



POR VIDA ACADEMY

CHARTER DISTRICT

FOR LIFE

Instructions for completing New Hire Paperwork

Employee File Check-List & Personnel Check-List for HR Purposes

Complete all sections of the application; include resume, Service Record and official transcripts (if applicable)

Maintenance and Skilled trade position: Complete only if applicable if not write NA

Social Security Form SSA 1945:

- Please read carefully. If you have any questions, consult the Social Security Office at the number or website listed on the form.
- Make sure your **Name and Social Security #** is listed on the top of this form.
- Sign and date the bottom of the form.

Summary of your rights under the fair credit reporting act:

- Please read form carefully
- Sign and date the form.

Release of Personal Information:

- Please read form carefully
- Make sure you have checked "Yes" or "No" release be given to the public box at the bottom of the page.
- Sign and date the form.

Fingerprinting:

- **Fingerprinting is mandatory and must be completed prior to start date.**
- **Fee for fingerprinting is nonrefundable by Por Vida.**
- Complete the form, sign and date

W-4 Form:

- It is **NOT** a requirement that you complete the Personal Allowances Worksheet attached.
- **Line 5** at the bottom must have a number in it. "0" means you want the **MOST** taxes taken out of your paycheck. You will need to consult someone (parent, spouse, accountant) if you are unsure.
- Please make sure to sign and date this form

I-9 Employment Eligibility Verification:

- Complete **SECTION 1 ONLY**, then sign and date it. You will need to bring **TWO FORMS OF ID** with you. Please see the List of acceptable documents (attached) for employment eligibility verification.

Direct Deposit:

- Please complete the appropriate information
- Attach a voided check
- Sign and date the form

Verification of Government issued cards

- Form is to be completed by Human Resources or Supervisor
- Sign and date the form

Teacher Retirement Systems Notice

- Please complete appropriate information

Employee Verification

- To be completed by HR or Supervisor

Workers Compensation:

- Sign and date the form

Confidentiality Agreement:

- Please read carefully
- Sign and date

Personnel Handbook: View online at www.pvacharter.org- Select About – Staff Resources (New Employee Documents) 2020-2021 Employee Handbook

- Please read carefully
- Sign and date

Insurance benefits information:

- Por Vida Academy provides \$50,000 life insurance to its employees at no cost to the employee.
- You may view benefits information at www.pvacharter.org- Select About – Staff Resources
- Your health coverage can be effective at time of employment (employee responsible for the full month premium) or the first of the month following your first day of employment.
- All elected benefits must be submitted to HR.
- If you do not elect coverage, you are still required to logon and decline coverage.



APPLICATION FOR EMPLOYMENT

Instructions: Please read the following carefully. Application for employment must be completed in black ink or typed. Resumes, Diplomas and transcripts must be attached for all applicants applying for a teaching or an administrative position. Certificates can be attached. All information furnished in this application is subject to verification by the Human Resource Office.

Date:	Location:	Position Applying For:	Start Date:
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Indicate your name as it appears on your social security card.

Last Name:	First Name:	Initial(s)
Social Security Number	Home No:	Business#:
Date of Birth:	Cell No:	Ext No:
Mailing Address (Street, City, State, Zip):		Email Address:
Race: <input type="checkbox"/> Asian <input type="checkbox"/> Black African American <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Pacific Islander		Ethnicity: <input type="checkbox"/> Not Hispanic/ Latino <input type="checkbox"/> Hispanic/Latino

Emergency Contact

Name/Relationship	Address	Phone
Name/ Relationship	Address	Phone

Medical Information

Physician	Office	Insurance	Policy / Group	Hospital
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The following information is optional and only use for medical emergencies.

Medical problems: _____

Medications: _____

	Yes	No		Yes	No
Are You Legally Authorized To Work In The U.S.	<input type="checkbox"/>	<input type="checkbox"/>	Full-time	<input type="checkbox"/>	<input type="checkbox"/>
Are you presently employed	<input type="checkbox"/>	<input type="checkbox"/>	Part-time	<input type="checkbox"/>	<input type="checkbox"/>
If yes, may we inquire of your present employer	<input type="checkbox"/>	<input type="checkbox"/>	Substitute	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been employed by us	<input type="checkbox"/>	<input type="checkbox"/>			
If yes, where, when, what position					
Do you have any relatives working for this school?	<input type="checkbox"/>	<input type="checkbox"/>			
List names/ Relationship:					
Are willing to Travel?	<input type="checkbox"/> Frequently <input type="checkbox"/> Occasional <input type="checkbox"/> not at all				

EDUCATION

Below write final grade attended: 1 2 3 4 5 6 7 8 9 10 11 12 GED School name/Location _____

College/University Name and Location Copies of college and university transcripts must be accompany for professional position.	Dates Attended		Degree Received	Major Field	Minor Field
	FROM	TO			

Items you can operate proficiently.

Certifications/Licenses (specify state)	
Microcomputers	
Applications/Software	
Machines/Equipment	
Other	

Additional Training (school name and location)	Dates Attended	Training Type

JOB RELATED INFORMATION

List information related to the position for which you are applying

EMPLOYMENT HISTORY

NAME Last	First	Middle	SOCIAL SECURITY NUMBER
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Position Title	Immediate Supervisor Name:	Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Substitute <input type="checkbox"/>
Employer	Supervisors Phone:	
Mailing Address:	City/State/Zip	
Employers Phone:	Reason for Leaving:	
Start Date	End Date	Final Salary:
Summary of Experience:		

Position Title	Immediate Supervisor Name:	Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Substitute <input type="checkbox"/>
Employer	Supervisors Phone:	
Mailing Address:	City/State/Zip	
Employers Phone:	Reason for Leaving:	
Start Date	End Date	Final Salary:
Summary of Experience:		

Position Title	Immediate Supervisor Name:	Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Substitute <input type="checkbox"/>
Employer	Supervisors Phone:	
Mailing Address:	City/State/Zip	
Employers Phone:	Reason for Leaving:	
Start Date	End Date	Final Salary:
Summary of Experience:		

REFERENCES

Name:	Occupation:	Address:	Phone:
Name:	Occupation:	Address:	Phone:
Name:	Occupation:	Address:	Phone:

MAINTENANCE AND SKILLED TRADE POSITION

PLEASE COMPLETE THE FOLLOWING if **Applicable** if not write **NA:**

PLUMBING

	Repair	Replace
Commodes	<input type="checkbox"/>	<input type="checkbox"/>
Water lines/mains	<input type="checkbox"/>	<input type="checkbox"/>
Sewer lines/main	<input type="checkbox"/>	<input type="checkbox"/>
Kitchen sink	<input type="checkbox"/>	<input type="checkbox"/>
Water heater	<input type="checkbox"/>	<input type="checkbox"/>
Washing machines	<input type="checkbox"/>	<input type="checkbox"/>

	Repair	Replace
Basins	<input type="checkbox"/>	<input type="checkbox"/>
Dryers	<input type="checkbox"/>	<input type="checkbox"/>
Faucets	<input type="checkbox"/>	<input type="checkbox"/>
Bathtub	<input type="checkbox"/>	<input type="checkbox"/>
Showers	<input type="checkbox"/>	<input type="checkbox"/>

CARPENTRY

	Repair	Replace
Doors	<input type="checkbox"/>	<input type="checkbox"/>
Window panes	<input type="checkbox"/>	<input type="checkbox"/>
Fixtures	<input type="checkbox"/>	<input type="checkbox"/>
Walls	<input type="checkbox"/>	<input type="checkbox"/>
Railings	<input type="checkbox"/>	<input type="checkbox"/>
Framing	<input type="checkbox"/>	<input type="checkbox"/>
Molding	<input type="checkbox"/>	<input type="checkbox"/>

	Repair	Replace
Windows	<input type="checkbox"/>	<input type="checkbox"/>
Cabinets	<input type="checkbox"/>	<input type="checkbox"/>
Floors	<input type="checkbox"/>	<input type="checkbox"/>
Ceiling	<input type="checkbox"/>	<input type="checkbox"/>
Roofs	<input type="checkbox"/>	<input type="checkbox"/>
Woodwork	<input type="checkbox"/>	<input type="checkbox"/>
Tile	<input type="checkbox"/>	<input type="checkbox"/>

ELECTRICAL

	Repair	Replace
Light fixtures/outlets	<input type="checkbox"/>	<input type="checkbox"/>
Temporary service	<input type="checkbox"/>	<input type="checkbox"/>
Install cathodic protection devices	<input type="checkbox"/>	<input type="checkbox"/>

	Repair	Replace
Install breaker panels	<input type="checkbox"/>	<input type="checkbox"/>
Install wiring	<input type="checkbox"/>	<input type="checkbox"/>
Other electrical work	<input type="checkbox"/>	<input type="checkbox"/>

PAINTING

	Yes	No
Interior/exterior painting with brushes/rollers	<input type="checkbox"/>	<input type="checkbox"/>
Varnishing, staining and finishes	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Spray painting	<input type="checkbox"/>	<input type="checkbox"/>
Caulking, sealing and patching interior and exterior surfaces	<input type="checkbox"/>	<input type="checkbox"/>

CONTINUE - MAINTENANCE AND SKILLED TRADE POSITION

GROUNDS MAINTENANCE	Yes	No		Yes	No
Mowing Grass (push mower/riding or tractor mower)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Watering/fertilizing grass and plants	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
			Trimming trees, shrubs and bushes	<input type="checkbox"/>	<input type="checkbox"/>
			Cultivating flower and shrubbery beds	<input type="checkbox"/>	<input type="checkbox"/>

APPLIANCES	Repair	Replace		Repair	Replace
Gas and/or electric ranges	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Air conditioning (window/central units)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
			Refrigerators	<input type="checkbox"/>	<input type="checkbox"/>
			Electric/gas heaters (central)	<input type="checkbox"/>	<input type="checkbox"/>

WELDING/CUTTING	Yes	No
Acetylenes torch	<input type="checkbox"/>	<input type="checkbox"/>
Soldering/brazing	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Arc Welder	<input type="checkbox"/>	<input type="checkbox"/>

CUSTODIAL	Yes	No
Cleaning housing/office fixtures	<input type="checkbox"/>	<input type="checkbox"/>
Strip floors	<input type="checkbox"/>	<input type="checkbox"/>
Buffer	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Minor building repair and maintenance	<input type="checkbox"/>	<input type="checkbox"/>
Wax floors	<input type="checkbox"/>	<input type="checkbox"/>



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Statement Concerning Your Employment in a Job Not Covered by Social Security

Employee Name _____ Employee ID# _____
Employer Name _____ Employer ID# _____

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

Windfall Elimination Provision

Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2005, the maximum monthly reduction in your Social Security benefit as a result of this provision is \$313.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to Social Security Publication, "Windfall Elimination Provision."

Government Pension Offset Provision

Under the Government Pension Offset Provision, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of \$600 based on earnings that are not covered under Social Security, two-thirds of that amount, \$400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a \$500 widow(er) benefit, you will receive \$100 per month from Social Security (\$500 - \$400=\$100). Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to Social Security Publication, "Government Pension Offset."

For More Information

Social Security publications and additional information, including information about exceptions to each provision, are available at www.socialsecurity.gov. You may also call toll free 1-800-772-1213, or for the deaf or hard of hearing call the TTY number 1-800-325-0778, or contact your local Social Security office.

I certify that I have received Form SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security benefits.

Signature of Employee _____ Date _____



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DIRECT DEPOSIT

I, _____ request that my payroll check be direct deposited

to the following:

Name of Bank: _____

Account No. _____

Bank Routing No. _____

Amount: \$ _____ or Entire Paycheck

Type of Account: Checking Savings (Check One)

Employee Signature: _____

Date: _____

*****ATTACH A VOIDED CHECK*****

*****ATTACH A VOIDED CHECK*****



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Verification of Government Issued Cards

Applicant's Name: _____

Date of Birth: ___/___/___

Verification of Applicant's Social Security Card

I, _____, certify that the applicant's legal name and social
(Name of Official)
security number match the information that was provided on the Por Vida Employment Application.

Discrepancies: _____

Verification of Applicant's Driver License

I, _____, certify that the information on the applicant's
(Name of Official)
driver license matches the information that was provided on the Employment Application.

Discrepancies: _____

Signature of HR Director or Principal

Date

Signature of Applicant

Date



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Teacher Retirement Systems (TRS)
NOTICE

TRS changes effective September 1, 2003.

SECTION 1.

Have you contributed to TRS in the past?

Yes

No

Section 1 - Note:

- If your answer is No, then your TRS will be effective 90 days after your date of hire.
- If your answer is Yes, proceed to Section 2.

SECTION 2.

Have you CLOSED your account with TRS?

Yes

No

Section 2 - Note:

- If your answer is No, your TRS will be effective from the date of hire.
- However, if your answer is Yes, the TRS effective date will be 90 days from date of hire.

Welcome to Membership

Teacher Retirement System of Texas

Benefits of Membership

1 Death and Survivor Benefits

A TRS member has death and survivor benefit coverage beginning on the first day of work. The greatest protection for a new member is either

- A lump sum payment equal to twice the member's annual compensation or \$80,000, whichever is less, or
- Survivor benefits which will pay the widow or widower with minor children a \$2,500 lump sum payment plus \$300 per month until the youngest child reaches age 18. At age 65, the spouse would begin receiving \$200 per month for life.

Other payment plans which are available may provide greater benefits after a member has 5 or more years of service.

PLEASE READ THESE SUGGESTIONS BEFORE NAMING A BENEFICIARY

You may name any person/persons as beneficiary/beneficiaries to receive death benefits.

Joint primary and/or joint alternate beneficiaries can be named.

The following suggestions are intended only as a guideline in naming your beneficiaries:

- **A married member should usually name the spouse as primary beneficiary and should not name an alternate beneficiary because by law all children including those not yet born would share equally if the member lived longer than the person named as primary beneficiary.**
- **A married member who has no children and is not likely to have any should normally name the spouse as primary beneficiary and some other person as the alternate beneficiary.**

2 Service Retirement

Normal retirement age is 65 with 5 years of service, or any combination of age and service that equals at least 80. A member may receive a reduced annuity at age 55 with at least 5 years of service or at any age with 30 or more years of service. The standard annuity benefit formula is 2% of the average of the best three annual salaries multiplied by the number of years of service. Higher salaries and more years of service will mean a greater retirement benefit.

3 Disability Retirement

Members who become permanently and totally disabled from the further performance of their duties may apply for a disability retirement. With less than 10 years of service, monthly payments would be \$150 for the shorter of the duration of the disability or number of months of service as of the date of disability retirement. With at least 10 years of service, a disabled member may receive the greater of a service retirement standard annuity without reduction for early age retirement, or \$150 per month, payable for the duration of the disability.

4 Vesting Benefits

Members with five years or more of service credit with TRS are entitled to maintain their accounts with TRS even if not currently employed in Texas public education and, if their deposits are not withdrawn, may retire with a benefit upon reaching retirement age and submitting proper application for retirement.

5 Return of Deposits

Members may apply for a return of their deposits with interests after they have permanently terminated employment that is covered by the retirement system. Application should be made through the school business office.

6 Health Insurance

A surviving spouse or dependent of a public school employee is eligible to purchase coverage under TRS-Care, the health insurance program for TRS public school retirees, if the employee dies on or after September 1, 1986, made contributions to the group insurance program at his or her last place of employment within public education, and had 10 or more years of TRS service credit. Public school employees contribute .25% of annual compensation to partially fund the retiree health insurance program. This contribution is nonrefundable. TRS-Care is also available to public school employees who have 10 or more years of service credit when they retire.

Cost of Membership

- Membership contribution rate - 6.4% of annual compensation
Member contributions are tax sheltered through an employee pickup which reduces the member's salary for federal income tax purposes only. Federal tax rules apply to the member's account if it is withdrawn or when the member retires.
The state contribution rate is 6%.

Applying for Benefits

Forms and information necessary for application for retirement or filing of claims are available from school business offices or Teacher Retirement System, 1000 Red River Street, Austin, Texas 78701-2698. A general information booklet *Teacher Retirement in Texas* which describes benefits in detail is furnished each new member. Keep this booklet for future reference. A copy of the complete plan is available at the Teacher Retirement System at the above address during normal working hours.

The attached Personal Data form will be used to:

- Establish your account or identify an account you already have, and
- Name your beneficiary to receive substantial benefits should your death occur before retirement.

Detach and retain this information sheet.

Death and survivor benefits are paid to the person/persons designated as beneficiary/beneficiaries. If you wish to change your beneficiary/beneficiaries, please complete a new Designation of Beneficiary form TRS 11 and send it to TRS.

Annual account statements, newsletters, trustee election ballots, information brochures, and other communication from TRS will be sent to your home mailing address. If your address changes, please complete form TRS 358 and send it to TRS.

Make sure all applicable blanks are completed on both sides of the Personal Data form before returning it to the proper school official.



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EMPLOYEE VERIFICATION

I _____ verify that the following documents have been submitted and offered to me on _____.

BEFORE ENTERING A CLASSROOM

Completed at Central Office:

1. Fingerprint Results Check Date _____.
2. Issued Employee Handbook Acknowledgement of understanding/Anti-Harassment

Completed at facility:

3. Employee Handbook & Anti Harassment Review
4. CPI certification completion

TRAINING TO FOLLOW

(Items must be completed within 30 days after hire date)

Completed at facility:

1. Observation hours complete
2. Referral and Incident Report Procedures
3. Safety and Security Procedures
4. CPS Reporting Procedures
5. Student Code of Conduct
6. ISS/After School Detention Procedures
7. Student Search Procedures

Please sign below if you have read and understood the above list.

Employee Signature

Date

Administrator Signature

Date



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Employee Acknowledgment of Worker's Compensation Network

I have received information that tells me how to get health care under my employer's workers' compensation insurance.

If I am hurt on the job and live in a service area described in the information, I understand that:

1. I must choose a treating doctor from the list of doctors in the network. Or I may ask my HMO primary care physician to agree to serve as my treating doctor. If I select my HMO primary care physician as my treating doctor, I will notify Human Resources or Workman's' Compensation carrier.
2. I must go to my treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go anywhere.
3. The insurance carrier will pay the treating doctor and other network providers if my employer decides not to cover the cost.
4. I might have to pay the bill if I get health care from someone other than a network doctor without network approval.
5. Making a false or fraudulent workers' compensation claim is a crime that may result in fines and or imprisonment.

Signature

Date

Printed Name

I live at:

Street

City

TX

Zip Code

Name of Employer: Por Vida Inc.

Name of Carrier: Hanover Insurance Group

Please indicate whether this is the:

Initial Employee Notification

Injury Notification (Date of Injury: ____/____/____)

DO NOT RETURN THIS FORM TO CARRIER UNLESS REQUESTED



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Confidentiality Agreement

I understand that in the course of my employment/volunteer/tutoring time with Por Vida, Inc. ALL student and staff information is confidential. I agree not to access, review, disclose or use confidential student or staff information without specific authorization from a school administrator, or as otherwise authorized and required by applicable law. I also understand that even when I am no longer an employee/volunteer/tutor at Por Vida, Inc. any confidential information I have learned must continue to be kept confidential. I understand that any breach of these confidentiality requirements will result in my immediate termination as an employee/volunteer/tutor and may result in legal action against me.

I understand that I must comply with all Por Vida, Inc. policies and school rules applicable to school staff as well as all directions from school administrators and staff while serving as a volunteer/tutor. I further understand that my employee/volunteer/tutor role may be terminated at the discretion of the Superintendent and/or school administrator at any time if they determine it is in the best interests of the school or the students.

I have read, understand, and agree to the information presented above:

Signature: _____ Date: _____

Print Name: _____

HR Rep: _____ Date: _____

Pre-Employment Affidavit for Applicant Offered Employment

The following affidavit is offered to satisfy the requirement of Texas Education Code section 21.009 for a pre-employment affidavit. For purposes of this affidavit:

Adjudication and conviction refer to a conviction, plea of guilty or no contest (nolo contendere), probation, suspension, or deferred adjudication.

Charge refers to a formal criminal charge as documented by a primary charging instrument (a complaint, information, or indictment) under the Texas Code of Criminal Procedure.

Inappropriate relationship refers to the crime of improper relationship between educator and student in Texas Penal Code section 21.12, and any other inappropriate relationship as determined by the State Board for Educator Certification.

I declare the following:

I have never been charged with, adjudicated for, or convicted of having an inappropriate relationship with a minor.

I have been charged with, adjudicated for, or convicted of having an inappropriate relationship with a minor. The charge, adjudication, or conviction was determined to be **false**. The following are all of the relevant facts pertaining to the charge, adjudication, or conviction:_____.

I have been charged with, adjudicated for, or convicted of having an inappropriate relationship with a minor. The charge, adjudication, or conviction was determined to be **true**. The following are all of the relevant facts pertaining to the charge, adjudication, or conviction:_____.

I declare under penalty of perjury that the foregoing is true and correct.

(Signature of Declarant)

(Date)

Name (First, Middle, Last)

Address (Street, City, State, Zip Code)

State of Texas
County of _____

Before me, a notary public, on this day personally appeared_____, known to me to be the person whose name is subscribed to the foregoing document and, being by me first duly sworn, declared that the statements therein contained are true and correct.

(Personalized Seal)

Notary Public's Signature