HAAS

Holistic Array of Authentic Services, LLC

Providing High Quality Homecare Services

Main Office: 651-756-8492 | **Cell:** 612-275-9063 |
Fax: 1-651-305-7170 **Email:** Info@haascares.com |
Web: www.haascares.com

PERSONAL CARE ATTENDANT - EMPLOYMENT APPLICATION

Application Information

Please complete all sections. We review applications within two weeks. Resume and cover letter welcome. **Note:** PCA schedules vary based on consumer needs.

HOW DID YOU HEAR ABOUT US?

☐ Employment Agency ☐ Online ☐ Print Ad ☐ Current Employee ☐ Friend ☐ Other

IF EMPLOYEE/FRIEND/OTHER, SPECIFY

POSITION APPLYING FOR

PERSONAL INFORMATION

FIRST NAME

MIDDLE INITIAL

LAST NAME

HOME PHONE

CELL PHONE

EMAIL ADDRESS

DATE OF BIRTH

SOCIAL SECURITY NUMBER

CURRENT ADDRESS

CITY

STATE

ZIP CODE

EMPLOYMENT HISTORY OVERVIEW

Have you ever been terminated from a job due to poor performance? ☐ No ☐ Yes

IF YES, PLEASE EXPLAIN

HAAS EMPLOYMENT APPLICATION - CONTINUED

List your employment history for the last 3 years, starting with most recent.

Employer #1 (Most Recent)

COMPANY NAME

YOUR POSITION/TITLE

SUPERVISOR NAME

SUPERVISOR PHONE

START DATE

END DATE

REASON FOR LEAVING

PRIMARY RESPONSIBILITIES

May we contact? ☐ Yes ☐ No If No, explain:

Employer #2

COMPANY NAME

YOUR POSITION/TITLE

SUPERVISOR NAME

SUPERVISOR PHONE

START DATE

END DATE

REASON FOR LEAVING

PRIMARY RESPONSIBILITIES

May we contact? ☐ Yes ☐ No If No, explain:

Employer #3

COMPANY NAME

YOUR POSITION/TITLE

SUPERVISOR NAME

SUPERVISOR PHONE

START DATE

END DATE

REASON FOR LEAVING

PRIMARY RESPONSIBILITIES

May we contact? ☐ Yes ☐ No If No, explain:

HAAS EMPLOYMENT APPLICATION - FINAL PAGE

AVAILABILITY & SCHEDULING

PRIMARY TRANSPORTATION

☐ Personal Vehicle ☐ Public Transit ☐ Other

ON-CALL COVERAGE?

☐ Yes ☐ No

If interested in on-call, select shifts:

☐ Weekdays ☐ Weeknights ☐ Weekends ☐ Overnights

WEEKLY AVAILABILITY (Write earliest start times - consider commute)

Day	AM Start	PM Start
Monday	AM	PM
Tuesday	AM	PM
Wednesday	AM	PM
Thursday	AM	PM
Friday	AM	PM
Saturday	AM	PM
Sunday	AM	PM

HAAS accepts applications from all applicants without regard to age, gender, disability, race, religion, marital status, national origin, political affiliation, veteran status, or any other status protected by law and employs qualified persons based on availability and consumer preference.

AUTHORIZATION & CONSENT

I authorize HAAS to contact all previous employers and references, and authorize them to release information about my employment. I authorize HAAS to share this application with consumers seeking PCAs. I understand HAAS may suspend or terminate my employment with valid reason. False information on this application is grounds for termination.

APPLICANT SIGNATURE ______________________ DATE ____________

Submit Application To:

Holistic Array of Authentic Services (HAAS)

Physical Office:
5851 Duluth St., Suite 302
Golden Valley, MN 55422

Mailing Address:
3813 51st Avenue North
Brooklyn Center, MN 55429

Phone: 651-756-8492 | **Cell:** 612-275-9063 | **Fax:** 651-305-7170
Email: haas@haascares.com | **Web:** www.haascares.com

HAAS

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Main Office: 651-756-8492 | **Fax:** 1-651-305-7170
Email: Info@haascares.com **Physical Address:** 5851 Duluth St. Suite 302, Golden Valley, MN 55422
Mailing Address: 3813 51st Avenue North, Brooklyn Center, MN 55429

PERSONAL CARE ATTENDANT - BACKGROUND CHECK INTAKE FORM

PERSONAL INFORMATION

FIRST NAME | MIDDLE NAME | LAST NAME

DATE OF BIRTH | GENDER | SOCIAL SECURITY NUMBER

PHONE NUMBER | EMAIL ADDRESS

PLACE OF BIRTH & IDENTIFICATION

BIRTH CITY | BIRTH STATE/COUNTRY

DRIVER'S LICENSE NUMBER | STATE ISSUED | EXPIRATION DATE

HEIGHT | WEIGHT | EYE COLOR

HAIR COLOR | ETHNICITY

CURRENT ADDRESS

STREET ADDRESS

CITY | STATE | ZIP CODE

PERSONAL CARE ATTENDANT - BACKGROUND CHECK INTAKE FORM

WORK AUTHORIZATION & RESIDENCY HISTORY

Are you a US Citizen? ☐ Yes ☐ No

If No, are you lawfully able to work in the US? ☐ Yes ☐ No

Have you lived outside of Minnesota in the last 5 years? ☐ Yes ☐ No

IF YES, WHERE DID YOU LIVE?

____

FROM DATE	TO DATE

⚠ IMPORTANT NOTICE

Fingerprinting Requirement: You may be required to complete fingerprinting after submitting your background check request. You must go to only one location from the list we provide.

Employment Process: We cannot begin your employment process until both your background check and fingerprinting (if required) are cleared.

I, ____________________ , acknowledge that all personal information provided above is true and correct. I give my consent to Holistic Array of Authentic Services (HAAS) to conduct a comprehensive background check for employment purposes.

APPLICANT SIGNATURE	DATE

REQUIRED DOCUMENTS

Please submit this form with copies of the following:

- Valid Driver's License or State ID Card
- Social Security Card OR documentation verifying lawful work status

HAAS

Holistic Array of Authentic Services, LLC

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Mailing Address: 3813 51st Avenue North, Brooklyn Center, MN 55429

PERSONAL CARE ATTENDANT - PCA AGREEMENT STATEMENT

PERSONAL INFORMATION

FIRST NAME	MIDDLE NAME	LAST NAME

SOCIAL SECURITY NUMBER	DATE OF BIRTH	PHONE NUMBER

ADDRESS

CITY	STATE	ZIP CODE

EMAIL ADDRESS

310 HOUR MONTHLY LIMITATION AGREEMENT

I, ______________________, acknowledge that I limit my PCA hours to **310 hours per month** according to Department of Human Services (DHS) law.

If I work over 310 hours a month in combination of all my other agencies' PCA hours, and as a result HAAS's claim to DHS is denied, I am obligated to pay back the amount I worked over the limit for which HAAS was denied reimbursement.

I give my consent to Holistic Array of Authentic Services (HAAS) to take any action necessary as mentioned above, including but not limited to wage deduction or legal action to recover denied reimbursements.

PERSONAL CARE ATTENDANT - PCA AGREEMENT STATEMENT

⚠ OVERTIME POLICY - STRICTLY ENFORCED

NO OVERTIME IS PERMITTED WITHOUT PRIOR WRITTEN APPROVAL FROM MANAGEMENT

Overtime is defined as any hours worked over 40 hours per week. All overtime must be:

- Pre-approved in writing by HAAS management BEFORE the overtime is worked
- Authorized by a supervisor or manager with approval authority

Working unauthorized overtime may result in disciplinary action up to and including termination. If you are approaching 40 hours in a work week, you must notify your supervisor immediately.

IMPORTANT REMINDERS

- Track your hours carefully across ALL agencies where you work as a PCA
- Report your total monthly hours to HAAS management if working for multiple agencies
- Notify management immediately if you are approaching the 310-hour monthly limit
- Keep accurate records of all hours worked for your own protection
- Remember that DHS regulations apply to your TOTAL PCA hours, not just hours with HAAS

ACKNOWLEDGMENTS

☐ I understand and agree to the 310-hour monthly limitation for PCA services across all agencies.

☐ I understand that overtime is NOT permitted without prior written approval from HAAS management.

☐ I understand that I am financially responsible for any DHS reimbursement denials resulting from my violation of hour limitations.

☐ I understand that working unauthorized overtime may result in disciplinary action including termination.

☐ I certify that all information provided above is true and accurate.

By signing below, I acknowledge that I have read, understood, and agree to comply with all terms and conditions stated in this PCA Agreement Statement, including the 310-hour monthly limitation and the overtime policy.

EMPLOYEE SIGNATURE ______________________________ DATE ______________

DEPARTMENT OF HUMAN SERVICES

DHS-4469-ENG 1-24

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

Individual Personal Care Assistant (PCA) Enrollment Application

Complete all fields to enroll an individual personal care assistant or complete your request using the Minnesota Provider Screening and Enrollment (MPSE) portal. If submitting by fax, complete this form online, print and then fax to Minnesota Health Care Programs (MHCP). An incomplete form will delay processing of this application. Check one of the following:

◯ New hire (requires new background study and completion of individual PCA training)

◯ Rehire (requires new background study and completion of individual PCA training)

PREVIOUS EMPLOYMENT END DATE

◯ Revalidation

Individual PCA Information

PROVIDER TYPE **38 - INDIVIDUAL**	**SOCIAL SECURITY NUMBER**	**UMPI** (if requesting reinstatement)
LEGAL NAME (FIRST)	**FULL MIDDLE NAME**	**LAST NAME**
DATE OF BIRTH	**Is the person 18 years old or older?** ◯ Yes ◯ No* *May affiliate with only one agency	PHONE NUMBER

Individual PCA Address

ADDRESS (RESIDENTIAL ADDRESS ONLY – DO NOT ENTER A P.O. BOX)			
CITY	**STATE**	**ZIP CODE**	COUNTY OF RESIDENCE

Individual PCA Training Information

INDIVIDUAL PCA/CFSSPCA TRAINING COMPLETION DATE	INDIVIDUAL PCA/CFSSPCA TRAINING CERTIFICATION NUMBER

Individual PCA Background Study Information

BACKGROUND STUDY NUMBER	APPLICATION NUMBER	FACILITY ID

Individual PCA Provider Statement

I have reviewed and certify the information provided on this form is true and correct to the best of my knowledge. **I will notify the MHCP Provider Eligibility and Compliance of any additions or changes to the information.**

By signing this form, I acknowledge I have read and understand the Data Privacy Notice (DHS-6287) (PDF). I also authorize MCHP to use the information you collect about me according to the Privacy Notice.

Check if signing electronically:

☐ I am signing this form electronically. My name as typed in the signature field is my legally binding signature. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (Minnesota Statutes 325L.02(h), 325L.05 and 325L.08)

NAME OF INDIVIDUAL PCA (print or type)	**SIGNATURE OF INDIVIDUAL PCA**	**DATE SIGNED**

Organization Affiliation Information

You may affiliate or enroll the individual PCA named on this form if the PCA is 18 years old or older with other agencies you directly own without completing another application and agreement. Do you want to affiliate this individual PCA with any other agencies you own? ◯ Yes ◯ No (If yes, enter information.)

1.	ORGANIZATION OR AGENCY NAME		FACILITY NPI OR UMPI
BACKGROUND STUDY NUMBER		APPLICATION NUMBER	FACILITY ID

2.	ORGANIZATION OR AGENCY NAME		FACILITY NPI OR UMPI
BACKGROUND STUDY NUMBER		APPLICATION NUMBER	FACILITY ID

Organization Information

Check if signing electronically:

☐ I am signing this form electronically. My name as typed in the signature field is my legally binding signature. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (Minnesota Statutes 325L.02(h), 325L.05 and 325L.08)

ORGANIZATION OR AGENCY NAME		FACILITY NPI OR UMPI
Holistic Array of Authentic Services (HAAS), LLC		
ORGANIZATION FAX NUMBER	ORGANIZATION PERSONNEL COMPLETING FORM	ORGANIZATION PERSONNEL SIGNATURE
1-651-305-7170		

Next Steps

Read, sign and date the Individual Support Worker (CDCS, CSG, PCA, CFSS) Provider Agreement (DHS-4611) (PDF) and fax it with this application to MHCP Provider Eligibility and Compliance at **651-431-7465**.

Or, complete the organization to direct support worker affiliation request in the MPSE portal and upload DHS-4611 in MPSE.

MHCP will process only complete requests.

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

Individual Direct Support Worker (CDCS, CSG, PCA, CFSS) Provider Agreement

As a participating provider in Minnesota Health Care Programs (MHCP) administered by the Minnesota Department of Human Services (DHS), the provider agrees to:

A. Submit documentation to your affiliated agency that fully discloses the extent of services provided to individuals under these programs. The documentation must be legible and meet the requirements of Minnesota Statutes, 256B.0659, subdivision 12 for all individual support workers in Consumer Directed Community Supports (CDCS), Consumer Support Grant (CSG), Personal Care Assistance (PCA), and Minnesota Statutes, 256B.85, subdivision 16 for Community First Services and Supports (CFSS).

B. Provide DHS, the secretary of the U.S. Department of Health and Human Services (DHHS), or the Minnesota Medicaid Fraud Control Unit such information as it may request regarding payments claimed for services provided under these programs.

C. Comply with all federal and state statutes and rules relating to the delivery of services to individuals and to the submission of claims for such services.

D. Accept as payment in full, amounts paid in accordance with schedules established by DHS, except where payment by the member has been authorized by DHS.

E. Make full disclosure of any conviction(s) of program crimes as required by the Code of Federal Regulations, title 42, section 455.106.

F. Comply with all federal statutes, implementing regulations and guidance prohibiting discrimination on the basis of race, color, national origin, sex, age, religion and disability in any program or activity receiving federal financial assistance from DHHS; and to comply with the Minnesota Human Rights Act.

G. Provide services to members of the same scope and quality as would be provided to the general public, within MHCP guidelines.

H. Comply with the provisions of any fully executed agreement or addendum required by DHS, which is incorporated herein by reference.

I. Comply with the advance directive requirements as required by the Code of Federal Regulations, title 42, sections 489.100 and 417.436.

J. Properly handle and safeguard protected information collected, created, used, maintained, or disclosed on behalf of DHS. For purposes of this agreement, "protected information" means data subject to any of the following laws:

   1. The Minnesota Government Data Practices Act (MGDPA), Minnesota Statutes, chapter 13, section 13.46 ("welfare data");
   2. The Minnesota Health Records Act, sections 144.291 and 144.298;
   3. The Health Insurance Portability and Accountability Act ("HIPAA"), including but not limited to the requirements of the Privacy Rule and the Security Regulations, the Code of Federal Regulations, title 45, parts 160 and 164, subparts A and E.
   4. Federal law and regulations that govern the use and disclosure of substance abuse treatment records, the United States Code, title 42, section 290dd-2 and the Code of Federal Regulations, title 42, sections 2.1 to 2.67; and

Electronic initials accepted.

DIRECT SUPPORT WORKER INITIALS

NAME OF SUPPORT WORKER (TYPE OR PRINT)	UMPI

5. Any other applicable state and federal statutes, rules, and regulations affecting the collection, storage, use and dissemination of private or confidential information.

K. Comply with the laws described in section J. This includes the provider:

1. Not using or further disclosing protected information created, collected, received, stored, used, maintained or disseminated in the course or performance of this agreement other than as necessary to perform its obligations under this Provider Agreement, or as required by law, either during the period of this agreement or after. See, respectively, the Code of Federal Regulations, title 45, sections 164.502(b) and 164.514(d), and Minnesota Statutes, 13.05, subdivision 3.
2. Using appropriate administrative, physical, and technical safeguards to prevent use or disclosure of the protected information other than as provided for by this agreement and to ensure the confidentiality, integrity, and availability of any electronic protected health information (PHI) that it creates, receives, maintains, or transmits on behalf of DHS. The provider will not transmit PHI over the Internet or any other unsecure or open communications channel unless such information is encrypted or otherwise safeguarded using procedures no less stringent than those described in the Code of Federal Regulations, title 45, section 164.312. If the provider stores or maintains PHI in encrypted form, the provider shall, at DHS' request, promptly provide DHS with the key or keys to decrypt such information. The provider shall not forward previously encrypted data to any other party, unless otherwise required by this agreement.
3. Mitigating, to the extent practicable, any harmful effects known to the provider of a use, disclosure, or breach of security with respect to protected information by the provider in violation of this agreement.

L. Agree that this agreement may be immediately terminated at the discretion of DHS if it determines that the provider has violated a material term of the agreement, including but not limited to, non-compliance by the provider with the HIPAA Privacy Rule and Security Standards. If termination is not feasible, DHS shall report the breach to the Secretary of DHHS.

Upon termination of this agreement, all of the protected information provided by DHS to the provider, or created or received by the provider on behalf of DHS, that the provider still maintains in any form, including information that is in the hands of subcontractors or agents of the provider, shall be destroyed or returned to DHS, and the provider shall retain no copies of such information. If it is infeasible to return or destroy the information, the provider shall provide DHS notification of the conditions that make return or destruction infeasible, and shall extend the protections of this agreement to such information and limit further use and disclosure of such information to those purposes that make return or destruction infeasible, for as long as the provider maintains the information.

M. Agree that any ambiguity in this agreement shall be resolved to permit DHS to comply with HIPAA, MDGPA, and other applicable state and federal statutes, rules, and regulations affecting the collection, storage, use and dissemination of private or confidential information and other state and federal laws and regulations.

Upon signature, this Provider Agreement supersedes and replaces all former Provider Agreements the provider has with DHS.

An individual applicant must personally sign the Provider Agreement. Sign and date this form, initial page 1, and return both page 1 and page 2 of this agreement.

Check if signing electronically:

☐ I am signing this form electronically. My name as typed in the signature field is my legally binding signature. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (Minnesota Statutes, 325L.02(h), 325L.05 and 325L.08)

NAME OF SUPPORT WORKER (TYPE OR PRINT)	TITLE Caregiver

SIGNATURE OF SUPPORT WORKER	DATE

Keep a copy of the Provider Agreement for your files and upload the original form using the online **Minnesota Provider Screening and Enrollment (MPSE) portal**, or fax to 651-431-7465.

Agreement Summary

As an individual support worker, you are providing health care services to individuals. We require your enrollment in the Minnesota Health Care Programs (MHCP) and to be listed as the rendering provider on the claim so that you are represented as the person who provided the services. Knowing that a qualified individual provided the service ensures the safety of the people that the Minnesota Department of Human Services (DHS) serves. It also allows DHS to perform auditing and tracking of services which protects against double-billing and other types of fraud. Before enrollment is approved, MHCP must make certain that:

1. There is no legal or other reason why you shouldn't provide these services,
2. You understand what is necessary to properly provide these services, and
3. You understand the need to protect the privacy of the people you care for.

To help ensure that each of these conditions is met, MHCP requires that you agree to the terms in the attached Provider Agreement. In general, this agreement requires that you:

A. Provide documents to your employer about the services you provide.

B. Provide documents to MHCP or other state and federal agencies related to the services you provide, when requested.

C. Comply with federal and state laws about the services you provide.

D. Accept payment made to your employer as payment in full for the services you provide. You cannot ask for nor accept additional payment from the member.

E. Disclose any criminal convictions you have related to Medicare, Medicaid, or title XX services.

F. Not discriminate against individuals because of their race, color, national origin, sex, age, religion or disability when you provide these services.

G. Provide the same quality of service to persons receiving public assistance as those who don't receive such assistance.

H. If you are enrolled to provide and bill for other services, you must continue to follow the requirements of the agreement you signed when you enrolled for those services. The terms of that agreement are different than the terms in the attached agreement.

I. Comply with federal requirements about advance directives. An advance directive is written instruction, such as a living will, to give a patient control over medical treatment decisions.

J. Properly protect private information about the people to whom you provide services, especially their health information.

K. Don't disclose the private information of someone for whom you provide services, unless it is needed for your work. This includes not discussing someone's private information unless your job requires it. Also, ensure that the information could not be accessed by someone who does not have permission to see it. This includes not leaving paperwork out where others can see it, and not sending private information over the internet.

L. Understand that this agreement may be canceled if you violate its terms. If this agreement is canceled, you must properly dispose of any private information you have about the people you serve so that it is not discovered by someone who does not have permission to see it.

M. Understand that by signing this agreement, you are agreeing to protect any private information you come in contact with in your job. When you protect private information, you are complying with federal and state laws, and you help DHS comply with these laws, as well.

This is a basic description of the terms of this agreement.

By signing this agreement, you are agreeing to be legally bound by all its terms. If you have questions about it, you should get answers to them before signing this agreement. If you need or want legal advice, you should contact your own attorney. For more information, call 651-431-2700.

DEPARTMENT OF HUMAN SERVICES

Data Privacy Notice

This notice describes how Minnesota Health Care Programs (MHCP) may use and disclose private information about you, and is provided as required by the Minnesota Government Data Practices Act and the Federal Privacy Act of 1974.

Why do we ask for this information?

MHCP uses this information to enroll and maintain enrollment for you or your organization as a provider in MHCP and to identify individuals for the purposes of program integrity. Federal regulations require that any person or entity that enrolls as an MHCP provider discloses full and complete information as to the identity of each person with an ownership or control interest in the provider (42 CFR 455 subp. B).

Do you have to answer the questions we ask?

Yes, completing and submitting these requests is a condition of participation in MHCP. Providers who do not complete these requests will not be enrolled, reenrolled or allowed to continue enrollment as a participating provider in MHCP.

Why do we ask for Social Security Numbers (SSNs)?

Federal law allows MHCP to collect SSNs to establish the identity of people affected by its programs (42 USC 405(c)(2)(C)(i)). Federal law allows us to collect the SSN of each person with an ownership or controlling interest (42 USC 1320a-3(a)(1)(B)). This information is used to check for providers who may be on the List of Excluded Individuals and Entities (LEIE), the System for Award Management (SAM) and the Social Security Administration's Death Master File.

With whom may we share information?

All government data is public, unless classified otherwise by statute. The information you provide that is not public data includes: SSNs, home addresses, and driver's license or state identification card numbers. We will share that information only as needed and as allowed or required by law. We may share that information with the following individuals or entities who need the information to do their jobs:

- MHCP employees who are trained to keep private information confidential
- Court officials, attorney general, and other state and federal law enforcement officials and fraud investigators
- Anyone else the law says we can or must give the information to

How will we use this information?

MHCP will use this information to:

- Enroll you as a provider in MHCP.
- Tell you apart from other people with the same or similar name.
- Check your information against databases maintained by the federal government of providers excluded from participating in federal health care programs.
- Investigate instances of fraud and abuse against MHCP.

What are our responsibilities?

- We must protect the privacy of information according to the terms of this notice.
- We may not use your information for reasons other than the reasons submitted on the request, or share your information with individuals and agencies other than those listed on the request unless you tell us in writing that we can.

What if you believe your privacy rights have been violated?

If you think MHCP has violated your privacy rights, send a written complaint to:

Minnesota Department of Human Services

Attn: Privacy Official

PO Box 64998

St. Paul, MN 55164-0998

HAAS

Holistic Array of Authentic Services **Home Care**

Providing high quality homecare services

Mailing Address: 3813 51st Avenue North, Brooklyn Center, MN 55429

Physical Address: 5851 Duluth St. Unit 302, Golden Valley, MN 55422

Phone: 651-756-8492, Cell: 612-275-9063 Fax: 1-651-305-7170 E-mail Info@haascares.com

Authorization for Direct Deposit

I authorize Holistic Array of Authentic Services (HAAS) to deposit my pay check in full automatically to my account indicated below. If necessary, I give permission to HAAS to adjust or reverse a deposit for any payroll entry made to my account in error. This authorization will remain in effect until I cancel it in writing and in such time as to afford a reasonable opportunity to act on it.

Name of the Bank: ____

Name on the Bank Account: ____

Bank account number: ______________________________ **Checking:** ☐ **Savings:** ☐

Bank routing number: ______________________________

Employee name: ______________________________

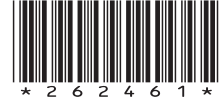
Employee signature: ______________________________

Date: ______________________________

***** Important:** Please attach a voided check for each bank account to which funds should be deposited. Please do not use a deposit slip as the bank routing information is not the same.

"Today is the best day to help the person in need"

DEPARTMENT OF REVENUE



2026 W-4MN, Minnesota Employee Withholding Certificate

Employees

Complete Form W-4MN so your employer can withhold the correct Minnesota income tax from your pay. Consider completing a new Form W-4MN each year and when your personal or financial situation changes. If no Form W-4MN is in effect, the number of withholding allowances claimed will be zero.

First Name and Initial	Last Name			Social Security Number
Permanent Address				**Marital Status** ***(Check one):*** ☐ Single; Married, but legally separated; or Spouse is a nonresident alien
City		State	ZIP Code	☐ Married ☐ Married, but withhold at higher Single rate

Complete Section 1 OR Section 2, then sign the bottom and give the completed form to your employer.

☐ **Section 1 — Determining Minnesota Allowances**

A Enter "1" if no one else can claim you as a dependent . . . . **A** ________

B Enter "1" if any of the following apply: . . . . **B** ________

- You are single and have only one job
- You are married, have only one job, and your spouse does not work
- Your wages from a second job or your spouse's wages are $1500 or less

C Enter "1" if you are married, or 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.)* . **C** ________

D Enter the number of dependents you will claim on your tax return. . . . . **D** ________

E Enter "1" if you will use the filing status Head of Household *(see instructions)*. . . . . **E** ________

F Add steps A through E. If you plan to itemize deductions on your 2026 Minnesota income tax return, you may also complete the Itemized Deductions and Additional Income Worksheet. . . . . **F** ________

1 **Minnesota Allowances.** Enter Step F from Section 1 above or Step 10 of the Itemized Deductions Worksheet . . . . **1** ________

2 Additional Minnesota withholding you want deducted for each pay period *(see instructions)* . . . . **2** $________

☐ **Section 2 — Exemption From Minnesota Withholding**

Complete Section 2 if you claim to be exempt from Minnesota income tax withholding *(see Section 2 instructions for qualifications)*. If applicable, check one box below to indicate why you believe you are exempt:

☐ **A** I meet the requirements and claim exempt from both federal and Minnesota income tax withholding.

☐ **B** Even though I did not claim exempt from federal withholding, I claim exempt from Minnesota withholding, because:
- I had no Minnesota income tax liability last year.
- I received a refund of all Minnesota income tax withheld.
- I expect to have no Minnesota income tax liability this year.

☐ **C** All of these apply:
- My spouse is a military service member assigned to a military location in Minnesota.
- My domicile (legal residence) is in another state.
- I am in Minnesota solely to be with my spouse. My state of domicile is ________________.

☐ **D** I am an American Indian that resides and works on a reservation for which I am enrolled *(see instructions)*.
Enter the reservation name: ________________
Enter your Certificate of Degree of Indian Blood (CDIB)/Enrollment number: ________________

☐ **E** I am a member of the Minnesota National Guard or an active-duty U.S. military member and claim exempt from Minnesota withholding on my military pay.

☐ **F** I receive a military pension or other military retirement pay as calculated under U.S. Code, title 10, sections 1401 through 1414, 1447 through 1455, and 12733, and I claim exempt from Minnesota withholding on this retirement pay.

I certify that all information provided in Section 1 ***OR*** *Section 2 is correct. I understand there is a $500 penalty for filing a false Form W-4MN.*

Employee's Signature	Date	Daytime Phone Number

Employees: Give the completed form to your employer.

Employers

See the employer instructions to determine if you must send a copy of this form to the Minnesota Department of Revenue. If required, enter your information below and mail this form to the address in the instructions. Incomplete forms are considered invalid. We may assess a $50 penalty for each required Form W-4MN not filed with us. Keep a copy for your records.

Name of Employer		Minnesota Tax ID Number	Federal Employer ID Number (FEIN)
HOLISTIC ARRAY OF AUTHENTIC SERVICES (HAAS), LLC		2642431	32-0220686
Address	**City**	**State**	**ZIP Code**
5851 DULUTH ST., STE 302	GOLDEN VALLEY	MN	55422

DEPARTMENT OF REVENUE

Form W-4MN Instructions for Employees

Complete this form for your employer to calculate the amount of Minnesota income tax to be withheld from your pay.

When must I complete Form W-4MN?

Complete Form W-4MN if any of these apply:

- You begin employment.
- You change your filing status.
- You reasonably expect to change your filing status in the next calendar year.
- Your personal or financial situation changes.
- You claim exempt from Minnesota withholding (see Section 2 instructions for qualifications).

If you have not had sufficient Minnesota income tax withheld from your wages, we may assess penalty and interest when you file your state income tax return.

Note: Your employer may be required to submit a copy of your Form W-4MN to the Minnesota Department of Revenue. You may be subject to a $500 penalty if you provide a false Form W-4MN.

You must enter your Social Security Number for this Form W-4MN to be valid.

What if I have completed federal Form W-4?

If you completed a 2026 Form W-4, you must complete Form W-4MN to determine your Minnesota withholding allowances.

What if I am exempt from Minnesota withholding?

If you claim exempt from Minnesota withholding, complete only Section 2 of Form W-4MN and sign and date the form to validate it. If you complete Section 2, you must complete a new Form W-4MN by February 15 in each following year in which you claim an exemption from Minnesota withholding.

You cannot claim exempt from withholding if all of these apply:

- Another person can claim you as a dependent on their federal tax return.
- Your annual income exceeds $1,300.
- Your annual income includes more than $350 of unearned income.

If you do not complete a new Form W-4MN to claim exempt from Minnesota withholding by February 15, your employer will withhold tax as if your filing status is single with zero withholding allowances.

What if I am a nonresident alien for U.S. income taxes?

If you are a nonresident alien, you are not allowed to claim exempt from withholding. You will check the single box for marital status regardless of your actual marital status and may enter one personal allowance on Step A of Section 1. Enter zero on steps B, C, and E of Section 1.

If you are resident of Canada, Mexico, South Korea, or India, and are allowed to claim dependents, enter the number of dependents on Step D.

Section 1 — Minnesota Allowances Worksheet

Complete Section 1 to find your allowances for Minnesota withholding tax. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

If you expect to owe more income tax for the year than will be withheld, you can claim fewer allowances or request additional Minnesota withholding from your wages. Enter the amount of additional Minnesota income tax you want withheld on line 2 of Section 1.

Nonwage Income

Consider making estimated payments if you have a large amount of "nonwage income." Nonwage income (other than tax-exempt income) includes interest, dividends, net rental income, unemployment compensation, gambling winnings, prizes and awards, hobby income, capital gains, royalties, and partnership income.

Two Earners or Multiple Jobs

If your spouse works or you have 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-4MN. Usually, your withholding will be more accurate when all allowances are claimed on the Form W-4MN for the highest paying job and zero allowances are claimed on the others.

Head of Household Filing Status

You may claim Head of Household as your filing status if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependents. Enter "1" on Step E if you may claim Head of Household as your filing status on your tax return.

What if I itemize deductions on my Minnesota return or have other nonwage income?

Use the Itemized Deductions and Additional Income Worksheet to find your Minnesota withholding allowances. Complete Section 1 on page 1, then follow the steps in the worksheet on the next page to find additional allowances.

Continued

Itemized Deductions and Additional Income Worksheet

1 Enter an estimate of your 2026 Minnesota itemized deductions. For 2026, you may have to reduce your itemized deductions if your income is over $244,500($183,350 for Married Filing Separately). . . . . ._______

2 Enter one of the following based on your filing status: . . . . ._______

a. $30,600 if Married Filing Jointly

b. $23,000 if Head of Household

c. $15,300 if Single or Married Filing Separately

3 Subtract step 2 from step 1. If zero or less, enter 0 . . . . ._______

4 Enter an estimate of your 2026 additional standard deduction (from page 11 of the Form M1 instructions) . . . . ._______

5 Add steps 3 and 4 . . . . ._______

6 Enter an estimate of your 2026 taxable nonwage income . . . . ._______

7 Subtract step 6 from step 5. If zero, enter 0. If less than zero, enter the amount in parentheses.. . . . . ._______

8 Divide the amount on step 7 by $5,300. If a negative amount, enter in parentheses. Do not include fractions . . . . ._______

9 Enter the number on step F of Section 1 on page 1 . . . . ._______

10 Add step 8 and 9 and enter the total here. If zero or less, enter 0. Enter this amount on line 1 of page 1. . . . . _______

Section 2 — Minnesota Exemption

Your employer will not withhold Minnesota taxes from your pay if you are exempt from Minnesota withholding. You cannot claim exempt from withholding if all of these apply:

- Another person can claim you as a dependent on their federal tax return.
- Your annual income exceeds $1,300.
- Your annual income includes more than $350 of unearned income.

Box A

Check box A of Section 2 to claim exempt if all of these apply:

- You meet the requirements to be exempt from federal withholding.
- You had no Minnesota income tax liability in the prior year and received a full refund of Minnesota tax withheld.
- You expect to have no Minnesota income tax liability for the current year.

Box B

Check box B of Section 2 if you are not claiming exempt from federal withholding, but meet the second and third requirements for box A.

Box C

Check box C in Section 2 to claim exempt if all of these apply:

- You are the spouse of a military member assigned to duty in Minnesota.
- You and your spouse are domiciled in another state.
- You are in Minnesota solely to be with your active-duty military spouse member.

Boxes D-F

If you receive income from the following sources, it is exempt from Minnesota withholding. Your employer will not withhold Minnesota tax from that income when you check the appropriate box in Section 2.

- **Box D:** You receive wages as a member of an American Indian tribe living and working on the reservation of which you are an enrolled member. Enter the name of your reservation and your Certificate of Degree of Indian or Alaskan Blood (CDIB) number/enrollment number. **Members of the Minnesota Chippewa Tribe** can exclude income regardless of which Minnesota Chippewa Tribe reservation you live and work on. This affects members of these tribes:
  - Mille Lacs
  - Nett Lake (Bois Forte)
  - Fond du Lac
  - Leech Lake
  - White Earth
  - Grand Portage
- **Box E:** You receive wages for Minnesota National Guard (MNG) pay or for active-duty U.S. military pay. MNG and active-duty U.S. military members can claim exempt from Minnesota withholding on these wages, even if they are taxable federally. For more information, see Income Tax Fact Sheet 5, *Military Personnel*.
- **Box F:** You receive a military pension or other military retirement pay calculated under U.S. Code title 10, sections 1401 through 1414, 1447 through 1455, and 12733. You may claim exempt from Minnesota withholding on this income even if it is taxable federally.

Note: You may not want to claim exempt if you (or your spouse if filing a joint return) expect to have other forms of income subject to Minnesota tax and you want to avoid owing tax at the end of the year.

If you complete Section 2, you must complete a new Form W-4MN by February 15 in each following year.

Nonresident Alien

If you are a nonresident alien for federal tax purposes, do not complete Section 2. See IRS Publication 519, *U.S. Tax Guide for Aliens*.

Continued

Line 2 — Additional Minnesota Withholding

If you would like an additional amount of tax to be deducted per payment period, enter the amount on line 2. Do not enter a percentage of the payment you want to be deducted.

Use of Information

All information on Form W-4MN is private by state law. It cannot be given to others without your consent, except to the IRS, other states that guarantee the same privacy, or by court order. Your name, address, and Social Security Number are required for identification. Information abou your allowances is required to determine your correct tax. We ask for your phone number so we can call if we have a question.

Questions?

- Website: www.revenue.state.mn.us
- Email: withholding.tax@state.mn.us
- Phone: 651-282-9999 or 1-800-657-3594 (toll-free)

Employer instructions are on the next page.

Form W-4 Employee's Withholding Certificate

Department of the Treasury
Internal Revenue Service

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2026

Step 1: Enter Personal Information

(a) First name and middle initial | Last name

(b) **Social security number**

Address

City or town, state, and ZIP code

Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.

(c)
- ☐ **Single** or **Married filing separately**
- ☐ **Married filing jointly** or **Qualifying surviving spouse**
- ☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if you: are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(b) is more accurate . . . . ☐

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

(a) Multiply the number of qualifying children under age 17 by $2,200 . . . . **3(a)** $

(b) Multiply the number of other dependents by $500 . . . **3(b)** $

Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here . . . . **3** $

Step 4: Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . **4(a)** $

(b) Deductions. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Exempt from withholding

I claim exemption from withholding for 2026, and I certify that I meet **both** of the conditions for exemption for 2026. See *Exemption from withholding* on page 2. I understand I will need to submit a new Form W-4 for 2027 . ☐

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) | **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)
Holistic Array of Authentic Services (HAAS), LLC 5851 DULUTH ST., STE 302, GOLDEN VALLEY, MN 55422		32-0220686

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2026 if you meet both of the following conditions: you had no federal income tax liability in 2025 **and** you expect to have no federal income tax liability in 2026. You had no federal income tax liability in 2025 if (1) your total tax on line 24 on your 2025 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2026 tax return. To claim exemption from withholding, certify that you meet both of the conditions by checking the box in the *Exempt from withholding* section. Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2027.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Are submitting this form after the beginning of the year;

2. Expect to work only part of the year;

3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;

4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

5. Prefer the most accurate withholding for multiple job situations.

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

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

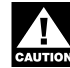
Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work. Submit a separate Form W-4 for each job.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

Instead, if you (and your spouse) have a total of only two jobs, you may check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount of tax withheld will be larger the greater the difference in pay is between the two jobs.



Multiple jobs. *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain credits. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4.

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 15, if you expect to claim deductions other than the basic standard deduction on your 2026 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for qualified tips, overtime compensation, and passenger vehicle loan interest; student loan interest; IRAs; and seniors. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain deductions. For additional eligibility requirements, see Pub. 501.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe when you file your tax return.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 5. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . **1** $ ____________

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 5 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . **2a** $ ____________

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 5 and enter this amount on line 2b . . . . **2b** $ ____________

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . **2c** $ ____________

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. . . . . . . **3** ____________

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (plus any other additional amount you want withheld) . . . . **4** $ ____________

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

See the Instructions for Schedule 1-A (Form 1040) for more information about whether you qualify for the deductions on lines 1a, 1b, 1c, 3a, and 3b.

1		Deductions for qualified tips, overtime compensation, and passenger vehicle loan interest.		
	a	**Qualified tips.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified tips up to $25,000	1a	$
	b	**Qualified overtime compensation.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified overtime compensation up to $12,500 ($25,000 if married filing jointly) of the “and-a-half” portion of time-and-a-half compensation	1b	$
	c	**Qualified passenger vehicle loan interest.** If your total income is less than $100,000 ($200,000 if married filing jointly), enter an estimate of your qualified passenger vehicle loan interest up to $10,000	1c	$
2		Add lines 1a, 1b, and 1c. Enter the result here	2	$
3		**Seniors age 65 or older.** If your total income is less than $75,000 ($150,000 if married filing jointly):		
	a	Enter $6,000 if you are age 65 or older before the end of the year	3a	$
	b	Enter $6,000 if your spouse is age 65 or older before the end of the year and has a social security number valid for employment	3b	$
4		Add lines 3a and 3b. Enter the result here	4	$
5		Enter an estimate of your student loan interest, deductible IRA contributions, educator expenses, alimony paid, and certain other adjustments from Schedule 1 (Form 1040), Part II. See Pub. 505 for more information	5	$
6		**Itemized deductions.** Enter an estimate of your 2026 itemized deductions from Schedule A (Form 1040). Such deductions may include qualifying:		
	a	**Medical and dental expenses.** Enter expenses in excess of 7.5% (0.075) of your total income	6a	$
	b	**State and local taxes.** If your total income is less than $505,000 ($252,500 if married filing separately), enter state and local taxes paid up to $40,400 ($20,200 if married filing separately)	6b	$
	c	**Home mortgage interest.** If your home acquisition debt is less than $750,000 ($375,000 if married filing separately), enter your home mortgage interest expense (including mortgage insurance premiums)	6c	$
	d	**Gifts to charities.** Enter contributions in excess of 0.5% (0.005) of your total income	6d	$
	e	**Other itemized deductions.** Enter the amount for other itemized deductions	6e	$
7		Add lines 6a, 6b, 6c, 6d, and 6e. Enter the result here	7	$
8		**Limitation on itemized deductions.**		
	a	Enter your total income	8a	$
	b	Subtract line 4 from line 8a. If line 4 is greater than line 8a, enter -0- here and on line 10. Skip line 9	8b	$
9		Enter: • $768,700 if you’re married filing jointly or a qualifying surviving spouse • $640,600 if you’re single or head of household • $384,350 if you’re married filing separately	9	$
10		If line 9 is greater than line 8b, enter the amount from line 7. Otherwise, multiply line 7 by 94% (0.94) and enter the result here	10	$
11		**Standard deduction.** Enter: • $32,200 if you’re married filing jointly or a qualifying surviving spouse • $24,150 if you’re head of household • $16,100 if you’re single or married filing separately	11	$
12		**Cash gifts to charities.** If you take the standard deduction, enter cash contributions up to $1,000 ($2,000 if married filing jointly)	12	$
13		Add lines 11 and 12. Enter the result here	13	$
14		If line 10 is greater than line 13, subtract line 11 from line 10 and enter the result here. If line 13 is greater than line 10, enter the amount from line 12	14	$
15		Add lines 2, 4, 5, and 14. Enter the result here and in Step 4(b) of Form W-4	15	$

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 with no other entries on the form; 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 territories 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.

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$480	$850	$850	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	480	1,480	1,850	2,050	2,220	2,220	2,220	2,220	2,220	2,220	2,620
$20,000 - 29,999	480	1,480	2,480	3,050	3,250	3,420	3,420	3,420	3,420	3,420	3,820	4,820
$30,000 - 39,999	850	1,850	3,050	3,620	3,820	3,990	3,990	3,990	3,990	4,390	5,390	6,390
$40,000 - 49,999	850	2,050	3,250	3,820	4,020	4,190	4,190	4,190	4,590	5,590	6,590	7,590
$50,000 - 59,999	1,020	2,220	3,420	3,990	4,190	4,360	4,360	4,760	5,760	6,760	7,760	8,760
$60,000 - 69,999	1,020	2,220	3,420	3,990	4,190	4,360	4,760	5,760	6,760	7,760	8,760	9,760
$70,000 - 79,999	1,020	2,220	3,420	3,990	4,190	4,760	5,760	6,760	7,760	8,760	9,760	10,760
$80,000 - 99,999	1,020	2,220	3,420	4,240	5,440	6,610	7,610	8,610	9,610	10,610	11,610	12,610
$100,000 - 149,999	1,870	4,070	6,270	7,840	9,040	10,210	11,210	12,210	13,210	14,210	15,360	16,560
$150,000 - 239,999	1,870	4,100	6,500	8,270	9,670	11,040	12,240	13,440	14,640	15,840	17,040	18,240
$240,000 - 319,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,780	14,980	16,180	17,380	18,580
$320,000 - 364,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,860	15,860	17,860	19,860	21,860
$365,000 - 524,999	2,720	5,920	9,390	12,260	14,760	17,230	19,530	21,830	24,130	26,430	28,730	31,030
$525,000 and over	3,140	6,840	10,540	13,610	16,310	18,980	21,480	23,980	26,480	28,980	31,480	33,990

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$90	$850	$1,020	$1,020	$1,020	$1,070	$1,870	$1,870	$1,870	$1,870	$1,870	$1,970
$10,000 - 19,999	850	1,780	1,980	1,980	2,030	3,030	3,830	3,830	3,830	3,830	3,930	4,130
$20,000 - 29,999	1,020	1,980	2,180	2,230	3,230	4,230	5,030	5,030	5,030	5,130	5,330	5,530
$30,000 - 39,999	1,020	1,980	2,230	3,230	4,230	5,230	6,030	6,030	6,130	6,330	6,530	6,730
$40,000 - 59,999	1,020	2,880	4,080	5,080	6,080	7,080	7,950	8,150	8,350	8,550	8,750	8,950
$60,000 - 79,999	1,870	3,830	5,030	6,030	7,100	8,300	9,300	9,500	9,700	9,900	10,100	10,300
$80,000 - 99,999	1,870	3,830	5,100	6,300	7,500	8,700	9,700	9,900	10,100	10,300	10,500	10,700
$100,000 - 124,999	2,030	4,190	5,590	6,790	7,990	9,190	10,190	10,390	10,590	10,940	11,940	12,940
$125,000 - 149,999	2,040	4,200	5,600	6,800	8,000	9,200	10,200	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,200	5,600	6,800	8,150	10,150	11,950	12,950	13,950	14,950	16,170	17,470
$175,000 - 199,999	2,040	4,200	6,150	8,150	10,150	12,150	13,950	15,020	16,320	17,620	18,920	20,220
$200,000 - 249,999	2,720	5,680	7,880	10,140	12,440	14,740	16,840	18,140	19,440	20,740	22,040	23,340
$250,000 - 449,999	2,970	6,230	8,730	11,030	13,330	15,630	17,730	19,030	20,330	21,630	22,930	24,240
$450,000 and over	3,140	6,600	9,300	11,800	14,300	16,800	19,100	20,600	22,100	23,600	25,100	26,610

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$280	$850	$950	$1,020	$1,020	$1,020	$1,020	$1,560	$1,870	$1,870	$1,870
$10,000 - 19,999	280	1,280	1,950	2,150	2,220	2,220	2,220	2,760	3,760	4,070	4,070	4,210
$20,000 - 29,999	850	1,950	2,720	2,920	2,980	2,980	3,520	4,520	5,520	5,830	5,980	6,180
$30,000 - 39,999	950	2,150	2,920	3,120	3,180	3,720	4,720	5,720	6,720	7,180	7,380	7,580
$40,000 - 59,999	1,020	2,220	2,980	3,570	4,640	5,640	6,640	7,750	8,950	9,460	9,660	9,860
$60,000 - 79,999	1,020	2,610	4,370	5,570	6,640	7,750	8,950	10,150	11,350	11,860	12,060	12,260
$80,000 - 99,999	1,870	4,070	5,830	7,150	8,410	9,610	10,810	12,010	13,210	13,720	13,920	14,120
$100,000 - 124,999	1,870	4,270	6,230	7,630	8,900	10,100	11,300	12,500	13,700	14,210	14,720	15,720
$125,000 - 149,999	2,040	4,440	6,400	7,800	9,070	10,270	11,470	12,670	14,580	15,890	16,890	17,890
$150,000 - 174,999	2,040	4,440	6,400	7,800	9,070	10,580	12,580	14,580	16,580	17,890	18,890	20,170
$175,000 - 199,999	2,040	4,440	6,400	8,510	10,580	12,580	14,580	16,580	18,710	20,320	21,620	22,920
$200,000 - 249,999	2,720	5,920	8,680	10,900	13,270	15,570	17,870	20,170	22,470	24,080	25,380	26,680
$250,000 - 449,999	2,970	6,470	9,540	12,040	14,410	16,710	19,010	21,310	23,610	25,220	26,520	27,820
$450,000 and over	3,140	6,840	10,110	12,810	15,380	17,880	20,380	22,880	25,380	27,190	28,690	30,190

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS Form I-9
OMB No.1615-0047
Expires 05/31/2027

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

Signature of Employee	Today's Date (mm/dd/yyyy)

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

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

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

	List A	Additional Information
Document Title 2 (if any)		
Issuing Authority		
Document Number (if any)		
Expiration Date (if any)		
Document Title 3 (if any)		
Issuing Authority		
Document Number (if any)		
Expiration Date (if any)		☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
Holistic Array of Authentic Services (HAAS)	5851 Duluth Street, Golden Valley, MN 55422

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.

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

LIST A **Documents that Establish Both Identity and Employment Authorization**	OR	LIST B **Documents that Establish Identity**	AND	LIST C **Documents that Establish Employment Authorization**
1. U.S. Passport or U.S. Passport Card		**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		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**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		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
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		**6.** Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.

For receipt validity dates, see the M-274.

List A	OR	List B		List C
• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.		Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

Supplement A, Preparer and/or Translator Certification for Section 1

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS Form I-9 Supplement A
OMB No. 1615-0047
Expires 05/31/2027

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

Supplement B,
Reverification and Rehire (formerly Section 3)

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 05/31/2027

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)

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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)

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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)

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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Confidentiality Agreement

THIS CONFIDENTIALITY AGREEMENT (the "Agreement") made this _____ day of _________, _____, by and between Holistic Array of Authentic Services (HAAS), LLC (the “Company”), a limited liability company organized under the laws of the state of Minnesota, and __________________ (the "Employee").

WHEREAS the Company operates in a manner where it is mandatory to protect sensitive information, including but not limited to confidential health information protected by the Health Insurance Portability and Accountability Act (HIPAA);

WHEREAS, the Employee agrees not to disclose any confidential information learned during employment, whether intentionally or unintentionally;

NOW, THEREFORE, in consideration of the mutual covenants contained herein and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the Company and the Employee (individually, each a "Party," and collectively, the "Parties") agree as follows:

1. **CONFIDENTIAL INFORMATION:** The term "Confidential Information" shall mean any and all technical and non-technical information provided by the Company including but not limited to proprietary information, trade secrets, and any other client details, business documents, strategies, and policies.

2. **PROTECTION OF CONFIDENTIAL INFORMATION:** Employee agrees to accept the Confidential Information, to use it only for the purposes of employment, and not to disclose it to any other parties.

3. **TERM:** This Agreement shall be effective as of the date first above written and shall continue in effect for the duration of the Employee's employment and for a period of 5 years thereafter while maintaining all necessary HIPAA guidelines.

4. **GENERAL PROVISIONS:** This Agreement sets forth the entire understanding of the Parties regarding confidentiality. Any amendments must be in writing and signed by both Parties.

(651) 756-8492 INFO @ HAASCARES.COM HAASCARES.COM

5851 Duluth St., Suite 302, Golden Valley, MN 55422

Confidentiality Agreement

This Agreement shall be construed under the laws of the state of Minnesota.

IN WITNESS WHEREOF, the Parties have executed this Confidentiality Agreement as of the date first above written.

Holistic Array of Authentic Services (HAAS), LLC

______________________	______________________
[Name and Title]	Date

____

Employee Signature

______________________	______________________
Employee's Name	Date

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(651) 756-8492 INFO @ HAASCARES.COM HAASCARES.COM

5851 Duluth St., Suite 302, Golden Valley, MN 55422

Holistic Array of Authentic Services (HAAS), LLC
Employee Handbook

Welcome to Holistic Array of Authentic Services (HAAS), LLC. Since our establishment in June 2006, we have been dedicated to providing high-quality and compassionate services in the state of Minnesota. We are proud of our diverse offerings, which include Personal Care Assistant (PCA) services, transitional housing for homeless individuals, and Integrated Community Supports (ICS) services.

Our mission is rooted in the belief that everyone deserves access to compassionate, comprehensive, and authentic care. Our PCA services are designed to assist individuals in achieving the highest possible level of health and independence. Our transitional housing program provides a safe and supportive environment for homeless individuals as they move towards stable, permanent housing. And our ICS services aim to enhance the integration of individuals with disabilities into the community.

At HAAS, we recognize that our team is our greatest asset. We are committed to creating a supportive and inclusive workplace where every team member is valued, respected, and empowered to make a difference. This handbook is designed to introduce you to our culture, values, and expectations, as well as to provide a clear understanding of our policies and procedures.

We are excited to have you join our team and contribute to our mission of providing holistic, authentic services to those in need in Minnesota!

Employment Policies

Employment Classification
At Holistic Array of Authentic Services (HAAS), LLC, employees are classified as either full-time or part-time, and either exempt or non-exempt, according to state and federal labor laws.

- Full-time employees: Those who are regularly scheduled to work at least 40 hours per week.
- Part-time employees: Those who are regularly scheduled to work fewer than 40 hours per week.
- Exempt employees: Those who are exempt from the overtime provisions of the Fair Labor Standards Act (FLSA) and state law.
- Non-exempt employees: Those who are eligible for overtime pay as per the FLSA and state law.

Working Hours:

Our standard workweek begins on Monday and ends on Sunday. Full-time employees are expected to work 40 hours per week. The specific working hours can vary depending on the job role and client needs.

Overtime:

Overtime must be approved in advance by a supervisor. Non-exempt employees will be paid overtime in accordance with state and federal laws.

Pay Periods:

HAAS pays employees on a bi-weekly basis. Paydays are every other Friday. If a regular payday falls on a holiday, employees will be paid on the last workday before the holiday.

Promotions:

Promotions at HAAS are based on merit. We strive to promote from within whenever possible. Employees are encouraged to apply for open positions that represent a promotion or lateral move.

Equal Employment Opportunity:

HAAS is committed to providing equal employment opportunities to all individuals without regard to race, color, religion, sex, national origin, age, disability, marital status, sexual orientation, or any other characteristic protected by law.

Harassment and Discrimination:

HAAS is committed to maintaining a work environment free from harassment and discrimination. Any form of harassment or discrimination will not be tolerated.

Attendance and Punctuality:

Regular attendance and punctuality are essential job functions. If you are unable to attend work or will be late, please notify your supervisor as soon as possible.

Leave Policies:

HAAS provides sick leave. Specific policy for this leave will be provided separately.

Equal Opportunity Statement

Holistic Array of Authentic Services (HAAS), LLC is committed to creating an inclusive and diverse work environment. We are proud to be an equal opportunity employer. All qualified applicants will receive consideration for employment without regard to race, color, religion, gender, gender identity or expression, sexual orientation, national origin, genetics, disability, age, veteran status, or any other characteristic protected by federal, state, or local laws.

Our policy applies to all terms and conditions of employment, including recruiting, hiring, placement, promotion, termination, layoff, recall, transfer, leaves of absence, compensation, and training. We believe that diversity and inclusion among our team members is critical to our success, and we seek to recruit, develop, and retain the most talented people from a diverse candidate pool.

At HAAS, we are dedicated to ensuring that our workplace is free from unlawful discrimination and harassment. We will not tolerate any form of discrimination or harassment that violates the dignity or rights of any individual. Any reports of potential violations will be taken seriously and investigated thoroughly, and any necessary corrective action will be taken.

Harassment Policy:

Holistic Array of Authentic Services (HAAS), LLC is committed to maintaining a work environment that is free from all forms of harassment, whether based on race, color, religion, gender, gender identity or expression, sexual orientation, national origin, genetics, disability, age, veteran status, or any other characteristic protected by law. This includes, but is not limited to, harassment that is sexual, racial, or related to disability or religion.
All employees, clients, vendors, and other people who interact with employees of HAAS are expected to adhere to this policy. Harassment of any sort will not be tolerated and will be subject to disciplinary action, up to and including termination of employment.

Discrimination Policy:

HAAS is an equal opportunity employer. We are committed to providing an inclusive work environment where everyone is treated with fairness, dignity, and respect. We will not tolerate any unlawful discrimination against any employee or applicant for employment based on race, color, religion, sex, pregnancy, national origin, age, disability, or genetic information.

This policy extends to all terms, conditions, and privileges of employment, including hiring, placement, promotion, compensation, training, and termination. We are committed to making decisions concerning employment strictly according to individual merit and the ability to perform the duties of the job, with reasonable accommodation when necessary.

Health and Safety Policy

Holistic Array of Authentic Services (HAAS), LLC is committed to maintaining a safe and healthy working environment for all employees, clients, and visitors. We believe that accidents and injuries are preventable, and it is our goal to achieve zero incidents.

Employee Responsibilities:
Safety: Employees are required to follow all safety procedures and use safety equipment as necessary. Any unsafe conditions or hazards should be immediately reported to a supervisor.

Health: Employees should maintain a high level of health and fitness for duty. Any concerns about work-related illnesses or stress should be reported to a supervisor.
Training: Employees must participate in all required safety training and demonstrate understanding of training content.

Incident Reporting: All workplace accidents, injuries, or near misses must be reported immediately, regardless of the severity of the incident.

Company Responsibilities:
Training: HAAS will provide necessary training and equipment to employees to perform their jobs safely.

Environment:
We will maintain a clean, safe work environment and will conduct regular safety inspections to identify and eliminate potential hazards.

Investigations:
We will promptly investigate all reported incidents and take corrective action to prevent future occurrences.

Compliance:
We will comply with all applicable local, state, and federal health and safety regulations.
Zero Tolerance for Workplace Violence

HAAS has a zero-tolerance policy for workplace violence. Threats, threatening behavior, acts of violence, or any related conduct will not be tolerated. Any person who engages in such behavior may be removed from the premises and may be subject to disciplinary action, criminal penalties, or both.

Professional Conduct Statement

Holistic Array of Authentic Services (HAAS), LLC is dedicated to maintaining a high standard of professionalism in all aspects of our work. As part of our commitment to providing quality services and creating a respectful, inclusive workplace, we expect all employees to adhere to the principles of professional conduct outlined below:
Respect and Integrity: Treat all individuals—colleagues, clients, and members of the community—with respect and dignity. Maintain honesty and integrity in all professional dealings.

Professional Competence:
Maintain and improve professional knowledge and competence. Always provide services to the best of your ability.

Responsibility:
Accept responsibility for your actions and decisions. Understand and follow all policies, procedures, and legal requirements applicable to your role.

Confidentiality:
Respect and protect the confidentiality of information gained as part of your work, in line with relevant laws and company policies.

Non-Discrimination:
Do not engage in or tolerate discrimination, harassment, or bullying on any grounds, including race, color, religion, gender, age, national origin, disability, or any other protected category.

Compliance with Laws and Regulations:
Comply with all relevant laws, regulations, and professional standards in the course of your work.

Conflict of Interest:
Avoid situations that could create a conflict of interest and disclose any potential conflicts to your supervisor.

Failure to adhere to these principles of professional conduct may result in disciplinary action, up to and including termination of employment. By upholding these standards, we can ensure that HAAS continues to provide quality services and fosters a positive work environment for all.

Termination Policy

Holistic Array of Authentic Services (HAAS), LLC is committed to treating all employees fairly and consistently. The following termination policy is designed to provide guidance for ending an employment relationship in a lawful, ethical, and professional manner.
Involuntary Termination: Employees may be terminated involuntarily due to performance issues, misconduct, violation of company policies, or business needs such as reorganization or downsizing. In the case of performance issues or misconduct, termination generally follows a progressive discipline process, starting with verbal warnings, written warnings, suspension, and finally termination. However, depending on the severity of the situation, immediate termination may be appropriate.

Voluntary Termination:
Employees who wish to end their employment with HAAS are asked to provide at least two weeks' notice to allow for a smooth transition. This notice should be given in writing to the immediate supervisor.

Exit Interview:
An exit interview may be conducted for employees leaving the organization to gain feedback and insights for continuous improvement.

Final Pay:
Employees will receive their final paycheck in accordance with state law, including payment for all hours worked and any unused, accrued vacation time if applicable under company policy and state law.

Return of Property:
Upon termination, employees are required to return all company property, including keys, equipment, and confidential documents.

Post-Termination Obligations:
Even after termination, former employees are still bound by obligations including confidentiality, non-compete, and non-solicitation, as outlined in their employment agreement.

Please note, this policy does not alter the at-will employment relationship. Both the employee and HAAS have the right to terminate employment at any time, with or without cause or advance notice.

ACKNOWLEDGMENT OF RECEIPT

I hereby acknowledge that I have read, understood, and agree to the Holistic Array of Authentic Services (HAAS), LLC Employee Handbook. I understand that it contains important information on the company's policies, procedures, and my responsibilities as an employee.

I understand that I am expected to read, understand, and adhere to the policies outlined in the handbook and any revisions made to it. I understand that if I have any questions about the handbook contents at any time, I should consult with HAAS admin.

I understand that this handbook does not constitute a contract of employment and does not alter the at-will employment relationship. I understand that HAAS has the right to amend, interpret, or terminate any of its policies or benefits at any time, with or without notice.

By signing below, I acknowledge that I have read and understood the above statements.

Employee Name (Print): ______________________

Employee Signature: _________________________

Date: ______________________________________

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