Our Vision

Anchor Behavioral Solutions LLC

as the premier service provider for individuals with

DEVELOPMENTAL DISABILITIES and their *families*.

Execution by maintaining **sound** foundational **principles**

though **ATTENTIVE** and **THOROUGH** customer service

where we **Value** relationships and **behavior change.** Providing

consistent **SUPPORT** through **evidence-based** practices.

SERVICES PROVIDED

Behavior Management

Community Based Support

Career Planning

Individual Supports

Respite

Supportive Employment – Individual

Transportation

info@myanchor.org

862-233-7552

Anchor Behavioral Solutions LLC is an approved as a Supports Program provider through the state of New Jersey's Division of Developmental Disabilities
Provider ID# 0594539 WWW.MYANCHOR.ORG

CHILD ABUSE RECORD INFORMATION FORM
STATE OF NEW JERSEY
DEPARTMENT OF CHILDREN & FAMILIES

Indicate Reason for CARI by Checking Appropriate Box

DHS/DDD Employee:
- ☑ Community Provider/Agency — ☐ *check here if Agency head*
- ☐ Community Care Residence Provider — ☐ *check here if CCR Licensee*
- ☐ DHS Developmental Center Staff — ☑ *check here if New Employee*
- ☐ *check here if Existing Employee*

Agency/Facility: Anchor Behavioral Solutions

COST CODE: 1977

PLEASE PRINT CLEARLY IN INK. DO NOT USE PENCIL. PLEASE GIVE YOUR FULL NAME; DO NOT USE INITIALS. COMPLETE BOTH PAGES OF THIS FORM. SIGN, DATE, AND RETURN THE FORM TO YOUR EMPLOYER FOR SUBMISSION TO DCF. ATTACH ADDITIONAL SHEETS IF MORE SPACE IS NEEDED.

Print your full name (first, middle, last): ______________________

Previous name, maiden name or nicknames: ______________________

Date of name change, if applicable: ______________________

Home Address: ______________________

City: ______________________ State: ________ Zip: ____________

Date of birth: ______________________ Race: ______________________

Social Security number:[1] ______________________ Sex: ________

Applicant Phone number: (   ) ______________________

Full Names and Dates of Birth of your children, if any, whether living with you or not:

NOTE: If none, check this box ☐

Child's First Name	Middle Name	Last Name	Date of Birth

[1] Pursuant to the Federal Privacy Act of 1974 (P.L. 93-579), the disclosure of your Social Security Number is voluntary. Your Social Security Number, race, date of birth, and sex will only be used for the purpose of conducting a Child Abuse Record Information background check as authorized by N.J.S.A. 30:6D-76.

Name: ______________________________

Your previous addresses since 1980 and the dates you lived at each address: **NOTE: If none, check this box ☐**
(ATTACH ADDITIONAL SHEETS IF MORE SPACE IS NEEDED)

1) ______________________________

From: ______________ To: ______________
(month) (year) (month) (year)

2) ______________________________

From: ______________ To: ______________
(month) (year) (month) (year)

3) ______________________________

From: ______________ To: ______________
(month) (year) (month) (year)

4) ______________________________

From: ______________ To: ______________
(month) (year) (month) (year)

5) ______________________________

From: ______________ To: ______________
(month) (year) (month) (year)

All persons completing this form **must** read the following and sign below:

I consent to have the Department of Children and Families conduct a Child Abuse Record Information check to determine whether an allegation of child abuse or neglect has been substantiated against me. I certify that I am not currently being investigated for any allegation of child abuse or neglect. I understand that if a record of substantiated child abuse or neglect is found, or if I refuse to sign this consent form, I may not be permitted to work, or continue to work as a DHS employee, contractor, or volunteer. I certify that all information I have given on this form is accurate and complete to the best of my knowledge.

Signature: ______________________________ Date: ______________

FOR DEPARTMENT OF CHILDREN & FAMILIES USE ONLY

CARI staff initials ______________

CONFIDENTIALITY AGREEMENT

Anchor Behavioral Solutions LLC care to individuals who are working to improve their skills and abilities, so they can lead healthy, safe and productive lives. Our individuals have a right to privacy and confidentiality, including the fact that they are in our care.

Our professional ethic requires that each employee maintain the highest degree of discretion when handling individual and employment related matters.

To protect privacy, information should be available only to those who "need to know" in order to deliver effective care and related services.

To maintain this professional assurance, no employee shall disclose youth information to outsiders, other youth, or youth's family members, members of on'e own family, other third parties or coworkers who do not have a "need to know."

All individuals and their families of Anchor Behavioral Solutions LLC services are entitled to privacy. Employees must ensure confidentiality and privacy regarding history, records and discussions about the people we serve. The very fact that an individual is served by Anchor Behavioral Solutions LLC must be kept confidential.

Disclosure may be made only under specified conditions, which are described below, for reasons relating to law enforcement, the safety of individuals, and the fulfillment of our mission. This means that staff shall not disclose any information about a youth, including the fact that s/he is or is not served by Anchor Behavioral Solutions LLC, to anyone outside of this organization unless authorized by the Chief Executive Officer or designated personnel such as the Agency's Privacy Officer. The principle of confidentiality must be maintained throughout all departments, functions and activities.

1. No information requested by someone outside Anchor Behavioral Solutions LLC may be given over the telephone. Shaff is instructed to respond with the statement: "Anchor" policy does not permit me to give out this information." That includes whether a person is or has been served by this Agency.
2. Release-of-information forms must be explained and completed in the presence of the person/guardian about whom any information may be released, <u>before</u> it is released.
3. When records are reviewed by an outside agency, the inspection must be specifically authorized to do so by the Chief Executive Officer, or her/his designee. The copy of records or removal of records is specifically prohibited in such cases.
4. Staff may not discuss any person served/family member with unauthorized individuals, whether on or off duty.

Violation of this policy may result in disciplinary action up to and including termination of employment, as well as personal legal action against the involved employee.

I acknowledge that I received a copy of this Anchor Behavioral Solutions LLC Confidentiality Agreement. I agree to abide by the terms of the agreement. I realize that failure to abide by this agreement will results in the termination of my services and could result in legal action by any individual harmed by a disclosure made by me.

____

Employee Print Name

____ __________________________

Employee Signature Date

Date:______________

The employee ____________________________ whose signature is at the bottom of this page ("Undersigned") represents and warrants that he/she grants permission and release set forth herein, and does hereby authorize and give consent to permit Anchor Behavioral Solutions LLC to:

Check or mark only those provisions that apply:

( ) Yes, Take and reproduce photographs or video and use such photographs or video of the employee in connection with any publication (including, but not limited to, Annual Reports, Brochures, Videotapes, Newspapers, Magazines, Television, Internet, and/or Print Advertising, hereinafter referred to as "Publication") in such a manner and at such times as the administration of Anchor Behavioral Solutions LLC at its sole discretion, shall determine. (Note: Leave space blank if you do not wish photographs or videos of the Individual to be taken and used.)

( ) Yes, Use the individual's name in connection with any Publication in such a manner and at such times as the administration of Anchor Behavioral Solutions, at its sole discretion, shall determine. (Note: Leave space blank if you do not wish the actual name of the individual to be used.)

( ) Yes, Use any quotation and comment made by the individual obtained and related verbally by the individual in connection with any Publication in such a manner and at such times as the administration of Anchor Behavioral Solutions LLC at its sole discretion, shall determine. (Note: Leave space blank if you do not wish comments made by the individual to be used.)

( ) Yes, Use any statements about the employee and such employee's involvement with Anchor Behavioral Solutions as obtained and related verbally by the employee, and/or an Anchor Behavioral Solutions LLC representative during an interview for the purposes of marketing and/or public relations in connection with any Publication in such a manner and at such times as the administration of Anchor Behavioral Solutions LLC, at its sole discretion, shall determine. (Note: Leave space blank if you do not wish statements about the individual's case history and involvement with Anchor Behavioral Solutions LLC to be used.)

The Undersigned, on his or her own behalf and on behalf of the individual, as well as on behalf of all of Undersigned and individual's heirs, successors and/or assigns, does hereby release Anchor Behavioral Solutions LLC Agents and Employees, and all of its and their heirs, successors and/or assigns, from any and all claims, demands, and liability of whatever kind, including but not limited to, for payment of any compensation, for misappropriation or misuse of any publicity, trademark, copyright, or other rights of the individual and/or Undersigned and their heirs, successors and/or assigns, arising out of Anchor Behavioral Solutions LLC's use of the above-designated information and photographs/video of the individual.

_________________________________ _________________________________

Signature **Anchor Behavioral Solutions LLC Witness**

_________________________________ _________________________________

Relationship to Undersigned **[Print Name of Staff Witness Above]**

Voluntary Self-Identification
Confidential EEO Form

Anchor Behavioral Solutions, LLC is committed to the belief that all persons are entitled to equal employment opportunities regardless of race, color, religion, national origin, sex, nationality, marital/familial status, domestic partnership status, affectional or sexual orientation, atypical hereditary cellular or blood trait, genetic information, liability for military service, AIDS and HIV status, age, disability, or history of disability, Veteran's status or any other protected group status.

Anchor Behavioral Solutions is subject to certain governmental recordkeeping and reporting requirements for the administration of civil rights laws and regulations. In order to comply with these laws, Anchor Behavioral Solutions invites you to voluntarily self-identify your race or ethnicity and veteran's status by checking the appropriate boxes below.

Submission of this information is strictly voluntary. It is not used in making employment decisions and thus, will be separated from your employment application. Refusal to provide this information will not subject you to any adverse treatment. The information obtained will be kept confidential and may only be sed in accordance with the laws including those that require the information to be summarized and reported to the federal government for civil-rights enforcement. When reported, data will not identify any specific individual.

Name:____ Date:____________________

Position applied for:_________________________________Please Check One: Male_________Female__________

Please check appropriate box:

☐ **AMERICAN INDIAN or ALASKA NATIVE** - A person having origin in any of the original peoples of Central, South and North America, and who maintains cultural identity through tribal affiliation or community attachment.

☐ **ASIAN**—(Not Hispanic or Latino) - A person having origins in any of the original peoples of the Far East, Southeast, Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ **BLACK or AFRICAN AMERICAN** — (Not Hispanic or Latino) – A person having origins in any of the black racial groups of Africa.

☐ **HISPANIC or LATINO** — A person of Mexican, Puerto Rican, Cuban, Central or South American origin, or any other Spanish origin or culture, regardless of race.

☐ **NATIVE HAWAIIN or OTHER PACIFIC ISLANDER**-(Not Hispanic or Latino) – A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ **WHITE** — (Not of Hispanic or Latino) – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ **TWO OR MORE RACES**-(Not Hispanic or Latino) Includes persons who identify with more than one of the above five races.

Please Check One:

________ **I have read the above and voluntarily provide the requested information.**
________ **I have read the above and decline to provide the requested information.**

Signature of Applicant____Date_______________

EMPLOYEE ACKNOWLEDGMENTS

I, the undersigned employee, understand and acknowledge the following:

That I have received a copy of this Employee Handbook and that it is my responsibility to read and be aware of, and comply with, ALL policies contained in it and any official notices that supersede it, including, but not limited to, policies on confidentiality, health, safety, anti-harassment, discrimination, and drugs and alcohol.

That this Employee Handbook contains important ABS policies that directly affect many aspects of my employment. It is essential that I have a full understanding of these policies, and I will consult a human resources manager if I do not have a full understanding of any policy herein or if I have any questions or concerns related to these policies.

That, unless expressly stated to the contrary in a written employment agreement between myself and ABS, **this is an at-will employment relationship, and as such, both myself and ABS may terminate this agreement at any time, with or without cause or notice, as permitted by law.** Nothing in this Employee Handbook is intended to modify my at-will employment relationship with ABS.

That **this is not a contract of employment or a guarantee of a continued employment relationship for any period of time**.

That this Employee Handbook and the policies contained herein modifies, supersedes, and revokes any and all prior policies, procedures, practices, and oral or written representations to the contrary or that are otherwise inconsistent with its terms.

That ABS reserves the right to change, remove, or add to the policies herein at any time by providing official notices to me or posted in a conspicuous place in my work setting designated for such purposes. Any such official notices will modify, supersede, and revoke any existing notices that are inconsistent with them. Furthermore, ABS reserves the right to change its implementation, interpretation, or application of the policies and procedures herein at any time.

That in the event that any of the terms or provisions of this Employee Handbook, including this Employee Acknowledgment, are declared invalid or unenforceable by any court of competent jurisdiction or any federal or state entity having proper jurisdiction over the subject matter herein, the remaining terms and provisions that are not effected thereby shall remain in full force and effect and employees will be afforded all rights required by law. Furthermore, in such event, ABS will provide employees with substitute terms and provisions for those declared invalid once it becomes aware of their invalidity.

I sign in acknowledgment of, and agreement with, the above provisions.

Employee Signature: ____________________ Date: ________

Printed Name: ____________________

TO BE PLACED IN EMPLOYEE FILE

Staff Name: ________________________

EMERGENCY CONTACTS

Name: __________________________________ Relationship: ____________

Phone number: ____________________________

Address:

____

____

Email: ____

Name: __________________________________ Relationship: ____________

Phone number: ____________________________

Address:

____

____

Email: ____

APPENDIX A
COMMUNITY AGENCY HEAD AND EMPLOYEE CERTIFICATION, PERMISSION FOR BACKGROUND CHECK AND RELEASE OF INFORMATION

I hereby authorize the Department of Human Services to conduct a criminal history background check and I agree to be fingerprinted in order to complete the state and federal background check process. I further authorize the release of all information regarding the results of my background check to the Department of Human Services. Check one of the options listed below.

Option 1__________I hereby certify under penalties of perjury, that I have not been convicted of any of the offenses listed below and no such record exits in the State Bureau of Identification in the Division of State Police or in the Federal Bureau of Investigation, Identification Division.

Option 2__________I hereby affirm that I have been convicted of the following offense listed below___________________________________
on _________.
(date)

If I have checked Option 2 or the criminal history background check reveals any conviction(s) for the offenses listed below, I understand that I may be subject to termination from employment.

FOR PROVISIONAL EMPLOYEES ONLY: As a provisional employee, I further understand that I may be employed by the agency for a period not to exceed six (6) months during which time a background check will be completed. I understand that I will work under the supervision of a superior where possible.

Offenses covered under P.L. 1999, C. 358:

In New Jersey, any crime or disorderly person offense:
-involving danger to the person as set forth in N.J.S.A. 2C:11-1 et seq. through 2C:15-1 et seq. including the following:

i. Murder
ii. Manslaughter
iii. Death by auto
iv. Simple assault
v. Aggravated assault
vi. Recklessly endangering another person
vii. Terroristic threats
viii. Kidnapping
ix. Interference with custody of children
x. Sexual assault
xi. Criminal sexual contact
xii. Lewdness
xiii. Robbery

-against the children or incompetents as set forth in N.J.S.A. 2C:24-1 et seq. including the following:

i. Endangering the welfare of a child

ii. Endangering the welfare of an incompetent person

-a crime or offense involving the manufacture, transportation, sale, possession or habitual use of a controlled dangerous substance as defined in N.J.S.A. 2C:24-1 et seq.

-in any other state or jurisdiction, conduct which, if committed in New Jersey, would constitute any of the crimes or disorderly persons offenses described above.

FOR COMMUNITY AGENCY HEAD: I understand the results of this background check will be reported to the President of the Board of my agency.

PLEASE LIST THE NAME AND HOME OR BUSINESS ADDRESS OF THE BOARD PRESIDENT.

____

____

____

____________________ ____________________ ______

Employee Name (please print) Employee Signature Date

____________________ ____________________ _______

Witnessed by (please print) Witness Signature Date

IdentoGO
By MorphoTrust USA

New Jersey Universal Fingerprint Form

www.bioapplicant.com/nj

(1) Originating Agency Number (ORI #) NJ920540Z	(2) Category HSK	(3) Statute Number 30:6D-64	
(4) Reason for Fingerprinting HUMAN SERVICES PRIVATE CONTRACTOR		(5) Document Type RB2	(6) Payment Information BILL STATE AGENCY
(7) Contributor's Case # (Unique Identifier) PC 1 9 7 7 (enter 4 digit cost code after PC)		(8) Miscellaneous	

(9) First Name	(10) MI	(11) Last Name		
(12) Daytime Phone Number ( ) -	(13) Social Security Number (Optional)	(14) Date of Birth	(15) Height	(16) Weight
(17) Maiden or Alias Last Name	(18) Place of Birth (US State if US Citizen; Country for all others)		(19) Country of Citizenship	
(20) Home Address Address	City	State	Zip	
(21) Gender (Select one) [ ] Female [ ] Male [ ] Both	(22) Hair Color	(23) Eye Color	(24) Race (Select One) [A] Asian/ Pacific Islander (includes Asian Indian) [B] Black [I] American Indian / Alaska Native [W] White (Includes Hispanic/ Spanish Origin) [U] Unknown	
(25) Occupation / Position (with respect to Requirement)	26) Employer / Organization Name (with respect to Requirement) **Anchor Behavioral Solutions** Employer Address **59 Main Street, Suite 350** City **West Orange** State **NJ** Zip **07052**			

Identification Requirement - *Identification must be presented at the time of printing.* Identification presented MUST be one (1) document that is current (not expired). A combination of documents will not be accepted. The single document must include the following criteria; Photo, Name, Address (home/employer), Date of Birth and is issued by a Federal, State, County or Municipal entity for Identification purposes. Examples of acceptable ID are: 1) Valid U.S. State Photo Driver's License/ Non Driver's License, 2) U.S. Passport, 3) USCIS Permanent Resident ID Card (issued after 5/10/2010), and 4) USCIS Employment Authorization Card (issued after 10/31/2010).

Please READ this form carefully
and follow all of the instructions provided by your agency/employer to complete the fingerprint process. You must have this form (Blocks 1 through 26) completed prior to scheduling your fingerprint appointment via the website or call center. ***PLEASE PRINT LEGIBLY.*** *It is* ***required*** *you* ***present*** *this completed Universal Fingerprint Form, IDG_NJAPP_020115_V2, at your scheduled appointment.*

Appointment Scheduling:
Scheduling is available anytime at **www.bioapplicant.com/nj.** Appointments may also be scheduled through our Call Center. English and Spanish speaking agents are available at **1-877-503-5981**, Monday through Friday, 8:00AM to 5:00PM EST and Saturday, 8:00AM to 12 Noon EST.

Payment:
When an Applicant is responsible for payment, Payment Is Required at the time of scheduling. The following forms of payment are accepted: Visa, MasterCard, or electronic debit (ACH) from a checking account; accounts will be debited immediately.

Cancel/ Reschedule:
Appointments may be canceled or rescheduled via the website or the call center before the deadline of 5PM EST the business day prior to the scheduled appointment (Saturday Noon for Monday appointments). An appointment fee of $10.00 will be incurred by applicants who do not cancel/reschedule their appointment prior to the deadline. MorphoTrust will refund the remainder of the fee paid (state/federal search fees) to the original payment method.

Unable to be Fingerprinted:
An applicant is considered "Unable to be Fingerprinted" for any of the following reasons: Failure to appear for scheduled appointment; Inability to present proper Identification; Inability to present this completed Universal Fingerprint Form IDG_NJAPP_020115_V2; Information on this form does not exactly match the information provided during the scheduling process. Applicants unable to be fingerprinted will incur a $10.00 appointment fee; MorphoTrust will refund the remainder of the fee paid (state/federal search fees) to the original payment method.

PCN and Receipts:
Upon the completion of fingerprinting you will be assigned a PCN number. The PCN will be recorded on this form and on your receipt. MorphoTrust will not provide *duplicate receipts, PCN Numbers or any appointment/printing information after the time of printing.*

Applicant ID Number:	Payment Authorization:	PCN:
Scheduled Day & Date:	Scheduled Time:	Scheduled Site:
Agency Information: **STATE AND FBI BACKGROUND CHECK**		

You **MUST** retain a copy of this form and the receipt of printing for your personal records.

APPLICANTS MUST NOT ALTER, SHARE, OR REUSE THIS FORM

HEALTH CLEARANCE FORM

Employee Name:_________________________________ Department: _____________________

To the Employee:

Anchor Behavioral Solutions LLC is licensed by the State of New Jersey to facilitate DDD Support Services. In order to comply with these regulations, new staff must submit a written statement from a licensed physician indicating that he or she is in good health and posses no health risk to persons in the program. Such statement shall be based on a medical examination conducted PRIOR to the start of your employment with the agency. Examination MUST have been completed within the last 6 months.

IMPORTANT: **This form *must be completed and returned to Human Resources <u>PRIOR</u> to the start of your employment.***

Please note, the physician's name, address and phone number must be legible and is subject to verification.

***Physician's Statement:* (please check <u>ONE</u> below)**

☐ I have conducted a medical examination on **(THIS DATE):** __________________ and she/he is in good health (free from communicable diseases) and poses no health risk to persons in the workplace.

OR

☐ I have conducted a medical examination on **(THIS DATE):** __________________ she/he **<u>may pose a health risk to others.</u>**

_______________________________ Physician's Signature

_______________________________ Date

_______________________________ Physician's Name

_______________________________ Phone Number

_______________________________ Address

Physician Stamp:

MOTOR VEHICLE REPORT

NEW JERSEY MOTOR VEHICLE SERIVCE REQUEST

PLEASE PRINT:

NAME: ____

ADDRESS: ____

____

DOB: ____

EYES: ____

SEX: ____

DRIVERS LICENSE # __________________________________

STATE ____

EXPIRATION DATE ____________________________________

THE INFORMATION I HAVE SUPPLIED ABOVE IS TRUE AND CORRECT.

____
Employee Print Name

____ _______________________
Employee Signature Date

Conscientious Employee Protection Act
"Whistleblower Act"

Employer retaliatory action; protected employee actions; employee responsibilities

1. New Jersey law prohibits an employer from taking any retaliatory action against an employee because the employee does any of the following:
   a. Discloses, or threatens to disclose, to a supervisor or to a public body an activity, policy or practice of the employer or another employer, with whom there is a business relationship, that the employee reasonably believes is in violation of a law, or a rule or regulation issued under the law, or, in the case of an employee who is a licensed or certified health care professional, reasonably believes constitutes improper quality of patient care;
   b. Provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any violation of law, or a rule or regulation issued under the law by the employer or another employer, with whom there is a business relationship, or, in the case of an employee who is a licensed or certified health care professional, provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into quality of patient care; or
   c. Provides information involving deception of, or misrepresentation to, any shareholder, investor, client, patient, customer, employee, former employee, retiree or pensioner of the employer or any governmental entity.
   d. Provides information regarding any perceived criminal or fraudulent activity, policy or practice of deception or misrepresentation which the employee reasonably believes may defraud any shareholder, investor, client, patient, customer, employee, former employee, retiree or pensioner of the employer or any governmental entity.
   e. Objects to, or refuses to participate in, any activity, policy or practice which the employee reasonably believes:
      (1) is in violation of a law, or a rule or regulation issued under the law or, if the employee is a licensed or certified health care professional, constitutes improper quality of patient care;
      (2) is fraudulent or criminal; or
      (3) is incompatible with a clear mandate of public policy concerning the public health, safety or welfare or protection of the environment. N.J.S.A. 34:19-3.
2. The protection against retaliation, when a disclosure is made to a public body, does not apply unless the employee has brought the activity, policy or practice to the attention of a supervisor of the employee by written notice and given the employer a reasonable opportunity to correct the activity, policy or practice. However, disclosure is not required where the employee reasonably believes that the activity, policy or practice is known to one or more supervisors of the employer or where the employee fears physical harm as a result of the disclosure, provided that the situation is emergency in nature.

CONTACT INFORMATION

Your employer has designated the following contact person to receive written notifications, pursuant to paragraph 2 above (N.J.S.A. 34:19-4):

Name: Natasha Menendez

Address: 59 Main St Suite 350
West Orange NJ 07052

Telephone Number: 862-233-7552

This notice must be conspicuously displayed.

Once each year, employers with 10 or more employees must distribute notice of this law to their employees.
If you need this document in a language other than English or Spanish, please call (609) 292-7832.

AD-270 (8/11)

Acknowledgement of Receipt

I acknowledge receiving and reading handouts on the ***Conscientious Employee Protection Act*** (the "Whistleblower Act"), and ***NJ's Department of Labor Disability/Family Leave Insurance Benefits Notice.***

I understand that the purpose of these policies is to foster a positive working atmosphere, and to provide me with clear guidelines for my employment, and that nothing in these policies creates an express or implied contract of employment between me and the Agency.

I accept full responsibility for familiarizing myself with the policies and procedures that are described herein and if I do not have a clear understanding of any part of this manual, I am encouraged to discuss my questions with my supervisor or the Director of Human Resources.

I understand that Anchor Behavioral Solutions, LLC may change these policies without my prior notice.

_______________________________________ __________

Employee's Name Date

_______________________________________ __________

Employee's Signature Date

ACKNOWLEDGEMENT
New Jersey Workers' Compensation

If you suffered an injury during work and are seeking coverage under the employer's workers' compensation policy, you must:

Immediately notify your Supervisor or the Human Resources Department or any one in authority as soon as possible.

1. Your employer will direct you to a preferred medical provider. All necessary and reasonable medical treatment, prescriptions and hospitalization services related to the work injury are paid by the employer's insurance carrier if the claim is accepted as compensable.

2. Physicians must accept payments as calculated under the New Jersey Workers' Compensation Act. You are not responsible for any payments in excess of the charges under the Act, unless your treatments are unrelated to the injury or are otherwise beyond the scope of your workers' compensation coverage.

3. Follow the treatment program established by the physician selected by your employer

4. Keep your employer informed of your treatment and recovery process

5. Cooperate with your employer and the treating physician as they strive to return you to work.

I have read this acknowledgement and by my signature, I affirm that I understand my rights and obligations:

Name: ____

Signature ____

Date: ____

TO ALL EMPLOYEES:

A Message About Reporting Claims and Obtaining Treatment

Our Workers' Compensation insurance coverage is written by Berkshire Hathaway GUARD Insurance Companies, a specialist in this line. Through Berkshire Hathaway GUARD, we have elected to participate in a network provided by Coventry Workers' Compensation Services. However, remember that this service is to be utilized specifically for injuries that occur at work and is not a health plan!

The medical practitioners in Coventry's network are qualified to treat any injury sustained within the course of your employment. As your employer, we are responsible for the payment of medical treatment of all claims deemed acceptable and compensable by Berkshire Hathaway GUARD as long as the treatment is directly related to the work injury, reasonable, and necessary.

If an injury does occur, please follow this procedure:

- Report the injury to your supervisor immediately! Together, you should then report the claim to Berkshire Hathaway GUARD by dialing **1-888-NEW-CLMS** (1-888-639-2567) toll-free. Your call can be handled 24 hours a day/seven days a week.
- Treatment should be sought from a provider shown on the list supplied by Berkshire Hathaway GUARD. (Unless one of the conditions outlined below is met, you must use an approved medical practitioner for your work-related injury.)

Exceptions to treating with a Preferred Provider:

1. You have the right to **"Emergency"** care anytime/anywhere! Follow-up care, however, must be sought from an approved provider.
2. You have the right to a second opinion at each level of treatment for a work-related injury.
3. If you are dissatisfied with the current determination of compensability, degree of disability, and/or degree of impairment arising from a work-related injury, you have the right to an independent medical examination with a provider of your choice as long as prescribed procedures have been followed.

POST THESE INSTRUCTIONS AND YOUR PANEL IN A CONSPICUOUS LOCATION!

Claims Reporting

By using Berkshire Hathaway GUARD Insurance Companies' toll-free claims reporting number, you enable us to process the claim much faster, facilitating prompt, appropriate treatment for the injured party. Benefits include reduced paperwork (because we complete the required forms), less time away from work for the injured employee (because we establish light- and modified-duty assignments when available), and potential insurance savings because of improved claims experience!

1-888-NEW-CLMS
6 3 9 2 5 6 7

is Berkshire Hathaway GUARD's Claims Hotline.

Call to report ALL new Workers' Compensation claims!

Customer Service
Need Help? Have Questions? Call Customer Service at 1-800-673-2465 or visit our *Policyholder Service Center*: https://policyholder.guard.com

Our Customer Service staff is available from 8 AM to 7:30 PM ET, Monday through Friday. If you are unable to call during the prescribed hours, you can leave a message with our after-hours voice mail. We guarantee you will receive responses by early the next business day. Our on-line *Policyholder Service Center* is available 24/7!

Contact us for:

- Changes of name and address;
- Miscellaneous requests for policy or audit information or questions about the content of our policies;
- Installment and payment due date information;
- Questions about claims reporting, medical management activities, and claims transactions;
- Requests for information about our products and services . . . and much more!

When calling:

- Contact us immediately; only the administration of emergency care should come first.
- Both the employer (or a designated representative) AND employee should jointly make the call whenever possible.
- The whole process should take about 15 minutes, and we do all the paperwork!
- The employer's tax identification and policy numbers will be needed as well as the employee's social security number and personnel file plus any accident reports.
- When appropriate, alternatives for light- or modified-duty will be discussed.
- If a later follow-up call is required, use the same toll-free number, and our automated telephone attendant will direct you to the appropriate staff.

Berkshire Hathaway **GUARD** Insurance Companies