

ADVICE OF EMPLOYMENT – INDIVIDUALISED FUNDING CLIENT

NEW EMPLOYEE FORM

***ALL SECTIONS/PAGES MUST BE COMPLETED AND RETURNED FOR EMPLOYEE TO BE SET UP**

Return to: DisabilitySupport@lifewise.org.nz before 12.30pm the Wednesday before the next pay deadline.

Employee #: _____
OFFICE USE ONLY

Employer's Details

**Please note you cannot be both the Employer & Employee. The Agent is the person managing the IF budget.*

Employer's Name: _____

IF Client's Agent Name (if different from Employer): _____

IF Client's Name: _____

IF Client #: _____
OFFICE USE ONLY

Employee's Details

Full Name: _____

Address: _____ Post Code: _____

Phone (Mobile): _____ Phone (Home): _____

Email Address: _____

Resident Family Carer (please tick if you live with the person you are caring for)

Date of Birth: _____ Consent to send Date of Birth to IRD (for payroll purposes)

Gender: Male / Female / Other Gender (Please Circle)

EMPLOYEE ALLOWANCES

Mileage: I would like my Employee to have mileage reimbursed for work related travel: Yes No

Mileage Rate: \$ _____ per Kilometre

Annual Holidays Type: 4 weeks (minimum legal requirement)

Other (please specify) _____

Sick Leave Type: 10 days (minimum legal requirement – commences after 6 months)

Other (please specify) _____

Union (if applicable): _____

BANK ACCOUNT DETAILS

Bank Account:

Bank	Branch	Account Number	Suffix

Bank Account in the Name of: _____

***We require proof of your bank account - please include this with your forms**

Password for email paylips: _____

(Your password may be any combination of up to a maximum of 10 letters and numbers. Please do not choose any obvious passwords, such as the word "password". You should not choose a password that you already use for something else, e.g. banking or email.)

Employment Details

Start Date: _____

Position: _____

Qualification: None Level 2 Level 3 Level 4 or higher
Minimum legalised rates: \$23.15 \$24.06 \$26.16 \$28.25

Name of Qualification: _____

Hourly Pay Rate: _____

Respite Sleepovers – *Only Applicable if IF Client has been allocated a **Respite Care Budget**

Yes No Sleepover Rate: _____
(minimum sleepover rate is \$23.15 per hour. The sleepover rate generally applies between 10pm - 6am)

Employment Type: ***Please check with your IF Coach if you are not sure**

<input type="checkbox"/> Permanent Employee <i>Example: Your Employee will be working a regular pattern of work hours each week or month (even if the days or hours change week to week. They will have consistent hours/work) and will be working full or part-time.</i>	<input type="checkbox"/> Casual Employee <i>Example: There is no regular or set pattern of hours your Employee will be working. The hours are variable/flexible and communicated and agreed with Employer when required and it is impractical to provide 4 weeks leave and sick leave.</i>
Minimum Hours per week : _____ as per Employment Agreement: (Agreed definition of a week for annual leave calculations)	*Email DisabilitySupport@lifewise.org.nz Or your Lifewise IF Coach for a Casual Employment Contract Template if hiring a Casual Employee.

Payslip

I, _____ (employee) consent to receiving my payslips via email. I understand I can withdraw my consent at any time.

Signed: _____ Date: _____
(by the employee)

Signed: _____ Date: _____
(by the employer)

***CHECK LIST: Have you also included these documents to submit?**

- | | |
|--|---|
| <input type="checkbox"/> IRD Tax Declaration Form | <input type="checkbox"/> Kiwi Saver Deduction or Opt Out Request Form |
| <input type="checkbox"/> Proof of valid Bank Account | <input type="checkbox"/> Eligibility to work in NZ if not a NZ Citizen or Resident (please provide a copy of passport/visa details) |
| <input type="checkbox"/> Individual Employment Agreement | |

Return completed forms to: DisabilitySupport@lifewise.org.nz before 12.30pm the Wednesday before the next pay deadline

Please note: Employees that have not worked within a 12 month period are terminated and will be required to sign forms again if they will be resuming employment outside of the 12 month period to ensure all information is correct and employment conditions are up to date.

Employer Details

Full Name: _____

Address: _____ Post Code: _____

Phone (Mobile): _____ Phone (Home): _____

Email Address: _____

Relationship to IF Client: _____

I understand my responsibilities as an Employer are:

- To participate in the development of the Individual Service Plan
- To use the support only for services funded by Whaikaha Ministry of Disabled People.
- To determine the level of service you want to manage
- To provide timely, accurate and verified information to enable LIFEWISE to invoice Whaikaha
- To not spend more than the total value of the support allocated by the NASC (Taikura Trust)
- If you do overspend your IF budget, you will be required to repay the overspend balance to LIFEWISE
- To send in timesheets/invoices within 90 days of the support being received; outside of this timeframe we may not be able to reimburse you from your IF budget
- Keep records of all support received for at least seven years
- To promptly discuss any changes needed to your support
- To cooperate with any Whaikaha audit of your IF budget
- Manage all aspects of recruitment and employment complying with Government legislation including job descriptions, individual employment agreements, and paying the minimum care and support worker wage
- Be a fair and reasonable employer, and provide a healthy and safe working environment
- Manage any employment disputes or performance issues

Signed: _____ Date: _____

(Employer Signature)

Support Worker Privacy Notice for Ministry of Health funding packages

You are being employed (or contracted) to provide disability supports, and the Person employing or contracting with you is using Funding arising from a NASC allocation for that purpose.

The Person employing you or contracting with you may be required to make available the following details about you to the organisation authorising release of these funds for that Person:

- Your full name, date of birth, address and contact phone number, and your IRD number (or that of the contractor employing you); and
- The dates and times when you provide services.

The purpose for which the information will be used is to monitor compliance with the requirements of this Funding and to verify claims made in relation to the services you provide for this Person.

Auditors appointed by the Ministry of Health may also review this information. The auditors may make contact with you if they have any questions about claims made.

The organisation contact details are:

Lifewise Homecare Services (09) 623 7631
disabilitysupport@lifewise.org.nz

You can access the information held about you, and ask for correction where necessary by contacting the Person. If you want further information refer to <http://www.health.govt.nz/system/files/documents/pages/privacy-notice-hosted-scheme-support-workers.docx>

Declaration

I understand that the Person employing or contracting me may be required to make available a number of details about me to the organisation specified above for the purpose specified above.

Name of Support Worker:

Signature of Support Worker:

Date: