corporation, the following form must be completed and submitted to the Human Resources Department prior to the time a final hiring decision is made for a vacant position.**

DATE:_____

POSITION APPLYING FOR: _____

APPLICANT'S NAME:_____

REFERRED BY:_____
(Employee's Name)

_____
(Employee's Street Address)

_____
(Employee's City, State, Zipcode)

_____
(Employee's Phone Number)

For Office use only:

Applicant hired: ☐ Yes ☐ No

Position:_____ Start date:_____

Enter date of completion:_____

☐ Employee notified of applicant's date of hire.

☐ Employee issued $50.00 incentive following applicant's successful completion of 90 day learning period

☐ Employee issued $50.00 incentive following applicant's successful completion of six consecutive months of employment.

Email

My signature below indicates that I have received my Human Technologies ID badge and Guidelines. I understand my responsibility as outlined in the Guidelines dated January 2015.

If I do not understand I will seek clarification from my supervisor.

Print Name: _____

Signature: _____

Date: _____

HUMAN TECHNOLOGIES
The Power of People with Purpose

Expense Report 2018

Name: _____ Date: _____

Destination/Purpose of Travel: _____

Receipt #	Date	Merchant Name	Description of Expense	Detail for 'Other'	Cost	Mileage	Travel Origination	Travel Destination	Cost Center

Please ensure you have done all of the following:

- ☐ Scan or attach ALL receipts
- ☐ On each receipt, identify the expense to be reimbursed
- ☐ For business meals, include names of attendees
- ☐ Remove all personal and non-reimbursable expenses
- ☐ Document receipt number to cross reference to the appropiate line item above

Reimbursement Summary

Total Expenses	$0.00
Advance	
Net Due to/from	**$0.00**

Expense Summary

Categories	Totals
Mileage	$0.00
Transportation	$0.00
Lodging	$0.00
Meals	$0.00
Other	$0.00

Employee Signature

Supervisor Signature

Open in New Document

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Insurance Premiums Repayment via Payroll Deduction

Notice of Intent

Employee Name:_____

I understand that the amount below will be deducted from each of my bi-weekly paychecks until such time that I have repaid Human Technologies for the insurance premiums paid on my behalf in the amount of _____ (list total amount paid on employee's behalf). Once repaid, I understand my regular premium will continue to be deducted. I also agree that upon termination, any balance amount due will be deducted from my final paycheck. If I disagree with the amount deducted from my paycheck, I will notify my immediate supervisor.

Total amount of missed premiums: _____

Number of pay periods to repay (not to exceed 6 months): ÷ _____

Amount of biweekly deduction (in arrears): = _____

Amount of bi-weekly deduction (regular premium): + _____

Total bi-weekly deduction: = _____

Repayment Start Date: _____ Repayment end date: _____

Employee Signature: _____ Date:_____

HR Signature: _____ Date:_____

Payroll Specialist Signature:_____ Date:_____

**Per Deductions in Accordance with Law 195-4 Authorized Deductions for the Benefit of the Employee.*

Original: Payroll
Copies: Employee's Personnel File
Accounts Payable

Clear Form

Open in New Page

LETTER OF APPOINTMENT

***Supervisor must** request IT equipment, keys, maintenance, business cards, office cleaning, etc. via our Help Desk at http://htckbox*

☐ New Employee (Complete entire form) ☐ Employee Change (Only complete changes)

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Name of Employee: _____ Date requested: _____

Desired Effective Date: _____ Requested by: _____

New Employee: ☐ New Hire ☐ Rehire ☐ Temporary ☐ Seasonal
(If temporary or Seasonal, expected end date: _____)

Employee Change: ☐ Position/Title ☐ Hours ☐ Supervisor ☐ Department ☐ Rate of Pay ☐ Location

Job Title: _____ Slot #: _____ (Replaces: _____)

Home Department: _____ Immediate Supervisor: _____

Department Allocations:

%							
Dept. Code							

Hours per week: _____ Rate of pay: Hourly: _____ Annual (salary/exempt only): _____
(PMG = Primary Contract Base)

Will this employee be a Human Technologies Driver? ☐ Yes ☐ No

Any special considerations that should be outlined in Employee's Letter of Appointment:

_____

PMG ONLY (List all contracts (new and existing), attach additional sheet if necessary.)

Primary Contract: ☐ Commercial ← OR → ☐ Government

Contract Name	Contract Address	Hours per week	H&W Rate	Base Rate

APPROVALS

_____ _____ _____ _____
Supervisor Date Manager/Director Date

_____ _____
Officer (New positions only) Date

HR DEPARTMENT USE ONLY

Company Code: ☐ 9LY (Direct Labor) ☐ 9L0 (Non-direct labor)
Payroll ID: _____

Benefit Eligibility (Medical/Dental): ☐ Yes ☐ No
(If yes, date eligible/effective: _____)

Social Security Recipient: ☐ Yes ☐ No

Paid Time Off (PTO) Accrual

EXECUTIVE (LT/Officers)	PMG DL	ALL OTHERS
☐ EF = FT	☐ PF = FT	☐ NF = FT
☐ LT = FT	☐ PP = PT	☐ NP = PT

☐ TT = TEMP ☐ Seasonal

Disability:
☐ MH (1) ☐ ID (2) ☐ OTH (4) ☐ B/VI (5) ☐ NON (3)

HR Initials_____ Date:_____
HR ID: _____

_____ _____
VP of HR Date

Lunch Voucher - Human Technologies
Sunrise Café

Name: _____

Date: _____

Item Description	Price per item

Total $ _____

I understand that the above amount, combined with other Lunch Vouchers I approve for this pay period, will be deducted from my bi-weekly paycheck associated with this pay period.

If I disagree with the amount deducted from my paycheck, I will notify my immediate supervisor.

Signature: _____

Payroll Check Date: _____

**Per Deductions in Accordance with Law 195-4 Authorized Deductions for the Benefit of the Employee.*

Rev: 8-29-17 http://htcorp.net/employee-pages/handbook-policies-procedures/

Lunch Voucher - Human Technologies
Sunrise Café

Name: _____

Date: _____

Item Description	Price per item

Total $ _____

I understand that the above amount, combined with other Lunch Vouchers I approve for this pay period, will be deducted from my bi-weekly paycheck associated with this pay period.

If I disagree with the amount deducted from my paycheck, I will notify my immediate supervisor.

Signature: _____

Payroll Check Date: _____

**Per Deductions in Accordance with Law 195-4 Authorized Deductions for the Benefit of the Employee.*

Rev: 8-29-17 http://htcorp.net/employee-pages/handbook-policies-procedures/

HUMAN TECHNOLOGIES
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Expense Report

Name: _____ Date: _____

Destination/Purpose of Travel: _____

Receipt #	Date	Merchant Name	Description of Expense	Detail for 'Other'	Cost	Mileage	Travel Origination	Travel Destination	Cost Center

Please ensure you have done all of the following:

- ☐ Scan or attach ALL receipts
- ☐ On each receipt, identify the expense to be reimbursed
- ☐ For business meals, include names of attendees
- ☐ Remove all personal and non-reimbursable expenses
- ☐ Document receipt number to cross reference to the appropiate line item above

Reimbursement Summary

Total Expenses	$0.00
Advance	
Net Due to/from	**$0.00**

Expense Summary

Categories	Totals
Mileage	$0.00
Transportation	$0.00
Lodging	$0.00
Meals	$0.00
Other	$0.00

Employee Signature

Supervisor Signature

HUMAN TECHNOLOGIES
The Power of People with Purpose

REASONABLE ACCOMMODATION REQUEST FORM FOR EMPLOYERS

A. Questions to clarify accommodation requested.

What specific accommodation are you requesting?

If you are not sure what accommodation is needed, do you have any suggestions about what options we can explore? Yes ☐ No ☐

If yes, please explain.

Is your accommodation request time sensitive? Yes ☐ No ☐

If yes, please explain.

B. Questions to document the reason for accommodation request.

What, if any, job function are you having difficulty performing?

What, if any, employment benefit are you having difficulty accessing?

What limitation is interfering with your ability to perform your job or access an employment benefit?

Have you had any accommodations in the past for this same limitation? Yes ☐ No ☐

If yes, what were they and how effective were they?

If you are requesting a specific accommodation, how will that accommodation assist you?

C. Other.

Please provide any additional information that might be useful in processing your accommodation request:

_____ _____

Signature Date

Return this form to _____

Submit

ACCOMMODATION APPROVAL FORM

HUMAN TECHNOLOGIES
The Power of People with Purpose

Employee Name:	Date of Approval:	
Accommodation(s) Approved:		
STEPS NEEDED TO IMPLEMENT		
Does equipment need to be ordered or a service purchased?	Yes ☐	No ☐
If yes, who will do it?		
Will Training be required?	Yes ☐	No ☐
If yes, who will do the training?		
Who needs to be notified of the accommodation?		
What other steps need to be taken?		
TIMEFRAMES		
When will the accommodation be fully implemented?	Date:	
If maintenance is needed, when will it be done?	Date:	
Is the accommodation being provided on a trial basis?	Yes ☐	No ☐
If yes, when will the trial period end?	Date:	
Comments:		
SIGNATURES		
Employer Representative:	Date:	
Employee:	Date:	

HUMAN TECHNOLOGIES
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Model Release Policy

I hereby grant permission to Human Technologies (HT) to take, use, and disseminate now, or any time in the future, my photograph, text copy, film, or videotape in which I appear for any activity which is within the functions or responsibilities of my job. I understand that appropriate identifying information may be released.

I understand that in the course of making such photographs, videotapes, or other images, I may be disclosing individually identifiable health information about myself to the Organization. I also understand that such photographs, videotapes, or other images will be used as media* to promote public understanding and support of HT's mission. *Media: means all media including social (Facebook, Twitter, YouTube, LinkedIn, Instagram etc.), digital, electronic, print, television, film, radio and other media now known or to be invented.

If this information is disclosed to someone who is not required to comply with federal privacy protection regulations, then it may be re-disclosed and would no longer be protected.

I understand that no royalty, or any other form of compensation for use of my photograph, approved text copy, film or video in which I appear is to be paid to any person, and I hereby release to HT any claims for royalties or other form of compensation in connection with such use now or in the future. I further understand that the photograph, text copy, film or videotape is public information and may be released by HT at any time without further permission or consent by my accordance with the permission set forth above.

I have the right to revoke this authorization at any time. My revocation must be in writing on the form provided to me by HT. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain services or maintain employment, nor will it affect my eligibility for benefits.

Print Name	**Signature**
Date	**Witness**

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

CLAIMANT: READ THE FOLLOWING INSTRUCTIONS CAREFULLY

1. USE THIS FORM IF YOU BECOME SICK OR DISABLED **WHILE EMPLOYED** OR IF YOU BECOME SICK OR DISABLED **WITHIN FOUR (4) WEEKS AFTER TERMINATION OF EMPLOYMENT**. USE CLAIM FORM **DB-300** IF YOU **BECOME SICK OR DISABLED AFTER HAVING BEEN UNEMPLOYED MORE THAN FOUR (4) WEEKS**.
2. YOU MUST COMPLETE ALL ITEMS OF PART A - THE **"CLAIMANT'S STATEMENT"**. BE ACCURATE. CHECK ALL DATES.
3. BE SURE TO DATE AND SIGN YOUR CLAIM (SEE ITEM 12). IF YOU CANNOT SIGN THIS CLAIM FORM, YOUR REPRESENTATIVE MAY SIGN IT IN YOUR BEHALF. IN THAT EVENT, THE NAME, ADDRESS AND REPRESENTATIVE'S RELATIONSHIP TO YOU SHOULD BE NOTED UNDER THE SIGNATURE.
4. **DO NOT MAIL THIS CLAIM UNLESS YOUR HEALTH CARE PROVIDER COMPLETES AND SIGNS PART B - THE "HEALTH CARE PROVIDER'S STATEMENT."**
5. YOUR COMPLETED CLAIM SHOULD BE MAILED **WITHIN THIRTY (30) DAYS AFTER YOU BECOME SICK OR DISABLED TO YOUR LAST EMPLOYER OR YOUR LAST EMPLOYER'S INSURANCE COMPANY. YOU MAY FAX THE COMPLETED FORM TO (781) 304-5599.**
6. MAKE A COPY OF THIS COMPLETED FORM FOR YOUR RECORDS BEFORE YOU SUBMIT IT.

PART A - CLAIMANT'S STATEMENT (Please Print or Type) ANSWER ALL QUESTIONS

Social Security Number ☐☐☐ ☐☐ ☐☐☐☐

1. My name is..... (First / Middle / Last)
2. Address..... (Number / Street / City or Town / State / Zip Code / Apt. No.)
3. Tel. No..... 4. Date of Birth ..... 5. Married (Check one) ❑Yes ❑No
6. My disability is (if injury, also state how, when and where it occurred) .....

   .....
7. I became disabled on ..... (Month / Day / Year) a. I worked on that day ❑ Yes ❑No

   b. I have since worked for wages or profit. ❑ Yes ❑ No If "Yes", give dates .....
8. Give name of last employer. If more than one employer during the last eight (8) weeks, name all employers.

EMPLOYER'S			DATES OF EMPLOYMENT						AVERAGE WEEKLY WAGES (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
BUSINESS NAME	BUSINESS ADDRESS	TELEPHONE NO.	FROM			THROUGH			
			Mo.	Day	Yr.	Mo.	Day	Yr.	

9. My job is or was ..... (Occupation) ..... (Name of Union and Local Number, if Member)
10. For the period of disability covered by this claim
    a. Are you receiving wages, salary or separation pay: ..... ❑ Yes ❑ No
    b. Are you receiving or claiming:
       (1) Workers' compensation for work-connected disability..... ❑ Yes ❑ No
       (2) Unemployment Insurance Benefits..... ❑ Yes ❑ No
       (3) Damages for personal injury ..... ❑ Yes ❑ No
       (4) Benefits under the Federal Social Security Act for long-term disability ..... ❑ Yes ❑ No

    IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 10a OR 10b, COMPLETE THE FOLLOWING:
    I have ❑ received ❑ claimed from ..... for the period ..... (Date) to..... (Date)
11. I have received disability benefits for another period or periods of disability within the 52 weeks immediately before my present disability began ..... ❑ Yes ❑ No
    If "Yes", fill in the following: I have been paid by .....From ..... (Date) To ..... (Date)
12. I have read the instructions above. I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled; and that the foregoing statements, including any accompanying statements, are to the best of my knowledge true and complete.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

Claim signed on ..... (Date) ..... (Claimant's Signature)

If signed by other than claimant, print below: name, address, and relationship of representative.

.....

Disclosure of Information: The Board will not disclose any information about your case to any unauthorized party without your consent. If you choose to have such information disclosed to an unauthorized party, you must file with the Board an original signed Form OC-110A, Claimant's Authorization to Disclose Workers' Compensation Records, or an original signed, notarized authorization letter. You may telephone your local WCB office to have Form OC-110A sent to you, or you may download it from our web page, www.wcb.state.ny.us. It can be found under the heading Common Forms Online. Mail the completed authorization form or letter to the address given below.

IF YOU HAVE ANY QUESTIONS ABOUT CLAIMING DISABILITY BENEFITS, CONTACT THE NEAREST OFFICE OF THE NYS WORKERS' COMPENSATION BOARD, OR WRITE TO: WORKERS' COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, NY 12241-0005

SI TIENE DUDAS RELACIONADAS CON LA RECLAMACIÓN DE BENEFICIOS POR INCAPACIDAD, COMUNIQUESE CON LA OFICINA MAS CERCANA DE LA JUNTA DE COMPENSACIÓN OBRERA DE NUEVA YORK, O ESCRIBA A: WORKER'S COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY- MENANDS, ALBANY, NY 12241-0005

Employment Separation Record

***Must be submitted to Human Resources within 24 hours of separation*

2260 Dwyer Avenue, Utica, NY | Phone: 315-724-989 Open in New Page

HUMAN TECHNOLOGIES
The Power of People with Purpose

Employee Name:		Job Title:
Slot #:	Department:	Full Time: ☐ Part Time: ☐
First Day Worked:	Last Day Worked:	Date of Separation:
Days/Week: M☐ T☐ W☐ R☐ F☐ S☐ Su☐		Scheduled Hours per Week:
Latest Rate of Pay: Annual Salary☐ Hourly☐ $		Payroll to Calculate PTO Balance

REASON FOR SEPARATION

VOLUNTARY:
- ☐ Resigned (Attach letter or state reason)
  - ☐ Moved
  - ☐ Accepted Position Elsewhere
  - ☐ Personal Reasons
  - ☐ Medical
  - ☐ Other (Explain below)
- ☐ Abandoned Job
- ☐ Retirement
- ☐ Other (Explain Below)

DISCHARGE:
- ☐ Absenteeism (list dates below)
- ☐ Tardiness (list dates below)
- ☐ Poor Job Performance
- ☐ Insubordination
- ☐ Violation of Policies
- ☐ Falsified Application
- ☐ Other (Explain Below)

OTHER:
- ☐ Lack of Work
- ☐ Corporate Reorganization
- ☐ Seasonal Position
- ☐ Temporary Position Ended
- ☐ Other (Explain Below)

***SUPERVISOR*:**

Attach all supporting documentation (resignation letter, warnings, dates absent, meeting notes, etc.)

Explain the final incident that resulted in separation (attach supporting information if more space needed):

_____

_____

If applicable, was a warning given? ☐yes ☐no

Would you consider re-employing? ☐yes ☐no

If no, provide reason: _____

Do you have work available? ☐yes ☐no

Did employee ask for Leave of Absence? ☐yes ☐no; LOA granted: ☐yes ☐no

Length of Leave: _____

Was grievance filed? ☐yes ☐no

***EMPLOYEE*:** State reason for separation, if different from above:

_____

Thereby acknowledge that the above is a true statement of my reason(s) for separation from employment.

EMPLOYEE'S SIGNATURE: _____ ***DATE:*** _____

SIGNATURES:

Direct Supervisor: _____ Date: _____

Director: _____ Date: _____

VP of HR: _____ Date: _____

R:

Payroll to send employee check with remainder of PTO, if applicable. HR to send separation letter within five days of separation.

Employment Separation Record

***Must be submitted to Human Resources within 24 hours of separation*

2260 Dwyer Avenue, Utica, NY | Phone: 315-724-9891 | Fax: 315-724-9896

HUMAN TECHNOLOGIES
The Power of People with Purpose

Employee Name:		Job Title:
Slot #:	Department:	Full Time: ☐ Part Time: ☐
First Day Worked:	Last Day Worked:	Date of Separation:
Days/Week: M☐ T☐ W☐ R☐ F☐ S☐ Su☐		Scheduled Hours per Week:
Latest Rate of Pay: Annual Salary☐ Hourly☐ $		Payroll to Calculate PTO Balance

REASON FOR SEPARATION

VOLUNTARY:
- ☐ Resigned (Attach letter or state reason)
  - ☐ Moved
  - ☐ Accepted Position Elsewhere
  - ☐ Personal Reasons
  - ☐ Medical
  - ☐ Other (Explain below)
- ☐ Abandoned Job
- ☐ Retirement
- ☐ Other (Explain Below)

DISCHARGE:
- ☐ Absenteeism (list dates below)
- ☐ Tardiness (list dates below)
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- ☐ Violation of Policies
- ☐ Falsified Application
- ☐ Other (Explain Below)

OTHER:
- ☐ Lack of Work
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Attach all supporting documentation (resignation letter, warnings, dates absent, meeting notes, etc.)
Explain the final incident that resulted in separation (attach supporting information if more space needed):

_____

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If applicable, was a warning given? ☐yes ☐no
Would you consider re-employing? ☐yes ☐no
If no, provide reason: _____
Do you have work available? ☐yes ☐no
Did employee ask for Leave of Absence? ☐yes ☐no; LOA granted: ☐yes ☐no
Length of Leave: _____
Was grievance filed? ☐yes ☐no

***EMPLOYEE*:** State reason for separation, if different from above:

_____

Thereby acknowledge that the above is a true statement of my reason(s) for separation from employment.

EMPLOYEE'S SIGNATURE: _____ ***DATE:*** _____

SIGNATURES:

Direct Supervisor: _____ Date: _____

Director: _____ Date: _____

VP of HR: _____ Date: _____

Payroll to send employee check with remainder of PTO, if applicable. HR to send separation letter within five days of separation.

Personnel Requisition Form
(Used for filling Vacant or New Positions)

HUMAN TECHNOLOGIES
The Power of People with Purpose

Date of Request: _____ Requested by: _____ Date to be filled: _____

Position: _____ Department./Location: _____

Days/Hours:_____ ☐ New – *(Needs VP of HR approval)*: _____

☐ Replacement – Who? _____

Slot Number: _____

☐ Full Time ☐ Part Time ☐ Temporary (Start date: _____ End date: _____)

Hours per week:_____ Pay Grade:_____

Type of Ad: ☐ Free (Corporate website, DOL, Indeed, colleges, etc.) ☐ Paid

Posting should include the following details:

_____

_____

_____

Approvals

Manager/Director: _____ Date: _____

VP of Human Resources: _____ Date: _____

COO ***(if new position/not budgeted)***: _____ Date: _____

HR Use Only

Internal Posting	Date: _____ to _____	☐Dwyer Avenue ☐DC ☐MHC PMG ☐Utica ☐Rome ☐Syr ☐Bing ☐ Buff		
Corp. Website/Indeed	Date: _____ to _____			
DOL/One Stop	Date: _____ to _____			
Other postings	_____	Date: _____	Price: _____	# of Days: _____
	_____	Date: _____	Price: _____	# of Days: _____
	_____	Date: _____	Price: _____	# of Days: _____
	_____	Date: _____	Price: _____	# of Days: _____

Post Injury Management
Follow-up Report

HUMAN TECHNOLOGIES
The Power of People with Purpose

☐ Preventable Accident
☐ Non-Preventable Accident

Employee Name: _____

Date and time spoke with Employee: _____

Was able to reach Employee: ☐ yes ☐ no Left message: ☐ yes ☐ no

Accident/Injury Date and Time: _____

Did he/she return to work the day of the accident? ☐ yes ☐ no

Did he/she lose any time from work? (Per medical note) ☐ yes ☐ no
If yes, what date(s)? _____ (Per medical notes)

Type of injury: _____

How is he/she doing? _____
_____
_____

Is he/she under Doctor's care: ☐ yes ☐ no

Doctor's Name: _____

Doctor's address/phone: _____

Doctor restrictions: _____

Form filled out by: _____ Date: _____

Second Contact Date: _____

Information: _____
_____

Third Contact Date: _____

Information: _____
_____

HUMAN TECHNOLOGIES

Request for Outside Temporary Staff

Date: _____ Submitted by: _____

Position Needed: _____ Wage/hour: _____

Dates Needed: _____ to _____ Temp to Hire? ☐Yes ☐No

Scheduled Hours: _____am/pm – _____ am/pm ☐M ☐T ☐W ☐R ☐F ☐S ☐Su

Skills/Duties:

_____

_____

_____

Reports to: _____ Location: _____

Department: _____ Division: _____

Approval: _____ _____
Director VP of Human Resources

Human Resources Department Use	
Agency Name: _____	Temp's Name: _____
HT's Cost: _____	Temp's Wage: _____
Comments:	
_____	
_____	

Copies to: Human Resources
Accounts Payable
Chief Financial Officer

Submit

The Power of People with Purpose

HUMAN TECHNOLOGIES
The Power of People with Purpose

Request for Paid Time off (PTO)

Employee Name:_____

Supervisor: _____

I would like the time requested, to begin and end as noted below:

Date	Time of Day	# Hours
	am/pm (circle one) - am/pm (circle one)	
	am/pm (circle one) - am/pm (circle one)	
	am/pm (circle one) - am/pm (circle one)	
	am/pm (circle one) - am/pm (circle one)	
	am/pm (circle one) - am/pm (circle one)	

Date Returning to Work:	

The request should be made as soon as possible as the employee is aware of their need for time off. The employee's immediate supervisor will make a decision on the request based on staff coverage requirements. Therefore, no guarantee is made that the requested time off will be approved as requested. An employee may request PTO up to their total accrued amount available. It is the employee's responsibility to keep track of their PTO balance as it appears on their pay stub.

_____ _____

Signature of Requestor Date

_____ _____

Approved by Date

Signing Authority

HUMAN TECHNOLOGIES
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Account Code(s): _____ Program Name: _____

☐ **ADD** _____
Print name of employee to be added

☐ **DELETE** _____
Print name of employee to be deleted

Effective Date: _____
May be back dated

Authorization for various personnel and purchasing documents: (bonus or allocations above approved increases must be authorized by an officer) (Check one box only)

☐ Evaluations, pay increases related to evaluation

☐ Requisitions, Purchase Orders

☐ All Expenditures (both payroll and other expenditures)

Authorized Expenditure Limit for Non-Payroll Expenditures
May not be higher than management level of grantee, but may be lower (Check one box only)

	Individual Limit
☐ Assistants/Office Mgrs., Front Line Supervisors	$500
☐ Operations/Business Mgrs, Clinical Supervisors, Regional Mgrs	$1,500
☐ General Managers, Directors, Assistant to the President	$2,500
☐ COO, VP of Human Resources, Purchasing	$5,000

CFO Authorization/Signature is required for ALL Purchases over $5,000

All non-listed employee types must obtain authorization from their immediate supervisor

Authorization granted by: _____ **Date:** _____
(Grantor must have supervisory responsibility for employee named above)

The signature below indicates that the employee above understands his/her authorization limits as well as the budgetary constraints present for the designated authorization. This authorization does not allow the above named employee to authorize an amount without first consulting with appropriate supervisor(s) regarding these budgetary constraints and potential purchase(s).

Employee Signature: _____ **Date:** _____

Contracts related to conducting business on behalf of Human Technologies must be reviewed and authorized by the President/CEO.

CC: Finance Office, Personnel File, Purchasing

TRANSPORTATION VOUCHER

(Through Payroll Deduction)

HUMAN TECHNOLOGIES
The Power of People with Purpose

Employee Name: _____ File # _____

Area Manager: _____ Date: _____

Amount of Voucher:

Utica Transit Authority $ _____ Needs By: _____

Birnie Bus Service $ _____ Route: _____
(Herkimer, Frankfort, Rome, Ilion, Mohawk, Little Falls)

Total $ _____

I understand that the above amount will be deducted from my biweekly paycheck associated with this pay period. If I disagree with the amount deducted from my paycheck, I will notify my immediate supervisor.

Payroll Date: _____

Employee Signature: _____

Business Office Staff Signature: _____

**Per Deductions in accordance with Law 195-4 Authorized Deductions for the Benefit of the Employee.*

Rev: 2/27/14 rls \\IOMEGA-NAS\Public1\Shared Folders\Forms and Policies\Corporate Forms\Transportation Voucher

TRANSPORTATION VOUCHER

(Through Payroll Deduction)

HUMAN TECHNOLOGIES
The Power of People with Purpose

Employee Name: _____ File # _____

Area Manager: _____ Date: _____

Amount of Voucher:

Utica Transit Authority $ _____ Needs By: _____

Birnie Bus Service $ _____ Route: _____
(Herkimer, Frankfort, Rome, Ilion, Mohawk, Little Falls)

Total $ _____

I understand that the above amount will be deducted from my biweekly paycheck associated with this pay period. If I disagree with the amount deducted from my paycheck, I will notify my immediate supervisor.

Payroll Date: _____

Employee Signature: _____

Business Office Staff Signature: _____

**Per Deductions in accordance with Law 195-4 Authorized Deductions for the Benefit of the Employee.*

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Emergency Wage Advancement Form

Name (Print): _____

Supervisor (Print): _____

Reason for request (use numbered list from procedure): #____

Is documentation attached? ☐ Yes ☐ No
(must provide documentation prior to approval of advancement)

Specific Reason for request:

_____

_____

_____

_____

_____

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

HR Signature: _____ Date: _____

Approval: ☐ Yes ☐ No

Comment and/or Referral:

_____

_____

_____

HUMAN TECHNOLOGIES
The Power of People with Purpose

Emergency Wage Advancement Repayment vis Payroll Deduction

Notice of Intent

Employee Name: _____

I understand that the amount below will be deducted from each of my bi-weekly paychecks until such time that I have repaid Human Technologies for the wage advancement amount of _____ *(list total amount advanced). I also agree that upon termination, any balance amount due will be deducted from my final paycheck. If I disagree with the amount deducted from my paycheck, I will notify my immediate supervisor. I also acknowledge that I have received the Dispute Resolution Procedure.*

Deduction Start Date: _____

Total Amount Advanced: _____

Amount of bi-weekly deduction: _____

Number of pay periods: (not to exceed 6 months): _____

Employee Signature: _____ Date: _____

VP of HR Signature: _____ Date: _____

Payroll Specialist Signature: _____ Date: _____

**Per Deductions in accordance with Law 195 –5.2 authorized deductions for advancements*

Make Check Payable to:

_____

_____

_____

Original: Payroll

Copies: Requester

Accounts Payable

Employee's Personnel File

Tuition Reimbursement Request Form

HUMAN TECHNOLOGIES
The Power of People with Purpose

Name: _____ **Date:** _____

Date of hire: _____ **Job title:** _____

Name of Accredited Institution: _____

Course name and description: _____

_____

_____

Course start date & end date: _____

What new job related skills will you develop?

_____

_____

Cost of tuition: $ _____

Are you working towards a certificate or degree? _____

If so, what certificate or degree? _____

Signature: _____ **Date:** _____

Supervisor: _____ **Date:** _____

Director: _____ **Date:** _____

Vice President: _____ **Date:** _____

Date of Approval: _____

Amount of Approval: _____

_____ _____

HUMAN TECHNOLOGIES
The Power of People with Purpose

TUITION REIMBURSEMENT CLAIM FORM

Names: _____ Date: _____

Name of Course: _____

Amount Requesting for Tuition Reimbursement (attached tuition bill): _____

Grade Achieved (Attach Grade from Academic Institution): _____

_____ _____
Signature Date

Approval/Denial of Tuition Reimbursement request.

_____ Approved

Please process a check for $ _____

Made payable to _____

_____ Denied

Reason for Denial:

_____

_____

_____ _____
Signature of VP of Human Resources Date

Cc: Accounts Payable
Employee Requesting Reimbursement

Submit