



**Catholic Charities  
of the Diocese of Raleigh**

Providing Help—Creating Hope—Serving All

**Catholic Charities of the Diocese of Raleigh, Inc.**  
**7200 Stonehenge Drive**  
**Raleigh, North Carolina 27613-1620**  
**(919) 821-9750**  
**FAX (919) 821-9712**

**ADMINISTRATION WILL NEED 5 WORKING DAYS AFTER RECEIVING ITEMS 1-5 LISTED BELOW, BEFORE AN OFFER OF EMPLOYMENT DECISION CAN BE MADE BY THE EXECUTIVE DIRECTOR.**

1- Catholic Charities Application for Employment	
2- Disclosure of Request for Consumer Report	
3- Letters of Professional Reference (3)/Telephone Notes (signed and dated)	
4- Resume	
<b>Background Check Completed</b>	
<b><u>THE FOLLOWING ITEMS ARE TO BE FILLED OUT AND RETURNED TO THE ADMINISTRATIVE OFFICE BEFORE THE FIRST DAY OF EMPLOYMENT:</u></b>	
New Hire Form (to be completed by Regional Director & approved by Executive Director)	
Verification of qualifications (License, transcript, etc.)	
Employment Eligibility (I-9) (include supporting documentation)	
Federal Withholding Certificate Form W-4	
North Carolina Withholding Certificate Form NC-4	
Code of Conduct (send complete Code of Conduct - not just signature page)	
Conflict of Interest (send complete Conflict of Interest - not just signature page)	
Employee Confidentiality Agreement	
Emergency Information Sheet	
Insurance Enrollment Forms - Regular Full-Time Only (30 or more hours/week) (if declining send signature page indicating such)	
Payroll Direct Deposit Form	
Acknowledgment form for Employee Handbook	
Electronic Accounts Set-up Form (set-up will be done after all forms are received and approved by the Executive Director)	
403 (B) Investment Materials - Regular Full-Time (30 or more hours/week) and Regular Part-Time Only (20 or more hours/week) (informational only - does not need to be returned to Administrative Office)	
Designation of Beneficiary Form - Regular Full-Time Only	
<b><u>FOLLOW-UP BY ADMINISTRATION:</u></b>	
Attendance at Safe Environment Training Please indicate the date attended or plan to attend and send copy of certification. Here is the link to the Safe Environment Training Calendar: <a href="http://dioceseofraleigh.org/offices/child-and-youth-protection/calendar">http://dioceseofraleigh.org/offices/child-and-youth-protection/calendar</a>	



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eAppsDB User ID \_\_\_\_\_

Password \_\_\_\_\_

## Catholic Charities of the Diocese of Raleigh Application for Employees

### Main Application

Name: \_\_\_\_\_  
First Middle Last

Street Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_  
City State Zip

Length at current address \_\_\_\_\_ Years \_\_\_\_\_ Months

Home Phone: \_\_\_\_\_  
Area Code Number

Work Phone: \_\_\_\_\_  
Area Code Number

Cell Phone: \_\_\_\_\_  
Area Code Number

Email Address: \_\_\_\_\_

### Catholic Charities Questionnaire

Type of Application: \_\_\_\_\_ Employment

***Catholic Charities of the Diocese of Raleigh participates in E-Verify. All employees, within three days of beginning work, must provide proof of eligibility to work in the United States.***

What position are you applying for?

\_\_\_\_\_

What interests you about the position you are applying for?

\_\_\_\_\_

\_\_\_\_\_

What has prepared you for the position that you are applying for?

\_\_\_\_\_

\_\_\_\_\_

### Residential History

\_\_\_\_\_ Check here if you have lived in your current residence for longer than 7 years.

If you have lived in your current residence for 7 or more years, please do not complete residential history. You only need to check the box at top of this section.

<b>Dates (mm/yyyy)</b>	<b>Street Address</b>	<b>City/State/Zip</b>	<b>Country</b>
Beg. Date _____ End Date _____			
Beg. Date _____ End Date _____			

### Employment History

\_\_\_\_\_ Check here if you have no employment history.

Start with current employer and indicate employment history for the last 7 years. If current employer, end date will be current.

<b>Dates of Employment (mm/yyyy)</b>	<b>Company name And address (City, State, Zip)</b>	<b>Immediate Supervisor name &amp; Phone Number</b>	<b>Position Held/Job Description</b>	<b>Reason for Leaving position</b>
Beg. Date _____ End Date _____				
Beg. Date _____ End Date _____				
Beg. Date _____ End Date _____				

## Educational History

\_\_\_\_\_ Check here if you have no educational history.

Educational history should include high school and forward. If currently enrolled in program, end date will be current.

Dates (mm/yyyy) (Start with most recent)	School name And address (City, State, Zip)	Type of School	Name of Program or Degree	Program Completed?
Beg. Date _____ End Date _____				
Beg. Date _____ End Date _____				
Beg. Date _____ End Date _____				

## Volunteer History

\_\_\_\_\_ Check here if you have no volunteer history.

Volunteer history should include any experience applicable to the position to which you are applying. If you are still participating in a volunteer program, do not list an end date.

Dates (mm/yyyy) Start with most recent	Organization City, State, Zip	Contact	Contact Phone Number	Position/Duties
Beg. Date _____ End Date _____				
Beg. Date _____ End Date _____				
Beg. Date _____ End Date _____				
Beg. Date _____ End Date _____				



## References

Reference Name First/Last	Address (City, State, Zip)	Daytime Phone	How long have you known this Person?	Has this person agreed to be a reference?
Professional/Civic				
Professional/Civic				
Personal				
Personal				
Family Member				

## Declarations

The **Catholic Charities of the Diocese of Raleigh, INC.** appreciates your willingness to share your faith, gifts and skills. Providing safe and secure programs for our members is of utmost importance to us. The information gathered in this application is designed to help us provide the highest quality Catholic programs for the people of our community. Please read and initial each of the statements below.

\_\_\_\_\_ I declare that all statements contained in this application are true and that any misrepresentation or omission is cause for rejection of my application or dismissal from my position.

\_\_\_\_\_ I agree to observe all of **Catholic Charities of the Diocese of Raleigh** guidelines and policies for the program in which I am applying, especially the Code of Conduct for Church Personnel for the Diocese of Raleigh.

\_\_\_\_\_ I understand that Catholic Charities has a ZERO TOLERANCE FOR ABUSE and takes all allegations of abuse seriously. I further understand that the **Catholic Charities of the Diocese of Raleigh** cooperates fully with the authorities to investigate all cases of alleged abuse. Abuse of minors or vulnerable adults is grounds for immediate dismissal and possible criminal charges.

\_\_\_\_\_ I understand that I can withdraw from the application process at any time.

\_\_\_\_\_ I understand and agree that false statements and/or omissions regarding past conduct and/or present situations may be grounds for denial of the application to provide employment and/or volunteer services.

\_\_\_\_\_ I hereby authorize **Catholic Charities of the Diocese of Raleigh** to conduct a personal and professional background check for the purposes of my application at **Catholic Charities of the Diocese of Raleigh**. **Catholic Charities of the Diocese of Raleigh** may contact any references, past and current employers, church, youth organizations, agencies where volunteer service has been completed, and any individual or organization which might be relevant to my desired position. I hereby release all of the above stated persons from any and all liability for damages that might occur during **Catholic Charities of the Diocese of Raleigh** contact with the individuals for purposes of employment or volunteer services. I understand and agree that information may be obtained from sources that I provided above and that this information will be held confidentially by **Catholic Charities of the Diocese of Raleigh**. I have also read and understood the above stated information within this release and am signing below of my own free will.

\_\_\_\_\_ I hereby acknowledge that I have been notified in a separate writing that **Catholic Charities of the Diocese of Raleigh** may request a Consumer Report about me. I understand that the Consumer Report may contain information bearing on my credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living. I understand that the Consumer Report may contain public record information such as consumer credit reports, criminal records, judgments, liens, driving records, educational history, prior employment history, or other public record information. I further understand that information may be requested from various Federal, State, local and other agencies that reflects my past activities.

\_\_\_\_\_ By my signature below, I authorize **Catholic Charities of the Diocese of Raleigh** to request and obtain a Consumer Report containing, without limitation, the above-described information in connection with my application. I also authorize, without reservation, any person, agency, or other entity contacted by or on behalf of **Catholic Charities** to furnish the above described or similar information. Also by my signature below, I waive any and all causes of action that I may have against **Catholic Charities of the Diocese of Raleigh** caused by the gathering or supplying of the above described or similar information.

\_\_\_\_\_ I understand that a criminal background check will be conducted prior to and may be conducted during my service. I authorize investigations of all statements contained in the application.

\_\_\_\_\_ My signature indicates that I have read and understand the above. **Do not sign until you have read and initialed the above statements.**

Applicant Signature \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## Confidential Background Check Information

*Please note: Information in this section is only used to obtain criminal records, which are reviewed by a Catholic Charities official in strictest confidence.*

\_\_\_\_\_ Yes \_\_\_\_\_ No Have you ever been convicted for physically, sexually, or emotionally abusing a child or an adult?

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Yes \_\_\_\_\_ No Has a civil lawsuit or employment complaint ever been filed against you for child abuse or sexual abuse?

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Yes \_\_\_\_\_ No Have you ever left an assignment or employment or been removed from an assignment or employment for reasons related to allegations of child abuse, physical abuse, or sexual abuse?

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Yes \_\_\_\_\_ No Have you changed your last name in the past 7 years?

If yes, what was your previous last name? \_\_\_\_\_

\_\_\_\_\_ Yes \_\_\_\_\_ No At any time during the past 7 years have you lived in a different state (within the United States) or do you currently live outside the state this Diocese is located in?

If yes, what state did you live in? \_\_\_\_\_

### ***To be completed ONLY after an offer of a position is made:***

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Driver's License: State \_\_\_\_\_ Number \_\_\_\_\_

Date of Birth: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Gender: Male \_\_\_\_\_ Female \_\_\_\_\_



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### **DISCLOSURE OF REQUEST FOR CONSUMER REPORT**

In connection with your application for employment, Catholic Charities of the Diocese of Raleigh may request and have prepared a Consumer Report about you that may be used to evaluate your eligibility for hire and continued employment. If you become an employee of the Catholic Charities, or are currently an employee, Catholic Charities may obtain a Consumer Report about you for employment purposes at any time while you are employed.

The Consumer Report may contain information bearing on your credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics or mode of living. It may contain public record information such as consumer credit reports, criminal records, judgments, liens, driving records and civil litigation records. Information for the Consumer Report may be requested from various Federal, State, local and other agencies.

I hereby acknowledge that I have been provided the foregoing Disclosure of Request for Consumer Report and have been allowed to keep a copy for my records.

Printed Name:

Address:

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

08.01.2016



**Employment Eligibility Verification**  
**Department of Homeland Security**  
U.S. Citizenship and Immigration Services

**USCIS**  
**Form I-9**  
OMB No. 1615-0047  
Expires 08/31/2019

► **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

**ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number [ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]		Employee's E-mail Address		Employee's Telephone Number	

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

<input type="checkbox"/> 1. A citizen of the United States
<input type="checkbox"/> 2. A noncitizen national of the United States ( <i>See instructions</i> )
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. ( <i>See instructions</i> )  <i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i>  1. Alien Registration Number/USCIS Number: _____ <b>OR</b> 2. Form I-94 Admission Number: _____ <b>OR</b> 3. Foreign Passport Number: _____ Country of Issuance: _____
QR Code - Section 1 Do Not Write In This Space

Signature of Employee	Today's Date (mm/dd/yyyy)
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**Preparer and/or Translator Certification (check one):**

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.  
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code



Employer Completes Next Page





**Employment Eligibility Verification**  
**Department of Homeland Security**  
U.S. Citizenship and Immigration Services

**USCIS**  
**Form I-9**  
OMB No. 1615-0047  
Expires 08/31/2019

**Section 2. Employer or Authorized Representative Review and Verification**

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

<b>Employee Info from Section 1</b>	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
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<b>List A</b> Identity and Employment Authorization	<b>OR</b>	<b>List B</b> Identity	<b>AND</b>	<b>List C</b> Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)
Document Title		<div>Additional Information</div> <div>QR Code - Sections 2 &amp; 3 Do Not Write In This Space</div>		
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				

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

The employee's first day of employment (mm/dd/yyyy): \_\_\_\_\_ (See instructions for exemptions)

Signature of Employer or Authorized Representative		Today's Date(mm/dd/yyyy)		Title of Employer or Authorized Representative	
Last Name of Employer or Authorized Representative		First Name of Employer or Authorized Representative		Employer's Business or Organization Name	
Employer's Business or Organization Address (Street Number and Name)			City or Town		State ZIP Code

**Section 3. Reverification and Rehires** (To be completed and signed by employer or authorized representative.)

<b>A. New Name (if applicable)</b>			<b>B. Date of Rehire (if applicable)</b>	
Last Name (Family Name)	First Name (Given Name)	Middle Initial	Date (mm/dd/yyyy)	

**C.** If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date (if any) (mm/dd/yyyy)
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I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
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## LISTS OF ACCEPTABLE DOCUMENTS

### All documents must be UNEXPIRED

Employees may present one selection from List A  
or a combination of one selection from List B and one selection from List C.

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

**Examples of many of these documents appear in Part 8 of the Handbook for Employers (M-274).**

**Refer to the instructions for more information about acceptable receipts.**

# Form W-4 (2017)

**Purpose.** Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

**Exemption from withholding.** If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

**Note:** If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds \$1,050 and includes more than \$350 of unearned income (for example, interest and dividends).

**Exceptions.** An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions don't apply to supplemental wages greater than \$1,000,000.

**Basic instructions.** If you aren't exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

**Head of household.** Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

**Tax credits.** You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

**Nonwage income.** If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

**Two earners or multiple jobs.** If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

**Check your withholding.** After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

**Future developments.** Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at [www.irs.gov/w4](http://www.irs.gov/w4).

## Personal Allowances Worksheet (Keep for your records.)

<b>A</b>	Enter "1" for <b>yourself</b> if no one else can claim you as a dependent . . . . .	<b>A</b>	_____				
<b>B</b>	Enter "1" if: <table><tr><td>• You're single and have only one job; or</td><td rowspan="3">} . . . . .</td></tr><tr><td>• You're married, have only one job, and your spouse doesn't work; or</td></tr><tr><td>• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.</td></tr></table>	• You're single and have only one job; or	} . . . . .	• You're married, have only one job, and your spouse doesn't work; or	• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.	<b>B</b>	_____
• You're single and have only one job; or	} . . . . .						
• You're married, have only one job, and your spouse doesn't work; or							
• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.							
<b>C</b>	Enter "1" for your <b>spouse</b> . But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . .	<b>C</b>	_____				
<b>D</b>	Enter number of <b>dependents</b> (other than your spouse or yourself) you will claim on your tax return . . . . .	<b>D</b>	_____				
<b>E</b>	Enter "1" if you will file as <b>head of household</b> on your tax return (see conditions under <b>Head of household</b> above) . . . . .	<b>E</b>	_____				
<b>F</b>	Enter "1" if you have at least \$2,000 of <b>child or dependent care expenses</b> for which you plan to claim a credit . . . . .	<b>F</b>	_____				
<b>(Note: Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)</b>							
<b>G</b>	<b>Child Tax Credit</b> (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than \$70,000 (\$100,000 if married), enter "2" for each eligible child; then <b>less</b> "1" if you have two to four eligible children or <b>less</b> "2" if you have five or more eligible children. • If your total income will be between \$70,000 and \$84,000 (\$100,000 and \$119,000 if married), enter "1" for each eligible child. . . . .	<b>G</b>	_____				
<b>H</b>	Add lines A through G and enter total here. <b>(Note: This may be different from the number of exemptions you claim on your tax return.)</b> ►	<b>H</b>	_____				
For accuracy, <b>complete all worksheets that apply.</b> <table><tr><td>• If you plan to <b>itemize</b> or <b>claim adjustments to income</b> and want to reduce your withholding, see the <b>Deductions and Adjustments Worksheet</b> on page 2.</td></tr><tr><td>• If you are <b>single and have more than one job</b> or are <b>married and you and your spouse both work</b> and the combined earnings from all jobs exceed \$50,000 (\$20,000 if married), see the <b>Two-Earners/Multiple Jobs Worksheet</b> on page 2 to avoid having too little tax withheld.</td></tr><tr><td>• If <b>neither</b> of the above situations applies, <b>stop here</b> and enter the number from line H on line 5 of Form W-4 below.</td></tr></table>				• If you plan to <b>itemize</b> or <b>claim adjustments to income</b> and want to reduce your withholding, see the <b>Deductions and Adjustments Worksheet</b> on page 2.	• If you are <b>single and have more than one job</b> or are <b>married and you and your spouse both work</b> and the combined earnings from all jobs exceed \$50,000 (\$20,000 if married), see the <b>Two-Earners/Multiple Jobs Worksheet</b> on page 2 to avoid having too little tax withheld.	• If <b>neither</b> of the above situations applies, <b>stop here</b> and enter the number from line H on line 5 of Form W-4 below.	
• If you plan to <b>itemize</b> or <b>claim adjustments to income</b> and want to reduce your withholding, see the <b>Deductions and Adjustments Worksheet</b> on page 2.							
• If you are <b>single and have more than one job</b> or are <b>married and you and your spouse both work</b> and the combined earnings from all jobs exceed \$50,000 (\$20,000 if married), see the <b>Two-Earners/Multiple Jobs Worksheet</b> on page 2 to avoid having too little tax withheld.							
• If <b>neither</b> of the above situations applies, <b>stop here</b> and enter the number from line H on line 5 of Form W-4 below.							

----- Separate here and give Form W-4 to your employer. Keep the top part for your records. -----

<b>Form W-4</b> Department of the Treasury Internal Revenue Service		<b>Employee's Withholding Allowance Certificate</b>		OMB No. 1545-0074	
► <b>Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</b>		<b>2017</b>			
<b>1</b> Your first name and middle initial		Last name		<b>2</b> Your social security number	
Home address (number and street or rural route)		<b>3</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. <b>Note:</b> If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.			
City or town, state, and ZIP code		<b>4</b> If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ► <input type="checkbox"/>			
<b>5</b> Total number of allowances you are claiming (from line <b>H</b> above <b>or</b> from the applicable worksheet on page 2)		<b>5</b>			
<b>6</b> Additional amount, if any, you want withheld from each paycheck . . . . .		<b>6</b>		\$	
<b>7</b> I claim exemption from withholding for 2017, and I certify that I meet <b>both</b> of the following conditions for exemption. • Last year I had a right to a refund of <b>all</b> federal income tax withheld because I had <b>no</b> tax liability, <b>and</b> • This year I expect a refund of <b>all</b> federal income tax withheld because I expect to have <b>no</b> tax liability. If you meet both conditions, write "Exempt" here . . . . . ►		<b>7</b>			
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.					
<b>Employee's signature</b> (This form is not valid unless you sign it.) ►					
<b>8</b> Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		<b>9</b> Office code (optional)		<b>10</b> Employer identification number (EIN)	



**Deductions and Adjustments Worksheet****Note:** Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

<b>1</b>	Enter an estimate of your 2017 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% of your income, and miscellaneous deductions. For 2017, you may have to reduce your itemized deductions if your income is over \$313,800 and you're married filing jointly or you're a qualifying widow(er); \$287,650 if you're head of household; \$261,500 if you're single, not head of household and not a qualifying widow(er); or \$156,900 if you're married filing separately. See Pub. 505 for details . . . . .	<b>1</b>	\$	_____
<b>2</b>	Enter: $\left\{ \begin{array}{l} \$12,700 \text{ if married filing jointly or qualifying widow(er)} \\ \$9,350 \text{ if head of household} \\ \$6,350 \text{ if single or married filing separately} \end{array} \right\}$ . . . . .	<b>2</b>	\$	_____
<b>3</b>	<b>Subtract</b> line 2 from line 1. If zero or less, enter "-0-" . . . . .	<b>3</b>	\$	_____
<b>4</b>	Enter an estimate of your 2017 adjustments to income and any additional standard deduction (see Pub. 505) . . . . .	<b>4</b>	\$	_____
<b>5</b>	<b>Add</b> lines 3 and 4 and enter the total. (Include any amount for credits from the <i>Converting Credits to Withholding Allowances for 2017 Form W-4</i> worksheet in Pub. 505.) . . . . .	<b>5</b>	\$	_____
<b>6</b>	Enter an estimate of your 2017 nonwage income (such as dividends or interest) . . . . .	<b>6</b>	\$	_____
<b>7</b>	<b>Subtract</b> line 6 from line 5. If zero or less, enter "-0-" . . . . .	<b>7</b>	\$	_____
<b>8</b>	<b>Divide</b> the amount on line 7 by \$4,050 and enter the result here. Drop any fraction . . . . .	<b>8</b>		_____
<b>9</b>	Enter the number from the <b>Personal Allowances Worksheet</b> , line H, page 1 . . . . .	<b>9</b>		_____
<b>10</b>	<b>Add</b> lines 8 and 9 and enter the total here. If you plan to use the <b>Two-Earners/Multiple Jobs Worksheet</b> , also enter this total on line 1 below. Otherwise, <b>stop here</b> and enter this total on Form W-4, line 5, page 1 . . . . .	<b>10</b>		_____

**Two-Earners/Multiple Jobs Worksheet** (See *Two earners or multiple jobs* on page 1.)**Note:** Use this worksheet *only* if the instructions under line H on page 1 direct you here.

<b>1</b>	Enter the number from line H, page 1 (or from line 10 above if you used the <b>Deductions and Adjustments Worksheet</b> ) . . . . .	<b>1</b>	_____
<b>2</b>	Find the number in <b>Table 1</b> below that applies to the <b>LOWEST</b> paying job and enter it here. <b>However</b> , if you are married filing jointly and wages from the highest paying job are \$65,000 or less, do not enter more than "3" . . . . .	<b>2</b>	_____
<b>3</b>	If line 1 is <b>more than or equal to</b> line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. <b>Do not</b> use the rest of this worksheet . . . . .	<b>3</b>	_____

**Note:** If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

<b>4</b>	Enter the number from line 2 of this worksheet . . . . .	<b>4</b>	_____
<b>5</b>	Enter the number from line 1 of this worksheet . . . . .	<b>5</b>	_____
<b>6</b>	<b>Subtract</b> line 5 from line 4 . . . . .	<b>6</b>	_____
<b>7</b>	Find the amount in <b>Table 2</b> below that applies to the <b>HIGHEST</b> paying job and enter it here . . . . .	<b>7</b>	\$ _____
<b>8</b>	<b>Multiply</b> line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . . . .	<b>8</b>	\$ _____
<b>9</b>	Divide line 8 by the number of pay periods remaining in 2017. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2017. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . . .	<b>9</b>	\$ _____

**Table 1**

Married Filing Jointly		All Others	
If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above
\$0 - \$7,000	0	\$0 - \$8,000	0
7,001 - 14,000	1	8,001 - 16,000	1
14,001 - 22,000	2	16,001 - 26,000	2
22,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 70,000	5
44,001 - 55,000	6	70,001 - 85,000	6
55,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 95,000	10	140,001 and over	10
95,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

**Table 2**

Married Filing Jointly		All Others	
If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above
\$0 - \$75,000	\$610	\$0 - \$38,000	\$610
75,001 - 135,000	1,010	38,001 - 85,000	1,010
135,001 - 205,000	1,130	85,001 - 185,000	1,130
205,001 - 360,000	1,340	185,001 - 400,000	1,340
360,001 - 405,000	1,420	400,001 and over	1,600
405,001 and over	1,600		

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

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

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

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

# NC-4EZ Employee's Withholding Allowance Certificate

Social Security Number _____		Marital Status _____	
_____ — _____ — _____		_____ Single _____ Head of Household _____ Married or Surviving Spouse	
First Name <small>(USE CAPITAL LETTERS FOR YOUR NAME AND ADDRESS)</small>	M.I.	Last Name	
_____		_____	
Address _____		County <small>(Enter first five letters)</small> _____	
_____		_____	
City _____	State _____	Zip Code <small>(5 Digit)</small> _____	Country <small>(If not U.S.)</small> _____
_____	_____	_____	_____

**FORM NC-4EZ:** Please use this form if you:

- Plan to claim the N.C. standard deduction
- Plan to claim no tax credits or only the credit for children
- Prefer not to complete the extended Form NC-4
- Qualify to claim exempt status (See lines 3 or 4 below)

**Important:** If you are a nonresident alien you must use Form NC-4 NRA.

You may complete Form NC-4, if you plan to claim N.C. itemized deductions, federal adjustments to income, or N.C. deductions.

If you do not plan to claim the credit for children, enter zero (0) on line 1. If you plan to claim the credit for children, use the table below for your filing status, amount of income, and number of children under age 17 to determine the number of allowances to enter on line 1. For married taxpayers, only 1 spouse may claim the allowance for the credit for each child.

Single & Married Filing Separately		Married Filing Jointly & Surviving Spouse		Head of Household	
Income	# of Children under age 17	Income	# of Children under age 17	Income	# of Children under age 17
	1 2 3 4 5 6 7 8 9 10		1 2 3 4 5 6 7 8 9 10		1 2 3 4 5 6 7 8 9 10
	# of Allowances		# of Allowances		# of Allowances
0-20,000	0 1 2 3 4 5 6 7 8 8	0-40,000	0 1 2 3 4 5 6 7 8 8	0-32,000	0 1 2 3 4 5 6 7 8 8
20,001-50,000	0 1 2 2 3 4 5 5 6 7	40,001-100,000	0 1 2 2 3 4 5 5 6 7	32,001-80,000	0 1 2 2 3 4 5 5 6 7

1. Total number of allowances you are claiming (Enter zero (0), or the number of allowances from the table above) \_\_\_\_\_

2. Additional amount, if any, withheld from each pay period (Enter whole dollars) \_\_\_\_\_ .00

3. I certify that I am exempt from North Carolina withholding because I meet both of the following conditions:

- Last year I was entitled to a refund of all State income tax withheld because I had no tax liability; and
- This year, I expect a refund of all State income tax withheld because I expect to have no tax liability

Check Here ☐

4. I certify that I am exempt from North Carolina withholding because I meet the requirements of the Military Spouses Residency Relief Act and I am legally domiciled in the state of (Enter state of domicile) \_\_\_\_\_ Check Here ☐

If line 3 or line 4 above applies to you, enter the effective year 20 \_\_\_\_\_

5. I certify that I no longer meet the requirements for exemption on line 3 ☐ or line 4 ☐ (Check applicable box)

Therefore, I revoke my exemption and request that my employer withhold North Carolina income tax based on the number of allowances entered on line 1 and any amount entered on line 2.

Check Here ☐

**CAUTION:** If you furnish an employer with an Employee's Withholding Allowance Certificate that contains information which has no reasonable basis and results in a lesser amount of tax being withheld than would have been withheld had you furnished reasonable information, you are subject to a penalty of 50% of the amount not properly withheld.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

*I certify, under penalties provided by law, that I am entitled to the number of withholding allowances claimed on line 1 above, or if claiming exemption from withholding, that I am entitled to claim the exempt status on line 3 or 4, whichever applies.*

# NC-4 Employee's Withholding Allowance Certificate

**PURPOSE** - Complete **Form NC-4, Employee's Withholding Allowance Certificate**, so that your employer can withhold the correct amount of State income tax from your pay. **If you do not provide an NC-4 to your employer, your employer is required to withhold based on single with zero allowances.**

**FORM NC-4 EZ** - You may use this form if you intend to claim either: exempt status, or the N.C. standard deduction and no tax credits or only the credit for children.

**FORM NC-4 NRA** - If you are a nonresident alien you must use Form NC-4 NRA.

**FORM NC-4 BASIC INSTRUCTIONS** - Complete the **Allowance Worksheet**. The worksheet will help you figure the number of withholding allowances you are entitled to claim. The worksheet is provided for employees to adjust their withholding allowances based on N.C. itemized deductions, federal adjustments to income, N.C. additions to federal adjusted gross income, N.C. deductions from federal adjusted gross income, and N.C. tax credits. However, you may claim fewer allowances if you wish to increase the tax withheld during the year. If your withholding allowances decrease, you must file a new NC-4 with your employer within 10 days after the change occurs. Exception: When an individual ceases to be head of household after maintaining the household for the major portion of the year, a new NC-4 is not required until the next year.

**TWO OR MORE JOBS** - If you have more than one job, figure the total number of allowances you are entitled to claim on all jobs using one Form NC-4 Allowance Worksheet. Your withholding will usually be most accurate when all allowances are claimed on the NC-4 filed for the higher paying job and zero allowances are claimed for the other. You should also refer to the Multiple Jobs Table to determine the additional amount to be withheld on line 2 of Form NC-4 (See Allowance Worksheet).

**NONWAGE INCOME** - If you have a large amount of nonwage income, such as interest or dividends, you should consider making estimated tax payments using Form NC-40 to avoid underpayment of estimated tax interest. Form NC-40 is available on our website at [www.dornc.com](http://www.dornc.com) under individual income tax forms.

**HEAD OF HOUSEHOLD** - Generally you may claim head of household status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. Note: "Head of Household" for State tax purposes is the same as for federal tax purposes.

**SURVIVING SPOUSE** - You may claim surviving spouse status only if your spouse died in either of the two preceding tax years and you meet the following requirements:

1. Your home is maintained as the main household of a child or stepchild for whom you can claim a federal exemption; and
2. You were entitled to file a joint return with your spouse in the year of your spouse's death.

**MARRIED TAXPAYERS** - For married taxpayers, both spouses must agree as to whether they will each complete the Allowance Worksheet based on married filing jointly or married filing separately.

- For married taxpayers completing the Allowance Worksheet based on married filing jointly, you will consider the sum of both spouses' incomes, adjustments, additions, deductions, and credits on the Allowance Worksheet to determine the number of allowances.
- For married taxpayers completing the worksheet on the basis of married filing separately, each spouse will consider only his or her portion of income, adjustments, additions, deductions, and credits on the Allowance Worksheet to determine the number of allowances.

**All NC-4 forms are subject to review by the North Carolina Department of Revenue. Your employer may be required to send this form to the North Carolina Department of Revenue.**

**CAUTION:** If you furnish an employer with an Employee's Withholding Allowance Certificate that contains information which has no reasonable basis and results in a lesser amount of tax being withheld than would have been withheld had you furnished reasonable information, you are subject to a penalty of 50% of the amount not properly withheld.

Cut here and give this certificate to your employer. Keep the top portion for your records.

## NC-4 Employee's Withholding Allowance Certificate

**1. Total number of allowances you are claiming**

(Enter zero (0), or the number of allowances from Page 2, line 16 of the NC-4 Allowance Worksheet)

**2. Additional amount, if any, withheld from each pay period (Enter whole dollars)**

\_\_\_\_\_.00

Social Security Number _____-_____-____		Marital Status <input type="radio"/> Single <input type="radio"/> Head of Household <input type="radio"/> Married or Surviving Spouse	
First Name (USE CAPITAL LETTERS FOR YOUR NAME AND ADDRESS) _____	M.I. _____	Last Name _____	
Address _____ _____		County (Enter first five letters) _____	
City _____	State _____	Zip Code (5 Digit) _____	Country (If not U.S.) _____

Employee's Signature \_\_\_\_\_

Date \_\_\_\_\_

I certify, under penalties provided by law, that I am entitled to the number of withholding allowances claimed on line 1 above.

# NC-4 Allowance Worksheet

## Part I

Answer **all** of the following questions for your filing status.

### Single -

1. Will your N.C. itemized deductions from Page 3, Schedule 1 exceed \$11,249? Yes ☐ No ☐
2. Will you have adjustments or deductions from income from Page 3, Schedule 2? Yes ☐ No ☐
3. Will you be able to claim any N.C. tax credits or tax credit carryovers from Page 4, Schedule 4? Yes ☐ No ☐

If you answered "No" to all of the above, **STOP HERE** and enter **ZERO (0)** as total allowances on Form NC-4, Line 1.  
If you answered "Yes" to any of the above, you may choose to go to Page 2, Part II to determine if you qualify for additional allowances. Otherwise, enter **ZERO (0)** on Form NC-4, Line 1.

### Married Filing Jointly -

1. Will your N.C. itemized deductions from Page 3, Schedule 1 exceed \$19,999? Yes ☐ No ☐
2. Will you have adjustments or deductions from income from Page 3, Schedule 2? Yes ☐ No ☐
3. Will you be able to claim any N.C. tax credits or tax credit carryovers from Page 4, Schedule 4? Yes ☐ No ☐
4. Will your spouse receive combined wages and taxable pensions of less than \$6,250 or only retirement benefits not subject to N.C. income tax? Yes ☐ No ☐

If you answered "No" to all of the above, **STOP HERE** and enter **ZERO (0)** as total allowances on Form NC-4, Line 1.  
If you answered "Yes" to any of the above, you may choose to go to Page 2, Part II to determine if you qualify for additional allowances. Otherwise, enter **ZERO (0)** on Form NC-4, Line 1.

### Married Filing Separately -

1. Will your portion of N.C. itemized deductions from Page 3, Schedule 1 exceed \$11,249? Yes ☐ No ☐
2. Will you have adjustments or deductions from income from Page 3, Schedule 2? Yes ☐ No ☐
3. Will you be able to claim any N.C. tax credits or tax credit carryovers from Page 4, Schedule 4? Yes ☐ No ☐

If you answered "No" to all of the above, **STOP HERE** and enter **ZERO (0)** as total allowances on Form NC-4, Line 1.  
If you answered "Yes" to any of the above, you may choose to go to Page 2, Part II to determine if you qualify for additional allowances. Otherwise, enter **ZERO (0)** on Form NC-4, Line 1.

### Head of Household-

1. Will your N.C. itemized deductions from Page 3, Schedule 1 exceed \$16,499? Yes ☐ No ☐
2. Will you have adjustments or deductions from income from Page 3, Schedule 2? Yes ☐ No ☐
3. Will you be able to claim any N.C. tax credits or tax credit carryovers from Page 4, Schedule 4? Yes ☐ No ☐

If you answered "No" to all of the above, **STOP HERE** and enter **ZERO (0)** as total allowances on Form NC-4, Line 1.  
If you answered "Yes" to any of the above, you may choose to go to Page 2, Part II to determine if you qualify for additional allowances. Otherwise, enter **ZERO (0)** on Form NC-4, Line 1.

# NC-4 Allowance Worksheet

## Surviving Spouse -

1. Will your N.C. itemized deductions from Page 3, Schedule 1 exceed \$19,999? Yes ☐ No ☐
2. Will you have adjustments or deductions from income from Page 3, Schedule 2? Yes ☐ No ☐
3. Will you be able to claim any N.C. tax credits or tax credit carryovers from Page 4, Schedule 4? Yes ☐ No ☐

If you answered "No" to all of the above, **STOP HERE** and enter **THREE (3)** as total allowances on Form NC-4, Line 1.  
If you answered "Yes" to any of the above, you may choose to go to Part II to determine if you qualify for additional allowances. Otherwise, enter **THREE (3)** on Form NC-4, Line 1.

## NC-4 Part II

1. Enter your total estimated N.C. itemized deductions from Page 3, Schedule 1 ..... 1. \$ \_\_\_\_\_.
2. Enter the applicable N.C. standard deduction based on your filing status.  $\left\{ \begin{array}{l} \$ 8,750 \text{ if single} \\ \$17,500 \text{ if married filing jointly or surviving spouse} \\ \$ 8,750 \text{ if married filing separately} \\ \$14,000 \text{ if head of household} \end{array} \right.$  ..... 2. \$ \_\_\_\_\_.
3. Subtract line 2 from line 1. If line 1 is less than line 2, enter ZERO (0) ..... 3. \$ \_\_\_\_\_.
4. Enter an estimate of your total federal adjustments to income and State deductions from federal adjusted gross income from Page 3, Schedule 2 ..... 4. \$ \_\_\_\_\_.
5. Add lines 3 and 4 ..... 5. \$ \_\_\_\_\_.
6. Enter an estimate of your nonwage income (such as dividends or interest) ..... 6. \$ \_\_\_\_\_.
7. Enter an estimate of your State additions to federal adjusted gross income from Page 3, Schedule 3 ..... 7. \$ \_\_\_\_\_.
8. Add lines 6 and 7 ..... 8. \$ \_\_\_\_\_.
9. Subtract line 8 from line 5 (*Do not enter less than zero*) ..... 9. \$ \_\_\_\_\_.
10. Divide the amount on line 9 by \$2,500. Round down to whole number ..... 10. \_\_\_\_\_  
Ex.  $\$3,900 \div \$2,500 = 1.56$  rounds down to 1
11. Enter the amount of your estimated N.C. tax credits from Page 4, Schedule 4 .. 11. \$ \_\_\_\_\_.
12. Divide the amount on line 11 by \$140. Round down to whole number ..... 12. \_\_\_\_\_  
Ex.  $\$200 \div \$140 = 1.43$  rounds down to 1
13. If filing as single, head of household, or married filing separately, enter zero (0) on this line.  
If filing as surviving spouse, enter 3.  
If filing as married filing jointly, enter the appropriate number from either (a), (b), (c), or (d) below.
- (a) Your spouse expects to have zero wages and expects to receive retirement benefits that will all be nontaxable for N.C. purposes, enter 3. (Nontaxable retirement benefits include: *Bailey*, Social Security, and Railroad retirement)
- (b) Your spouse expects to have combined wages and taxable pensions of more than \$1, but less than \$3,750, enter 2.
- (c) Your spouse expects to have combined wages and taxable pensions of more than \$3,750 but less than \$6,250, enter 1.
- (d) Your spouse expects to have combined wages and taxable pensions of more than \$6,250, enter 0 ..... 13. \_\_\_\_\_
14. Add lines 10, 12, and 13, and enter the total here ..... 14. \_\_\_\_\_
15. If you completed this worksheet on the basis of married filing jointly, the total number of allowances determined on line 14 may be split between you and your spouse, however, you choose. Enter the number of allowances from line 14 that your spouse plans to claim ..... 15. \_\_\_\_\_
16. Subtract line 15 from line 14 and enter the total number of allowances here and on line 1 of your **Form NC-4, Employee's Withholding Allowance Certificate** ..... 16. \_\_\_\_\_

# NC-4 Allowance Worksheet Schedules

**Important: If you cannot reasonably estimate the amount to enter in the schedules below, you should enter ZERO (0) on line 1, NC-4.**

## Schedule 1

### Estimated N.C. Itemized Deductions

Qualifying mortgage interest	\$		
Real estate property taxes	\$		
Total qualifying mortgage interest and real estate property taxes*	\$		
Charitable Contributions (Same as allowed for federal purposes)	\$		
Medical and Dental Expenses (Same as allowed for federal purposes)	\$		
Total estimated N.C. itemized deductions. Enter on Page 2, Part II, Line 1	\$		

\*The sum of your qualified mortgage interest and real estate property taxes may not exceed \$20,000. For married taxpayers, the \$20,000 limitation applies to the combined total of qualified mortgage interest and real estate property taxes claimed by both spouses, rather than to each spouse separately.

## Schedule 2

### Estimated Federal Adjustments to Income

Federal adjustments to income are the amounts that are deducted from total income claimed on your federal return. Adjustments to income may include:

Health savings account deduction	\$		
Moving expenses	\$		
Alimony paid	\$		
IRA deduction	\$		
Student loan interest deduction	\$		
Certain business expenses of reservists, performing artist, and fee-basis governmental officials	\$		
Total Federal Adjustments to Income	\$		

### Estimated State Deductions from Federal Adjusted Gross Income to Consider for NC-4 Purposes

20% of prior bonus depreciation addback	\$		
20% of prior section 179 addback	\$		
Amount by which North Carolina basis of property exceeds federal basis of property - in year taxpayer disposes of property	\$		
Total State Deductions from Federal Adjusted Gross Income	\$		

**(Do not consider any amount of the portion of Bailey Retirement Benefits, Social Security Benefits, or Railroad Retirement Benefits included in Adjusted Gross Income.)**

Total Federal Adjustments to Income and State Deductions from Federal Adjusted Gross Income. Enter on Page 2, Part II, Line 4	\$		
---	----	--	--

## Schedule 3

### Estimated State Additions to Federal Adjusted Gross Income to Consider for NC-4 Purposes

Shareholder's share of built-in gains tax that the S corporation paid for federal income tax purposes	\$		
Amount by which federal basis of property exceeds NC basis of property - in year taxpayer disposes of property	\$		
Amount of gross income from domestic production activities that a taxpayer excludes from gross income under section 199 of the Internal Revenue Code	\$		
Amount excluded from the taxpayer's gross income for the discharge of qualified principal residence indebtedness under Section 108 of the code.	\$		
Adjustment for bonus depreciation	\$		
Adjustment for section 179 expense deduction	\$		
Total State Additions to Federal Adjusted Gross Income. Enter on Page 2, Part II, Line 7	\$		

# NC-4 Allowance Worksheet Schedules

## Schedule 4

### Estimated N.C. Tax Credits

Tax Credit for Income Taxes Paid to Other States by Individuals \$ \_\_\_\_\_.

#### Credit for Children

A taxpayer who is allowed a federal child tax credit under section 24 of the Internal Revenue Code is allowed a tax credit for each dependent child unless adjusted gross income exceeds the threshold amount shown below.

The credit can be claimed only for a child who is under 17 years of age on the last day of the year.

Filing Status	Adjusted Gross Income	No. of Children	Credit Amount per Qualifying Child	Estimated Credit
Single	Up to \$20,000	_____	\$125	\$ _____.
	Over \$20,000 and up to \$50,000	_____	\$100	\$ _____.
	Over \$50,000	_____	\$0	\$ _____.
Married Filing Jointly or Surviving Spouse	Up to \$40,000	_____	\$125	\$ _____.
	Over \$40,000 and up to \$100,000	_____	\$100	\$ _____.
	Over \$100,000	_____	\$0	\$ _____.
Head of Household	Up to \$32,000	_____	\$125	\$ _____.
	Over \$32,000 and up to \$80,000	_____	\$100	\$ _____.
	Over \$80,000	_____	\$0	\$ _____.
Married Filing Separately	Up to \$20,000	_____	\$125	\$ _____.
	Over \$20,000 and up to \$50,000	_____	\$100	\$ _____.
	Over \$50,000	_____	\$0	\$ _____.

### Additional Tax Credits and Carryovers

G.S. 105-129.105, Credit for Rehabilitating Income-Producing Historic Structure \$ \_\_\_\_\_.

G.S. 105-129.106, Credit for Rehabilitating Nonincome-Producing Historic Structure \$ \_\_\_\_\_.

Tax Credit Carryover from previous years \$ \_\_\_\_\_.

Total Tax Credits and Carryovers. Enter on Page 2, Part II, Line 11 \$ \_\_\_\_\_.

## **Multiple Jobs Table**

Find the amount of your estimated annual wages from your lowest paying job(s) in the left hand column. Follow across to find the amount of additional tax to be withheld for each pay period. Enter the additional amount to be withheld on line 2 of your **Form NC-4**.

### **Additional Withholding for Single, Married, or Surviving Spouse with Multiple Jobs**

<b>Estimated Annual Wages</b>		<b>Payroll Period</b>			
<b>At Least</b>	<b>But Less Than</b>	<b>Monthly</b>	<b>Semimonthly</b>	<b>Biweekly</b>	<b>Weekly</b>
0	500	1	1	1	0
500	1500	5	2	2	1
1500	2500	9	5	4	2
2500	3500	14	7	6	3
3500	4500	19	9	9	4
4500	5500	23	12	11	5
5500	6500	28	14	13	6
6500	7500	33	16	15	8
7500	8500	37	19	17	9
8500	Unlimited	41	20	19	9

### **Additional Withholding for Head of Household Filers with Multiple Jobs**

<b>Estimated Annual Wages</b>		<b>Payroll Period</b>			
<b>At Least</b>	<b>But Less Than</b>	<b>Monthly</b>	<b>Semimonthly</b>	<b>Biweekly</b>	<b>Weekly</b>
0	1000	2	1	1	1
1000	2000	7	3	3	2
2000	3000	12	6	5	3
3000	4000	16	8	8	4
4000	5000	21	10	10	5
5000	6000	26	13	12	6
6000	7000	30	15	14	7
7000	8000	35	17	16	8
8000	9000	40	20	18	9
9000	10000	44	22	20	10
10000	11000	49	24	23	11
11000	12000	54	27	25	12
12000	13000	58	29	27	13
13000	14000	63	31	29	15
14000	Unlimited	65	33	30	15





# Catholic Charities of the Diocese of Raleigh

Providing Help—Creating Hope—Serving All

## **Code of Conduct for Church Personnel for Catholic Charities of the Diocese of Raleigh\***

Revision Date: 01/2013

### **SECTION ONE: Preamble**

- 1.1 By virtue of our baptism, all Catholics share in the mission of the Church to continue the work of Jesus Christ. Jesus is Lord and we must seek the Kingdom as He did. We must preach the Good News that there is a God who loves us beyond our imagining. We must give our love and the provisions of life to those who have them in small measure. By our actions we must share our conviction that everything that occurs between us is a function of our relationship with God.
- 1.2 The call to discipleship is abundant in grace. It is also an awesome responsibility. We who represent the Church, the bishop, priests, deacons, seminarians, non-ordained religious, lay employees and lay volunteers who are involved in work for the Diocese of Raleigh, its parishes and agencies and who represent the Church by virtue of office, designated position, employment or contract (hereafter called Church Personnel) have a special obligation due to roles of leadership and positions of trust. Our brothers and sisters, young and old, invite us into their lives, open their hearts, share their joys and hopes, their grief and anxieties with us. They are confident that we will listen compassionately and act honorably in their best interest. Our behavior as Church Personnel, both public and private, has the potential to inspire those entrusted to our pastoral care to faith and hope and to motivate them toward greater generosity and participation in a life of faith. Sadly, when trust is abused it also has the potential to weaken or destroy faith, and cause scandal.
- 1.3 It is essential that Church Personnel be constantly mindful of the trust given to them. Faithfully discharging the responsibilities that accompany our work requires constant prayerful reflection and must be sustained and supported by God's grace. Our obligations require each of us to act with love and prudence. This Code of Conduct will assist in this task.
- 1.4 These statements do not presume to provide answers to all ethical questions. They present a set of general standards to help guide day to day actions and form a framework for developing policies and discussing ethical questions. Church Personnel in the Diocese of Raleigh agree to abide by this Code of Conduct and understand that disregarding these principles through personal conduct or life style contrary to the moral and religious doctrines or teachings of the Roman Catholic Church may lead to corrective and/or disciplinary action.

## **SECTION 2: Principles**

### 2.1 Church personnel of the Diocese of Raleigh shall:

- a. Respect the teachings and precepts of the Catholic Church
- b. Respect the rights, dignity and worth of each person from conception to natural death.
- c. Conduct their relationships with others free of deception, manipulation, exploitation or intimidation.
- d. Work to ensure just treatment for colleagues, employees, volunteers, parishioners and others with whom they interact.
- e. Seek to provide an environment that is non-discriminatory, free from all forms of abuse and promotes respect, self control and personal safety.
- f. While under our supervision to protect, to the best of our ability those entrusted to our care, especially children and youth as well as adults who are physically or mentally challenged.
- g. Provide guidance for individuals or groups in a way that protects and respects each person, and is free from deception, manipulation, exploitation or intimidation.
- h. Keep all information received in the course of formal counseling or spiritual direction in the strictest confidence in accord with professional ethical codes and as mandated by canon and civil law.
- i. Make no false accusations against another or reveal the faults and failings of another to those who have no right to know.
- j. Be responsible stewards of the human, temporal, and financial resources of the Church.
- k. Maintain a high level of competence in our designated role in the Church and prudently attend to our physical, spiritual, mental and emotional well-being.
- l. Avoid accepting or conferring an office, position, assignment or compensation that creates a conflict of interest or the perception of impropriety.
- m. Examine our own actions and intentions objectively to ensure that our behavior promotes the welfare of the community and exemplifies the strong moral tradition of the Church.
- n. Promptly report incidents of ethical misconduct by other Church Personnel to the proper Church and/or civil authority
- o. Church personnel are prohibited from speaking in a manner that is derogatory or demeaning. All are expected to refrain from swearing or using foul language.

- p. Church personnel are prohibited from possessing or viewing child pornography as is consistent with North Carolina State Law. Church personnel are prohibited from possessing or allowing a person to view pornography or any sexually explicit or morally inappropriate materials on Church property, at Church sponsored events or in the presence of minors. Such materials include, but are not limited to: magazines, videos, films, recordings, computer software, computer games, or printed materials. In addition, topics of conversation or discussion, vocabulary or any other form of personal interaction or entertainment that could not be used in the presence of parents or a responsible adult are also prohibited.
- q. Church personnel are to refrain from sexually offensive humor and conversation.

2.2 In addition to these guidelines church personnel shall abide by any applicable professional codes of conduct, ethical norms, canon or civil laws.

### **SECTION 3: Behavioral Guidelines for Church Personnel Working with Minors**

- 3.1 The following guidelines are intended to assist Church Personnel in making decisions about interactions with minors in Church sponsored and affiliated programs. They are not intended to address every possible situation or designed to address interactions within families. For clarification of any guideline or to inquire about a behavior not addressed here, please contact your pastor, agency director, principal or the Director for the Program for the Protection of Children and Young People.
- a. Corporal punishment is prohibited when disciplining minors. Physical force may only be used to restrain individuals from inflicting harm on themselves and/or others.
  - b. Church Personnel are prohibited from engaging in sexually oriented conversations with minors except in the context of sharing the Church's teaching on human sexuality. Church personnel are never permitted to use examples from their own sexual history or experience.
  - c. Church Personnel are prohibited from using tobacco products in the presence of minors or having in their possession or being under the influence of any alcoholic beverage or any illegal drugs when working with minors. Church Personnel are prohibited from providing minors with any alcoholic beverage, tobacco, drugs or any substance prohibited by law.
  - d. Medications may be administered to minors only with written parental permission. Parents should provide the medication clearly labeled (prescriptions or over-the counter medications) and dosing instructions for the medication.
  - e. Church Personnel should schedule one-on-one guidance sessions or meetings with minors at times and locations that promote accountability and meet accepted standards of propriety. This includes limiting the length and the number of meetings, making referrals and notifying the parents and/or guardians as appropriate. Church Personnel providing counseling services should follow the standards of care and code of ethics for their respective professions in terms of services to minors and notification of parents and/or guardians.

- f. Adults should avoid being alone with a minor so as to remove the opportunity for, or perception of impropriety. Church Personnel are prohibited from sleeping in the same bed, hotel room, van, sleeping bag or tent with a minor unless the adult is a parent, guardian or sibling of the minor. Church personnel should not take an overnight trip alone with a minor who is not an immediate family member. Church Personnel should avoid being alone with a minor (not a member of the family) in a locker room, rest room, dressing facility, car or vehicle or other isolated area that is not appropriate to a ministerial relationship. When the good of the minor requires that they be accompanied by an adult to any of these locations, the time alone with the minor should be minimal and another adult should be made aware of the circumstances. As a general rule, changing and showering facilities should be separate for male and female and facilities and arrangements for minors separate from adults or should be used by adults and minors at different times.

NOTE: When there is only one large room that serves as the sleeping area for each gender, at least two adult leaders should be present in each sleeping area.

- g. Church Personnel, acting in their ministerial role, should not host minors who are not family members for overnight accommodations where there is no other adult supervision present. This includes, but is not limited to, accommodations in any church-owned facility, private residence, hotel room, or any other place where there is no other adult supervision present.
- h. Clergy should not allow minors who are not members of their family to stay overnight in their private accommodations or residence unless accompanied by other adults.
- i. Appropriate demonstrations of affection between Church Personnel and minors can be important for a child's development and a positive part of ministry. Touching must be age appropriate and based on the need of the minor not the adult. If an adult has questions regarding demonstrating affection toward a minor they should discuss the matter with their supervisor or an adult qualified to render an opinion about appropriate ministerial boundaries.

### 3.2 Church Personnel may be in a position to provide transportation for minors.

The following guidelines apply:

- a. Ordinarily minors should not be transported without written permission.
  - b. Minors should be transported directly to their destination with no unauthorized stops.
  - c. Drivers must be validly licensed and insured.
  - d. Drivers may not drive a diocesan vehicle without prior authorization.
  - e. Drivers are to abide by all applicable state laws (including safety seats /belts) and diocesan policies regarding the safe transportation of children and youth.
- ### 3.3 Church Personnel observing anyone (adult or minor) abusing a minor, must take immediate steps to intervene to provide a safe environment for the minor and report the misconduct in accord with diocesan policies and civil law. **Church personnel who have cause to suspect that a minor has been abused must report the suspected abuse in accord with the Diocese of Raleigh Policies and Procedures for the Protection of Children and Young People and civil law.**

#### **SECTION 4: Guidelines for the Supervision of Minors**

Guidelines include, but are not limited to, the following:

- 4.1 Church personnel are responsible for releasing minors in their care at the close of activities only to parents, legal guardians or other persons designated by parents or legal guardians in writing. Special circumstances for the release of children require written parental/guardian permission.
- 4.2 Programs for minors should be administered by at least two adult supervisors.
- 4.3 Church personnel should report uncontrollable, dangerous, or unusual behavior of minors to parents /guardians as soon as possible.
- 4.4 Church personnel are to report substance abuse by minors to parent/guardian as soon as possible.
- 4.5 As far as possible, facilities should be monitored during church services, and during all other (school and parish) activities on the church/school grounds.
- 4.6 Parents should be encouraged to be part of all services and programs in which their children and young people are involved.
- 4.7 Parental permission should be obtained, including a signed medical treatment authorization form before taking minors on trips.
- 4.8. Parental approval must always be obtained before permitting any minor to participate in athletic or other activities.

*\*Formerly the Code of Professional Responsibility*

**I have read and agree to abide by the Code of Conduct for Church Personnel for the Diocese of Raleigh – Catholic Charities.**

---

**Name**

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**Date**



# Catholic Charities of the Diocese of Raleigh

Providing Help—Creating Hope—Serving All

## **Conflict of Interest Policy Board of Directors and Employees**

**1. Scope.** The following statement of policy applies to each member of the Board of Catholic Charities of the Diocese of Raleigh, Inc. (Catholic Charities) and to all persons employed by Catholic Charities, regardless of position. Catholic Charities, its Board of Directors (Board) and Staff (employees and contract workers) are committed to ethical, business like, and lawful conduct. To ensure understanding and compliance with Catholic Charities standards and relevant Federal Government requirements, each member of the Board, (including the Officers as Ex Officio members), and each Staff member, including contract workers, will be required to read, agree to and sign this Conflict of Interest Policy. Each Board member shall complete the Annual Conflict of Interest Statement (1) upon entry onto the Board and (2) annually while a member of the Board. Each Catholic Charities employee shall sign the annual Conflict of Interest Statement (1) at the time of hire and (2) annually.

**2. Responsibility.** All decisions of the Board and employees of Catholic Charities are to be made solely on the basis of a desire to promote the best interests of Catholic Charities and those it serves.

**3. Disclosure of Conflicts with Respect to Potential Financial Transactions.** In the event any financial transaction or other matter involving Catholic Charities also involves (1) a Board member, employee or their relative, or (2) an organization with which any Board member, employee or their relative has any material financial interest, the Board member or employee having the affiliation or interest, at the first knowledge of the transaction or other matter, shall disclose fully the precise nature of the interest or involvement. For the purposes of this policy, a relative is any person who is related by blood or marriage, or whose relationship with the employee is similar to that of persons who are related by blood or marriage.

**4. Disclosure Statement.** Each Board member and employee of Catholic Charities shall be required to submit a disclosure statement listing all organizations with which he or she is affiliated and describing the nature of the affiliation as defined below. In the event there is any material change in the information contained in any disclosure statement, the person who submitted it shall promptly submit written notification of the change.

A Board member or employee is deemed to be affiliated with any organization that may be potentially related to the financial operation of Catholic Charities if he or she, or their relative (1) is a director, trustee, officer, partner, employee, or agent; or (2) receives direct financial benefit from sales or services; or (3) has a 35 percent or greater interest. In no way should this policy imply that Board members or employees or their relatives should reveal any religious, ethnic, political, fraternal or civic affiliations.

All personnel of Catholic Charities, including Board members and Staff members and their relatives, are expected to be alert to and to avoid conflicts of interest that jeopardize the care of persons served and that interfere with the Staff's delivery of services as further delineated in the Code of Ethics of Catholic Charities of the Diocese of Raleigh, Inc., especially IV Ethical Standards.

**5. Administration.** All disclosures required under this policy and amendments thereto, if by Board members, shall be directed in writing to the Chairperson of the Board, or if by employees, in writing to the Executive Director. The Chairperson of the Board and the Executive Director shall be responsible for the administration of this policy. Issues identified as a result of disclosures under this policy concerning Board members shall be reported initially to the Chairperson of the Board for appropriate action; those concerning Staff shall be referred initially to the Executive Director. Information disclosed under this policy shall be held in confidence by the persons authorized to receive and act upon it except where, in the judgment of any of such persons, the best interest of Catholic Charities requires further disclosure. The Chairperson of the Board will report annually that he or she and the Executive Director have supervised the completion of the signing of the annual statement by Board members and Staff members and that either there are no reportable issues or there are some issues and the Chairperson will disclose what those issues are to the Board.

**6. Restraint on Participation.** A Board member who has declared or has been found to have a conflict of interest in any proposed transaction or other matter shall refrain from participating in consideration of the proposed transaction or other matter, unless for special reasons the Board requests information or interpretation from the person or persons involved. In the case of a Board member, he or she shall not vote on the matter in question and, if so requested by the Chairperson or any other member of the Board, shall not be present at the time of the vote. With respect to restraint on participation by a staff member, the Executive Director, or, where applicable, the Chairperson, shall take such action as is necessary to assure that the transaction or other matter is completed in the best interests of Catholic Charities without the substantive involvement of the person who has the possible conflict of interest.

**7. Advance Determinations.** Any staff member who is uncertain about possible conflict of interest in any matter may request the Executive Director to determine whether a possible conflict exists. Any Board member who is uncertain about possible conflict of interest in any matter may request the Executive Committee to determine whether a possible conflict exists; the Executive Committee shall resolve the question by majority vote. If required, the question of potential conflict might be referred to counsel for an opinion prior to the Executive Committee vote.

**Print Name:**\_\_\_\_\_

**Signature:**\_\_\_\_\_ **Date:**\_\_\_\_\_

**Title(Board Member or Staff Member):**\_\_\_\_\_



Catholic Charities  
of the Diocese of Raleigh

Providing Help—Creating Hope—Serving All

## **EMPLOYEE CONFIDENTIALITY AGREEMENT**

I, the undersigned, hereby agree that I will not at any time, during my employment or after my employment or association ends, access or use protected health information, or reveal or disclose to any persons within or outside of Catholic Charities of the Diocese of Raleigh, Inc., any protected health information except as may be required in the course of my duties and responsibilities and in accordance with applicable local, state or federal laws governing proper release of information.

I also understand that unauthorized use or disclosure of protected health information will result in disciplinary action up to and including termination of employment or association and the possible imposition of fines pursuant to applicable state and federal laws.

Protected Health Information is “individually identifiable health information including, without limitation, all information, data, documentation, and materials, including without limitation, demographic, medical, and financial information, that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.”

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Date

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Employee signature

08.01.2016





# Catholic Charities of the Diocese of Raleigh

Providing Help—Creating Hope—Serving All

## EMERGENCY INFORMATION SHEET

NAME: \_\_\_\_\_

DEPARTMENT: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

phone: \_\_\_\_\_

### EMERGENCY DATA:

Person(s) to notify in case of Emergency:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Do you wish your personal physician to be contacted? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please indicate the physician's name, address and telephone number.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Please list anything you feel would be important information concerning your physical condition that would be of help to a doctor in an emergency (i.e., allergies to medicines, diabetes, medications, etc.):

\_\_\_\_\_

## Diocese of Raleigh



CHRISTIAN  
BROTHERS  
SERVICES

Employee Benefit Trust  
1205 Windham Parkway  
Romeoville, IL 60446  
800.807.9460 / 630.378.3005 fax

### Request for Group Coverage/Enrollment Form

Due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), certain provisions contained within this plan may or may not apply while you are covered. PLEASE READ THE FOLLOWING CAREFULLY.

If you have a condition for which medical advice, diagnosis, care, or treatment was recommended or received within three months before your enrollment date and within three months after your effective date with the CBEBT, you will be subject to pre-existing condition exclusion. A pre-existing condition exclusion period is the amount of time when payment for service related to that condition is limited. The exclusion period from the date of enrollment will be: 12 months for timely entrants (individuals who enroll when first eligible); or 6 months deferral period plus 12 months for late entrants (See Late Entrant/Prior Waiver Form). The pre-existing exclusion will not apply to any member (employee, spouse or child) under the age of 19; or pregnancy.

The pre-existing exclusion period may be reduced by the number of days you were covered under a prior health plan. You have the right to demonstrate coverage under a prior health plan. To do this, you may request a certificate of coverage from a prior health plan or insurer. When it is received, please forward a copy of this certificate to our office. Once the length of prior creditable coverage has been determined, you will receive a notice from us stating the length of your pre-existing condition exclusion period, if any.

#### SPECIAL ENROLLMENT RIGHTS

If you waive (or decline) enrollment for yourself or your dependents because of other health coverage, you may later enroll within 31 days of a loss of other health coverage. Loss of health coverage includes separation, divorce, death, termination of employment, reduction in work hours, exhaustion of COBRA continuation or state continuation, or if employer contributions toward your coverage have terminated.

In addition, any change in your family status may allow you to enroll within 31 days of the event. It includes marriage, birth, adoption, or placement for adoption of a child. (See Special Enrollment Form)

If enrollment is not made at the time these special enrollment opportunities occur, you may apply for coverage via a Late Entrant/Prior Waiver Form. Benefits will not be effective until the first of the month following a six month deferral period. The six month deferral period begins on the day we receive the form. Once enrolled, there will be a twelve month pre-existing condition period (less prior creditable coverage if applicable) and deferred dental.

With the Onset of the **Children's Health Insurance Program Reauthorization Act of 2009** two additional enrollment opportunities apply for CBEBT Trust members and their enrolled dependents if either of the following occurs:

- Termination of Medicaid or Children's Health Insurance Program (**CHIP**) due to loss of eligibility; or
- Become eligible for state premium assistance under Medicaid or **CHIP**.

Trust members and their dependents who are eligible but not enrolled for coverage under the Christian Brothers Employee Benefit Trust are allowed up to **60 days** to request coverage under the group health plan.

If enrollment is not made at the time these special enrollment opportunities occur, you may apply for coverage via a Late Entrant/Prior Waiver Form. Benefits will not be effective until the first of the month following a 6 month deferral period. The 6 month deferral period begins on the day we receive the form. Once enrolled, there will be a 12 month pre-existing condition period (less prior creditable coverage if applicable) and deferred dental.

**Please contact your employer for any clarification regarding your enrollment in the CBEBT.**

**Diocese of Raleigh**

Please read and fill out ALL applicable sections carefully.

## 1. Employer Section

**Please print or type.**

Location Name:				Location#:	
First Active Day of Work:		Enrollment Use Only:		Effective Date of Coverage:	
Annual Salary:					

## 2. Employee Section

Employee's Last Name:			Employee's First Name:		
Employee's Home Address:					
City:		State:		Zip:	
Employee's Soc. Sec. #:			Employee's Date of Birth:		
Email Address:			Home Phone:		
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Religious <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced					
I request to be covered under the Group Plan with the following options; if dependent coverage is selected, the dependent information below must be completed (Eligibility is first day of month following date of hire unless hire date is 1 <sup>st</sup> day of the month):					
<input type="checkbox"/> <b>Employee</b> <input type="checkbox"/> Medical * <input type="checkbox"/> Dental		<input type="checkbox"/> <b>Spouse</b> <input type="checkbox"/> Medical * <input type="checkbox"/> Dental		<input type="checkbox"/> <b>Child(ren)</b> <input type="checkbox"/> Medical * <input type="checkbox"/> Dental	

**\*Medical Includes Rx and Vision**

## Medical PPO Network: CIGNA

<b>Please Complete section below if selecting dependent coverage.</b>				<b>Must be completed entirely or can result in delay.</b>			
List the name of each dependent and answer each question for each dependent.	Social Security Number	Birth date MM/DD/YY	Sex F/M	Natural/Adopted Child	Are you Legal Guardian	Step-Child	Handi-capped
Spouse:				<u>N/A</u>	<u>N/A</u>	<u>N/A</u>	
<b>List Children Below</b>							
1.							
2.							
3.							
4.							

NOTE: For Step-Children or any child for whom you have legal guardianship, a *DEPENDENT ELIGIBILITY FORM* must be completed. If you are required to complete the Dependent Eligibility Form, coverage will not take effect until after approved by **CHRISTIAN BROTHERS EMPLOYEE BENEFIT TRUST** in writing.

Signature of Employee:		Date:	
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## 3. Waiver of Group Coverage

**I hereby certify that I have been given an opportunity to apply for group coverage. I understand that if I waive coverage at this time, future coverage may be delayed. I decline to enroll:**

☐ Myself ☐ My Dependents for coverage(s) because:

☐ Covered under spouse's plan  
 ☐ Individual Policy  
 ☐ Medicare  
 ☐ Medicaid  
☐ Enrolled on another employer plan  
☐ Other: \_\_\_\_\_

Signature of Employee:		Date:	
------------------------	--	-------	--

## 4. Life Insurance

**PLEASE NOTE: DO NOT USE THIS FORM TO CHANGE THE BENEFICIARY DESIGNATION.**

Employer Name:		Location #:	
Employee Name:			
Social Security #:			

### Primary Beneficiary Designation

(If additional Beneficiaries, please attach additional page)

Full Name (Last, First, MI)	Relationship	Date of Birth	Share %

**Payment will be made in equal shares or all to the survivor unless otherwise indicated.**

In the event said primary beneficiary(ies) predecease(s) the insured, I designate as contingent beneficiary(ies)

### Contingent Beneficiary Designation

(If additional Beneficiaries, please attach additional page)

Full Name (Last, First, MI)	Relationship	Date of Birth	Share %

**Payment will be made in equal share or all to the survivor unless otherwise indicated.**

**If no beneficiary or contingent beneficiary designated shall be living following the insured's death, the amount payable by reason of the insured's death shall be payable as provided in the Group Policy.**

Signature of Employee:		Date:	
------------------------	--	-------	--

**POPULAR BENEFICIARY DESIGNATIONS (SEE NEXT PAGE)**

### Popular Beneficiary Designations

Be sure to use given names such as “Mary M. Doe”, not Mrs. John Doe”. The following sample designations may be helpful to you.

<u>Type of Beneficiary</u>	<u>Standard Wording</u>
1. insured's estate	my estate
2. one beneficiary	Anna L. Doe wife
3. two beneficiaries	John A. Doe, father, and Mary I. Doe, mother, equally or to the survivor
4. three or more beneficiaries	John A. Doe, father, and Mary I. Doe, mother, and Henry J. Doe, son, equally or to the survivor(s)
5. one beneficiary and one contingent beneficiary	Anna L. Doe, wife, if living; otherwise, Henry J. Doe, son
6. one beneficiary and two or more contingent beneficiaries	Anna L. Doe, wife, if living, otherwise Henry J. Doe, son, Alice G. Doe, daughter, equally or to the survivor
7. one beneficiary and three or more contingent beneficiaries	Anna L. Doe, wife, if living, otherwise Henry J. Doe, Alice G. Doe and Charles B. Doe, children, equally or to the survivor(s)
8. two beneficiaries and one contingent beneficiary	John A Doe, father, and Mary I. Doe, mother, equally or to the survivor; otherwise, Anna L. Doe, wife
9. two beneficiaries in unequal portions	three-quarters of the proceeds to John A. Doe, father, if living, and one-quarter to Anna L. Doe, mother, if living, the share of a deceased beneficiary to be paid to the survivor, if any
10. trust with individual trustees	Richard Doe and John Smith, trustees, or a successor in trust under (trust name) established (date of trust agreement)
11. present or living trust	ABC Bank and Trust Company, Des Moines, Iowa, trustee or successor in trust under (trust name) established (date of trust agreement), provided however that the company has received within 180 days of the death of the insured, evidence satisfactory to the existence of such trust; otherwise to the estate of the insured.
12. testamentary trust	Trustee of the Mary L. Doe trust or successor in trust established by the last will and testament of the insured dated.....
13. minor beneficiaries	When either the primary or contingent beneficiary designation includes one or more minor children, you need to complete an additional form, beneficiary designation with UTMA custodian. Please contact CBEBS for this form.

## 5. Other Coverage/ Authorization To Release Information

**As a new participant of the Christian Brothers Employee Benefit Trust, it is necessary for you to complete the information requested below. Failure to do so will result in a delay in processing your initial request for benefits.**

Employee Name:		Location #:	
Employee SSN:			
Employee Address:			

### Other Coverage Information

Please **x** one of the following categories and provide the requested information if it applies.

☐ Single ☐ Widowed ☐ Divorced ☐ Religious

☐ Married(Spouse's Name): \_\_\_\_\_ Birth Date: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Do you have any additional Employers?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide name address and telephone number. _____ _____ _____ _____
Do you have any other coverage (including AARP)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide name address and telephone number. _____ _____ _____ _____
Do your dependent children (if any) have any other coverage (including AARP)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide name address and telephone number. _____ _____ _____ _____
Is your spouse employed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide name address and telephone number. _____ _____ _____ _____
Spouse's other coverage (including AARP)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide name address and telephone number. _____ _____ _____ _____

**ANY CHANGE IN OTHER COVERAGE INFORMATION MUST BE REPORTED TO OUR OFFICE.**

<b>I HEREBY CERTIFY THAT ALL INFORMATION, STATEMENTS AND ANSWERS MADE ON THIS FORM ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE.</b>	Signed (Employee) _____ Date _____
<b>AUTHORIZATION TO RELEASE INFORMATION:</b> I authorize any physician, hospital, or other health care provider to release to Christian Brothers Employee Benefit Trust, or its representative, any information regarding my medical history, symptoms, treatment, examination results, or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for one year from the date signed. I understand I have a right to received a copy of this authorization.	Signed (Employee) _____ Date _____

## **Christian Brothers Employee Benefit Trust History**

The ***Christian Brothers Employee Benefit Trust (CBEBT)*** was established on January 1, 1977, by the Christian Brothers. It began in 1966 as a collective effort to provide a comprehensive package of Employee Benefits to the employees of the Christian Brothers schools. As the news spread of the benefits and savings received by participating in a large group, it was opened in 1977 to any Catholic institution registered in the Kenedy Catholic Directory nationwide.

The **CBEBT** has evolved into a cooperative effort of Catholic organizations continuously working together to provide a package of benefits for their employees in a cost-effective manner.

The **CBEBT** is governed by a board of Trustees who have been elected by the members of the Trust. The Trustees have contracted with ***Christian Brothers Services*** to act as the Plan Administrator for the Trust. ***Employee Benefit Services*** is the division of ***Christian Brothers Services*** that administers all the benefits plans funded by the Trust.

## **Christian Brothers Services Mission Statement**

The Mission of ***Christian Brothers Services*** is to serve the Catholic Community by helping to fulfill organizational and managerial needs through the development of quality, cost-effective, innovative programs and administrative services.

We accomplish this mission in collaboration with other Catholic organizations by combining leadership and insight with the practice of good business principles and belief in the tenets of the Catholic Church.

## **Important Phone Numbers**

**Customer Service/Benefit Information.....800.807.0400**  
**Christian Brothers Employee Benefit Services**  
**1205 Windham Parkway, Romeoville, IL 60446-1679**



Catholic Charities  
of the Diocese of Raleigh

Providing Help—Creating Hope—Serving All

## DIRECT DEPOSIT AUTHORIZATION

Name: \_\_\_\_\_

Name of Bank: \_\_\_\_\_

Please check one:

☐ Please deposit into my checking account

☐ Please deposit into my savings account

For deposits to checking: Attach an unused check marked “Void” in the space provided above. (Deposit slips do not work for checking accounts because they do not always contain the correct bank information.)

For deposits to savings: Do not use a pre-printed deposit slip as they do not always contain the correct bank information. You can always obtain a form from the bank with your correct account information to be used for deposits.

I authorized credit entries and any adjustments to be made to my account.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date





Catholic Charities  
of the Diocese of Raleigh

Providing Help—Creating Hope—Serving All

## EMPLOYEE ACKNOWLEDGMENT FORM

The employee handbook describes important information about this organization, and I understand that I should consult my immediate supervisor or the Executive Director of Catholic Charities regarding any questions not answered in the handbook.

Since the information, policies, and benefits described here are necessarily subject to change, I acknowledge that revisions to the handbook may occur. All changes will be communicated through official notices, and I understand that revised information may supersede, modify, or eliminate existing policies. I acknowledge that any changes to the handbook to be effective must be in writing.

While I look forward to ongoing employment with Catholic Charities, I acknowledge that I have entered into my employment relationship with Catholic Charities voluntarily and that there is no specified length of employment.

Furthermore, I acknowledge that this handbook is neither a contract of employment nor a legal document. I have had the opportunity to review the handbook, and understand where to access the handbook in the future. I understand that it is my responsibility to read and comply with the policies contained in this handbook and any revisions made to it.

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Employee's Signature

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Date

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Employee's Name (Typed or Printed)



**Electronic Accounts Set-up for Catholic Charities of the Diocese of Raleigh**

Name: \_\_\_\_\_

Office Location: \_\_\_\_\_

First Date of Work: \_\_\_\_\_

**Please select which applies:**

Employee: \_\_\_\_

Contract Worker: \_\_\_\_

Intern \_\_\_\_

**Indicate the appropriate role(s) of staff, contractor or intern:**

Counselor: \_\_\_\_

Family Support Staff: \_\_\_\_

Office Manager: \_\_\_\_

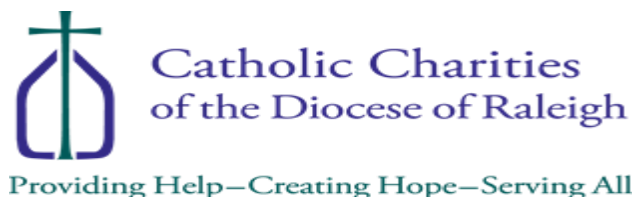
Other: \_\_\_\_ Position: \_\_\_\_\_

**Passwords must be**

- Minimum of 8 characters long (3xamp!e#)
- Contain at least 1 Number (419...)
- Contain at least 1 Special Character (!#^)

Requested password: \_\_\_\_\_

**Mail with employee packet or Email this form to Jarrett McClellan @ [jarrett.mcclellan@raldioc.org](mailto:jarrett.mcclellan@raldioc.org)**





## Catholic Charities of the Diocese of Raleigh

Providing Help—Creating Hope—Serving All

### **Retirement: 403(b) Plan**

Catholic Charities provides a 403(b) retirement plan through The Diocese of Raleigh for all Regular Full-Time and Regular Part-Time employees who have attained the age of 21. Catholic Charities 403(b) retirement plan is administered by Lincoln Financial Group ([www.lfg.com](http://www.lfg.com)).

Enrollment in the 403(b) Retirement Plan is automatic for eligible employees. Catholic Charities will contribute an employer core contribution of 4% of salary into an employee's account with Lincoln Financial Group. Vesting on the employer core contributions, plus earnings they generate, is based on a five (5) year vesting schedule of 20% per year. Eligible service years attained under the previous defined benefit plan apply to the vesting schedule.

In addition, Catholic Charities will make an employer matching contribution in an amount equal to 50% of the first 5% contributed by an employee. Employee contributions must abide by certain maximum limitations on salary deferral contributions made to the plan. These limitations are set by the Internal Revenue Service (IRS) each year. If an employee has attained or will attain age 50 by the end of the calendar year, the employee may contribute more up to the IRS limit. Employees are always 100% vested in the employer matching contributions and any earnings they generate.

An employee can direct his or her contributions to a variety of widely-recognized mutual funds. If an employee does not select investment choices, contributions will be invested in a default fund based on the employee's date of birth and the date when the employee will reach normal retirement age (65).

Eligible new employees, hired on or after July 1, 2014, will automatically be enrolled in the Diocese of Raleigh 403(b) Plan automatic-deferral feature at 5% beginning on the 1<sup>st</sup> of the month following their date of hire or as soon as administratively feasible. Employees may increase, decrease, or opt out of the auto-deferral feature at any time.

Employees whose employment classification does not make them eligible for the core contribution or matching funds may still contribute to the plan for tax-deferred savings.

For enrollment and investment information, employees can contact Lincoln Financial Group at 1-800-234-3500 or visit their website at: [www.lfg.com](http://www.lfg.com).

[Enrollment Kit](#) - This link takes you to the Lincoln Financial Group website. The enrollment book is found under the Enrollment Plan Documents tab.

[Summary Plan Description PDF](#)  
[403\(b\) Automatic Deferral Notice.pdf](#)

This designation will apply to the following Standard Insurance Company coverage(s) if available to you through your Employer: Life Insurance, Life with Accidental Death & Dismemberment (AD&D) Insurance, AD&D Insurance and, unless specified otherwise on a separate signed sheet of paper, Supplemental Life Insurance.

Designations made below, or on a separate sheet of paper, are not valid unless signed, dated, and delivered to your Employer during your lifetime. Return the completed form to your Human Resources Department.

**MEMBER/EMPLOYEE INFORMATION**

Your Name (Last, First, Middle)		Date of Birth
Your Address		
City	State	Zip
Group Name <b>Roman Catholic Diocese of Raleigh</b>	Group No. <b>161846</b>	

**BENEFICIARY INFORMATION**

<ul style="list-style-type: none"><li>Your designation revokes all prior designations.</li><li>Benefits are payable to a contingent Beneficiary only if you are not survived by one or more primary Beneficiaries.</li><li>If you name two or more Beneficiaries in a class (primary or contingent), two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.</li><li>If a minor (a person not of legal age) or your estate is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated _____."</li><li>A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have questions, consult your legal advisor.</li><li>Dependents Insurance and Supplemental Life Insurance on your Spouse, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.</li><li>If you complete the "% of Benefit" box(es), the amounts should add up to 100% for each class (primary or contingent). For example, "Primary - John Q. Doe, 60%; Jane Q. Doe, 40%."</li></ul>				
PRIMARY - Full Name	Address	Date of Birth	Relationship	% of Benefit
CONTINGENT - Full Name	Address	Date of Birth	Relationship	% of Benefit
Signature of Member/Employee _____ Date _____				