TREASURERS AND HUMAN RESOURCES

Treasurers workshop

April 10, 2016

Topics

- Recruitment
- Employment
  - Hiring
  - Payroll
  - Changes/Benefits
  - Terminations/Resignations
- Workers Compensation
- Volunteers
- Independent Contractors vs. Employee

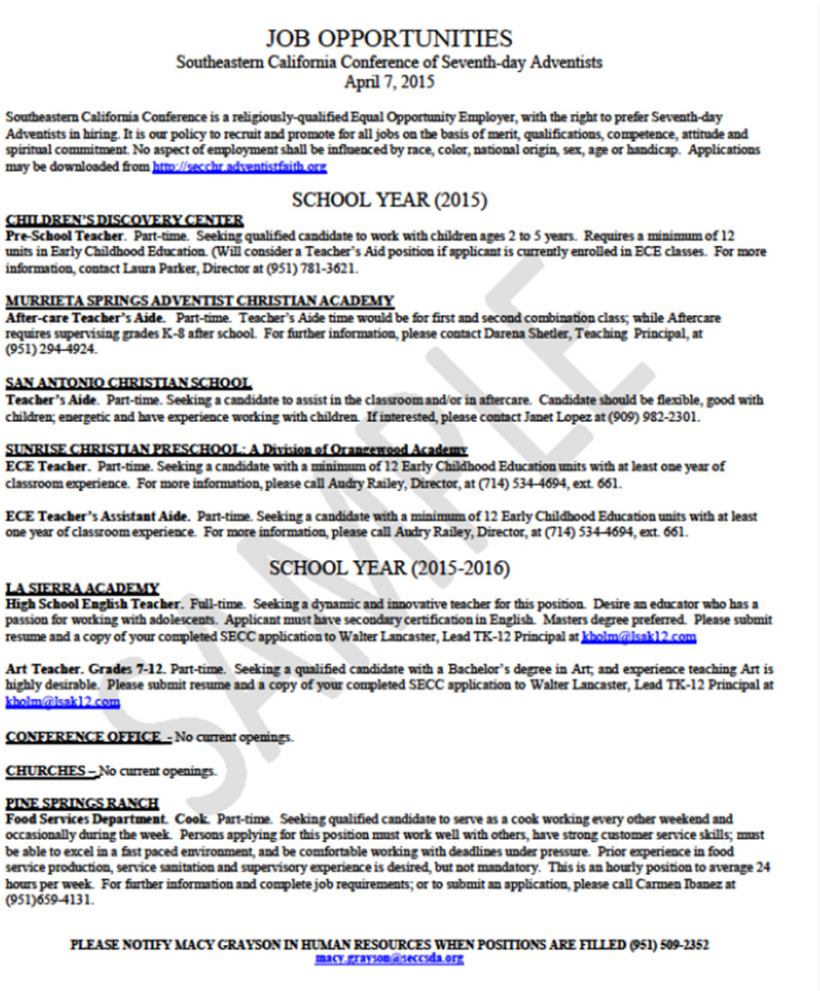
RECRUITMENT

Contact Macy Grayson, 951-509-2352

Macy.grayson@seccsda.org

Advertising for Open Positions

- Create Job Description
- SECC Job Ops
  - Online
- Church Bulletin



JOB OPPORTUNITIES
Southeastern California Conference of Seventh-day Adventists
April 7, 2015

Southeastern California Conference is a religiously-qualified Equal Opportunity Employer, with the right to prefer Seventh-day Adventists in hiring. It is our policy to recruit and promote for all jobs on the basis of merit, qualifications, competence, attitude and spiritual commitment. No aspect of employment shall be influenced by race, color, national origin, sex, age or handicap. Applications may be downloaded from http://secchr.adventistfaith.org

SCHOOL YEAR (2015)

CHILDREN'S DISCOVERY CENTER
Pre-School Teacher. Part-time. Seeking qualified candidate to work with children ages 2 to 5 years. Requires a minimum of 12 units in Early Childhood Education. (Will consider a Teacher's Aid position if applicant is currently enrolled in ECE classes. For more information, contact Laura Parker, Director at (951) 781-3621.

MURRIETA SPRINGS ADVENTIST CHRISTIAN ACADEMY
After-care Teacher's Aide. Part-time. Teacher's Aide time would be for first and second combination class; while Aftercare requires supervising grades K-8 after school. For further information, please contact Darena Shetler, Teaching Principal, at (951) 294-4924.

SAN ANTONIO CHRISTIAN SCHOOL
Teacher's Aide. Part-time. Seeking a candidate to assist in the classroom and/or in aftercare. Candidate should be flexible, good with children; energetic and have experience working with children. If interested, please contact Janet Lopez at (909) 982-2301.

SUNRISE CHRISTIAN PRESCHOOL - A Division of Orangewood Academy
ECE Teacher. Part-time. Seeking a candidate with a minimum of 12 Early Childhood Education units with at least one year of classroom experience. For more information, please call Audry Railey, Director, at (714) 534-4694, ext. 661.

ECE Teacher's Assistant Aide. Part-time. Seeking a candidate with a minimum of 12 Early Childhood Education units with at least one year of classroom experience. For more information, please call Audry Railey, Director, at (714) 534-4694, ext. 661.

SCHOOL YEAR (2015-2016)

LA SIERRA ACADEMY
High School English Teacher. Full-time. Seeking a dynamic and innovative teacher for this position. Desire an educator who has a passion for working with adolescents. Applicant must have secondary certification in English. Masters degree preferred. Please submit resume and a copy of your completed SECC application to Walter Lancaster, Lead TK-12 Principal at kholm@lsak12.com

Art Teacher. Grades 7-12. Part-time. Seeking a qualified candidate with a Bachelor's degree in Art; and experience teaching Art is highly desirable. Please submit resume and a copy of your completed SECC application to Walter Lancaster, Lead TK-12 Principal at kholm@lsak12.com

CONFERENCE OFFICE - No current openings.

CHURCHES – No current openings.

PINE SPRINGS RANCH
Food Services Department. Cook. Part-time. Seeking qualified candidate to serve as a cook working every other weekend and occasionally during the week. Persons applying for this position must work well with others, have strong customer service skills; must be able to excel in a fast paced environment, and be comfortable working with deadlines under pressure. Prior experience in food service production, service sanitation and supervisory experience is desired, but not mandatory. This is an hourly position to average 24 hours per week. For further information and complete job requirements; or to submit an application, please call Carmen Ibanez at (951)659-4131.

PLEASE NOTIFY MACY GRAYSON IN HUMAN RESOURCES WHEN POSITIONS ARE FILLED (951) 509-2352
macy.grayson@seccsda.org

SAMPLE

Screening/Selection Process

- Testing (optional)
- Screening/Interview Packet available
- Applications and Resumes need to be stored

EMPLOYMENT

Contact Brooke Hess, 951-509-2353

Brooke.hess@seccsda.org

New Hire

- Contact Brooke Hess in HR *BEFORE* the employee starts working
  - New Hire Forms
    - PAR
    - Application
    - Membership Check
    - Background Check
    - Service Record Request
    - New Employee Data Collection Sheet
    - Conflict of Interest Statement
    - W-4
    - I-9, with copies of documents
  - Possible Benefits, located in treasurers handbook

Payroll

- Bi-weekly pay date
- 26 pay days
- Timecards are due the Monday before pay day
- Do not turn in timecards late
- Timecards may be mailed, e-mailed, or faxed
- No duplicates
- Direct Deposit available

Change in Employment

- Create a Change PAR for:
  - Step increases/decreases
  - Title change
  - Work location change
  - Change in the amount of Hours a week
  - Status (ex. Part-time to Full-time or Temporary to Regular)
- Submit to Brooke Hess in HR via e-mail, mail, or fax *BEFORE* the change takes place

Resignation vs. Termination

Resignation

- Resignation Letter/Note
- Create PAR and submit to HR BEFORE employee's last day
- Possibly cash out any unused vacation time with final check

Termination

- Notify HR if employee will be terminated
- Possible termination review
- Create PAR after review is completed
- Possibly cash out any unused vacation time with final check

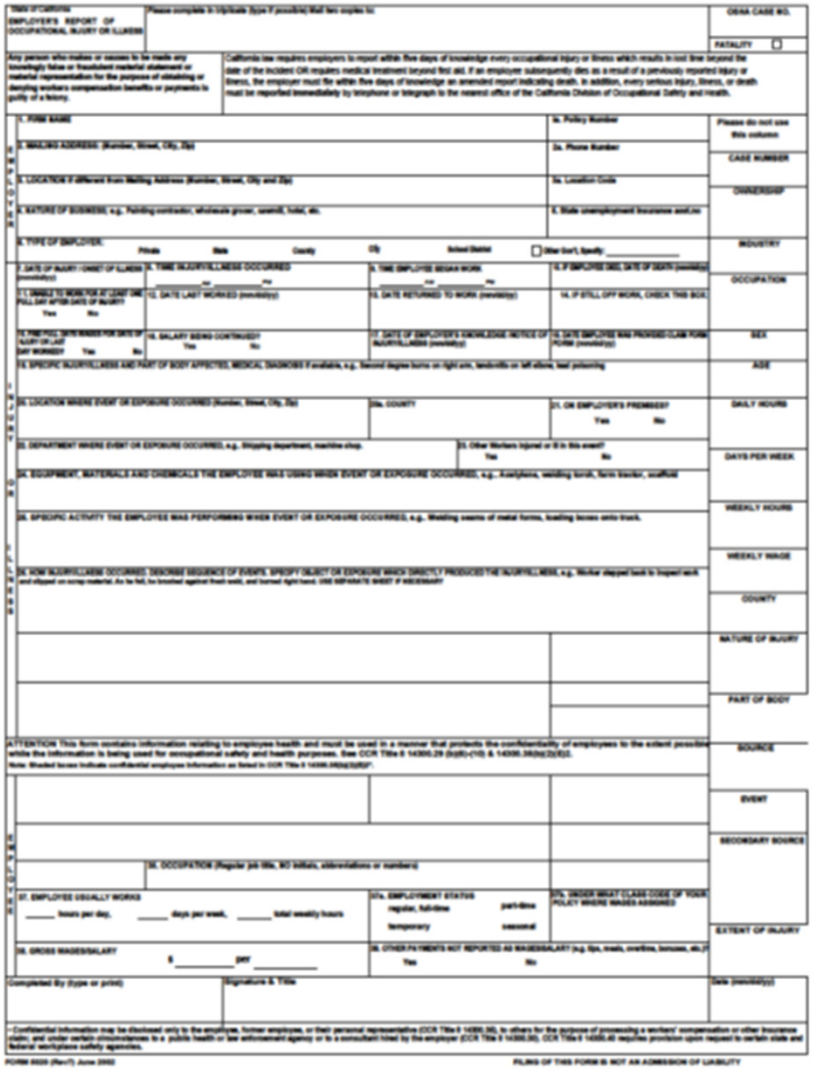
WORKERS COMPENSATION

Contact Macy Grayson, 951-509-2352

Macy.grayson@seccsda.org

How to Report a Workers Comp Claim

- Employees who have been injured at work will file a workers compensation claim using forms DWC1 and form 5020. They will then fax them to the Human Resources department 951-509-2395.
- Once we receive the forms we must audit for accuracy and send them to intake and our claims representative Lauren Evans
- Print out copies of the confirmation e-mails as well as the sent e-mails and create a new file with the injured employee's name and DOI (Date of injury) and file it with the current workers comp claims.
- Have the employee take a copy of these completed forms with them when they go to seek treatment.
  - Inform the employee that if they are asked to pay for any treatment or prescriptions for this work-related injury, they must keep the receipts to present to our Workers' Compensation provider for reimbursement up to a cap.
  - Employees must submit these receipts to Macy Grayson in HR
- Have the employee visit the nearest workers comp medical provider:
  - Kaiser Occupational Health Center
  - US Healthworks
  - Loma Linda Occupational Medicine Center 328 Commercial Road Suite 101, San Bernardino, 92408
  - If employees are not near one of these locations they can call the Human Resources department and we can contact Sedgwick at 925.988.1174
- E-mail all work status notifications you receive from the employee to Macy Grayson in HR
  - You may be required to complete a wage statement
  - A wage statement is a listing that asks for days worked and amount earned in a pay period over the course of one year from date of injury.
- If an employee is placed 'Off Work' keep track of the amount of days missed and notify the Benefits Specialist if the employee will need to transition to TTD or LTD.



TBN (IT'S BROWN)
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type if possible) Mail two copies to:

OSHA CASE NO.

FATALITY ☐

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.

California law requires employers to report within five days of knowledge every occupational injury or illness which results in lost time beyond the date of the incident OR requires medical treatment beyond first aid. If an employer subsequently dies as a result of a previously reported injury or illness, the employer must file within five days of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be reported immediately by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME
1a. Policy Number
2. MAILING ADDRESS: (Number, Street, City, Zip)
2a. Phone Number
3. LOCATION if different from Mailing Address (Number, Street, City and Zip)
3a. Location Code
4. NATURE OF BUSINESS, e.g., Painting contractor, wholesale grocer, sawmill, hotel, etc.
5. State unemployment insurance acct.no

Please do not use this column

CASE NUMBER

OWNERSHIP

6. TYPE OF EMPLOYER: Private State County City School District Other Gov't, Specify:

INDUSTRY

INJURY

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)
8. TIME INJURY/ILLNESS OCCURRED: __:__ __M
9. TIME EMPLOYEE BEGAN WORK: __:__ __M
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)

OCCUPATION

11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? Yes No
12. DATE LAST WORKED (mm/dd/yy)
13. DATE RETURNED TO WORK (mm/dd/yy)
14. IF STILL OFF WORK, CHECK THIS BOX

SEX

15. PHYSICIAN'S NAME FOR DATE OF INJURY OR LAST DAY WORKED? Yes No
16. SALARY BEING CONTINUED? Yes No
17. DATE OF EMPLOYER'S KNOWLEDGE NOTICE OF INJURY/ILLNESS (mm/dd/yy)
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM (mm/dd/yy)

AGE

19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g., Second degree burns on right arm, tendonitis on left elbow, lead poisoning

INJURY

20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)
20a. COUNTY
21. ON EMPLOYER'S PREMISES? Yes No

DAILY HOURS

22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., Shipping department, machine shop.
23. Other Workers injured or ill in this event? Yes No

DAYS PER WEEK

24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Acetylene, welding torch, farm tractor, scaffold

WEEKLY HOURS

25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., Welding seams of metal forms, loading boxes onto truck.

WEEKLY WAGE

26. HOW INJURY/ILLNESS OCCURRED: DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY

COUNTY

NATURE OF INJURY

PART OF BODY

SOURCE

EVENT

SECONDARY SOURCE

ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(3)(B).

Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(3)(B)*.

EMPLOYEE

27. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)

28. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours
29a. EMPLOYMENT STATUS regular, full-time part-time temporary seasonal
29b. UNDERWRITING CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED

EXTENT OF INJURY

30. GROSS WAGES/SALARY $ _____ per _____
30. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g. tips, meals, overtime, bonuses, etc.)? Yes No

Completed By (type or print)
Signature & Title
Date (mm/dd/yy)

*Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim, and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.35), CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

FORM 5020 (Rev7) June 2002

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it **"Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401**. An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la División de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información grabada. En la hoja cubierta de esta forma esta la explicación de los beneficios de compensación al trabajador.*

Ud. también debería haber recibido de su empleador un folleto describiendo los beneficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonía".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ *Zip. Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____ a.m. _____ p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde ocurrió el accidente.* _____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

9. Name of employer. *Nombre del empleador.* _____
10. Address. *Dirección.* _____
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia administradora de seguros.* _____
15. Insurance Policy Number. *El número de la póliza de Seguro.* _____
16. Signature of employer representative. *Firma del representante del empleador.* _____
17. Title. *Título.* _____ 18. Telephone. *Teléfono.* _____

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

☐ Employer copy/*Copia del Empleador* ☐ Employee copy/ *Copia del Empleado* ☐ Claims Administrator/*Administrador de Reclamos* ☐ Temporary Receipt/*Recibo del Empleado*

6/10 Rev.

VOLUNTEERS

Call Human Resources or General Services Dept. with questions

Volunteers pg. 131

- A volunteer, according to wage and hour laws, is an individual who performs or donates services for humanitarian, public service, or religious reasons without ***contemplation of payment of any kind***.
- There are typically two types of volunteers with which Southeastern California Conference deals:
  - An individual who has never been an employee of the organization who performs or donates services.
  - The second is an established employee performing or donating services for the employer on their off time. An employee cannot be considered an unpaid volunteer when performing their same duties within the same workweek.
- In either case, the Human Resources Department should be notified when such individuals perform such services. For your convenience, Volunteer Services forms are available in the Human Resources Department.

INDEPENDENT CONTRACTORS

Call Human Resources or General Services Dept. with questions

Classification

- Employee vs. Independent Contractor
  - pg. 117 Treasurers handbook
- Complete Contract and Liability Insurance