

# Welcome to the Federal Work-Study Program

## Instructions to Participate


If Federal Work-Study is listed on your award letter you must complete the following paperwork and return it to the Financial Aid Office. You will not be permitted to participate until ALL documents are completed and submitted. Do not submit Federal Work-Study paperwork unless it is listed on your award letter. You must be eligible and awarded Federal Work-Study to participate.

Your first step in participating in Federal Work-Study is to determine where you'd like to work. The job descriptions will clearly indicate the duties you will perform and any other pertinent information you'll need to know about the job. Read them carefully and after you've made your decision, contact the supervisor of the site to inquire about any openings. You will then need to complete the following documents indicated below.

### Federal Work-Study Paperwork Completion Instructions:

**It is your responsibility to secure a Federal Work-Study position.**

*You will not be assigned a position.*

1. **Federal Work-Study Employment Application:** This application **must** be read, completed and signed by both you and the supervisor of the site at which you wish to work . It is then your responsibility to contact the supervisor of that site to set up an interview and obtain their signature on the employment application. Please return the application to the Financial Aid Office. An incomplete employment application will be returned to you for proper completion. You can determine the number of hours you have been allotted by reviewing the **pay scale** chart and comparing it to the amount of Federal Work-study that you've been allotted on your financial aid award letter.
2. **Personal Data Sheet:** Both pages of this form must be completed and signed in order for the Controller's Office to process your paycheck accurately. This form should be returned to the Financial Aid Office.
3. **W-4 Form:** The bottom half of this form must be completed, signed and dated by you. It is a requirement in order to process your paycheck. Return this form to the Financial Aid Office.
4. **Confidentiality Agreement:** This form must be completed, signed and dated by you. By signing this form, you are confirming you understand the College Confidentiality policy. Return this form to the Financial Aid Office
5. **Worker's Compensation Acknowledgement:** Please print your name and the name of the department where you will be working. You will also need to sign and date the acknowledgement indicating you have read and understand the worker's compensation information provided. Return all pages of the signed acknowledgement sheet to the Financial Aid Office.
6.  **I-9 Form:** This form is available at the Financial Aid Office and **must** be completed in the presence of a Financial Aid staff member. The I-9 must be on file before you can begin work. You will need to bring two forms of identification with you. A driver's license and social security card are acceptable.

Once you have completed all required forms please submit them to the Financial Aid Office as soon as possible. Before the beginning of the semester, you will receive a postcard confirming your Federal Work-Study placement and the number of hours you may work. Your supervisor will also receive a postcard indicating you may work at their site. You may not begin working until the first day of the semester. During the first week of school, you must contact your supervisor to set up a schedule. If you do not contact your supervisor, your FWS will be canceled.

**MOUNT ALOYSIUS COLLEGE  
FEDERAL WORK-STUDY EMPLOYMENT APPLICATION**



**STUDENT SECTION: (PLEASE PRINT & ANSWER ALL QUESTIONS)**

**NAME:** \_\_\_\_\_ **SSN:** \_\_\_\_\_  
LAST FIRST MI

**ADDRESS:** \_\_\_\_\_

**THIS SECTION MUST BE COMPLETE AND SIGNED BY BOTH PARTIES. AS A FEDERAL WORK-STUDY PARTICIPANT, IT IS YOUR RESPONSIBILITY TO OBTAIN THE SIGNATURE OF THE SUPERVISOR OF THE SITE YOU WISH TO WORK AT. REVIEW THE ON AND OFF CAMPUS JOB LISTINGS AT [WWW.MTALOY.EDU/ONCAMPUSJOBS](http://WWW.MTALOY.EDU/ONCAMPUSJOBS) or [WWW.MTALOY.EDU/OFFCAMPUSJOBS](http://WWW.MTALOY.EDU/OFFCAMPUSJOBS). ALL INCOMPLETE EMPLOYMENT APPLICATIONS WILL BE RETURNED FOR COMPLETION.**

**WHERE WILL YOU BE WORKING?** \_\_\_\_\_  
(Work site & Job Title must be listed) **Work site** **Job Title**

**STATEMENT OF EDUCATIONAL PURPOSE AND STUDENT RESPONSIBILITIES:**  
**By signing this statement, I acknowledge that I have read and understand the educational purpose of Federal Work-Study money and my responsibilities as a student worker as listed below:**

I certify that I will use any money I receive under Title IV funding for only expenses related to my study at Mount Aloysius College. I have thoroughly reviewed the job description for this job and understand my responsibilities while working at this site. My responsibilities are as follows: I must report to my assigned position and it is my responsibility to notify my supervisor if I cannot attend for any reason; I am permitted to work only the number of hours assigned to me unless I receive written permission from the Financial Aid Office; I understand I must attend one Federal Work-Study seminar during my enrollment at Mount Aloysius College and failure to do so will result in the loss of my Federal Work-Study; I certify I have read and understand the confidentiality policy of the College and will adhere to those policies; I understand it is my responsibility to notify my supervisor and the Financial Aid Office if, at any point, I decide I no longer wish to participate in Federal Work-Study; I understand that I do have the opportunity to switch work-study positions, however, it will be at the discretion of the Financial Aid Office---I will be required to complete a new Employment Application and obtain a signature from the new supervisor; I understand that I am a representative of the College and I will maintain the utmost professionalism when communicating with faculty, staff, students, etc.; I understand I am responsible for recording only actual hours worked, not anticipated hours on my timesheet; I am responsible for signing and reviewing my timesheet for accuracy before my supervisor submits it to the Controller's Office. If I fail to sign the timesheet by the due date, I relinquish my right to question my timesheet and paycheck accuracy; I understand my eligibility for FWS may be affected if I change my enrollment status. I understand that failure to adhere to any of the listed responsibilities may result in the loss of my Federal Work-Study.

**STUDENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**ACCEPTANCE AND SIGNATURE OF SUPERVISOR:** I agree to hire this student as an employee for my office/ job site. I have discussed the job description, my expectations of a work-study student and my philosophy on absenteeism from the job. I understand this student must be engaged in work when scheduled for work-study in my office/ job site.

**SUPERVISOR SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Mount Aloysius College does not discriminate on the basis of race, color, sex, sexual orientation, religion, national or ethnic origin, age, disability or status as disabled Vietnam Era veteran in the administration of its educational policies, programs or activities, financial aid policies and procedures, scholarship and loan programs, employment or other College administered programs.

**FOR FINANCIAL AID OFFICE USE ONLY:**

**DEPARTMENT:** \_\_\_\_\_ **SUPERVISOR:** \_\_\_\_\_

<b>SEMESTER:</b>	<b>FALL</b>	<b>SPRING</b>	<b>SUMMER I</b>	<b>SUMMER II</b>
_____	_____	_____	_____	_____
_____	MAXIMUM DOLLAR AMOUNT PER SEMESTER		<input type="checkbox"/> W-4 COMPLETED	<input type="checkbox"/> DATA SHEET
_____	MAXIMUM HOURS PER SEMESTER		<input type="checkbox"/> I-9 COMPLETED	<input type="checkbox"/> CONFIDENTIALITY AGREEMENT
_____	AVERAGE HOURS PER WEEK		<input type="checkbox"/> WORKMEN'S COMP FORM	<input type="checkbox"/> ATTENDED SEMINAR

PAY SCALE BASED ON \$7.15/HOUR

AWARD	HRS/SEMESTER	HRS/WEEK
\$1,000	140	9
\$975	136	9
\$950	133	9
\$925	129	9
\$900	126	8
\$875	122	8
\$850	119	8
\$825	115	8
\$800	112	7
\$775	108	7
\$750	105	7
\$725	101	7
\$700	98	7
\$675	94	6
\$650	91	6
\$625	87	6
\$600	84	6
\$575	80	5
\$550	77	5
\$525	73	5
\$500	70	5
\$475	66	4
\$450	63	4
\$425	59	4
\$400	56	4
\$375	52	3
\$350	49	3
\$325	45	3
\$300	42	3
\$275	38	3
\$250	35	2
\$225	31	2
\$200	28	2
\$175	24	2
\$150	21	1
\$125	17	1
\$100	14	1



**MOUNT ALOYSIUS COLLEGE  
PERSONAL DATA SHEET**

**HIGHEST EDUCATIONAL DEGREE ACHIEVED:**

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

Degree \_\_\_\_\_ Major \_\_\_\_\_ Date graduated \_\_\_\_\_

**CREDENTIALS VERIFICATION:**

Complete this section if you have a current professional certification, registration, and/or licensure. **Type-** indicate “**C**” for certification, “**R**” for registration, “**L**” for licensure. **Description** refers to what type of credential you have, i.e. Registered Nurse. **Number** refers to the certification number or license number or registration number.

TYPE	DESCRIPTION	Number	Expiration date (if applicable)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____





MOUNT ALOYSIUS COLLEGE  
CONFIDENTIALITY AGREEMENT

I, \_\_\_\_\_, understand and agree that as a condition of my employment at Mount Aloysius College, that I must at all times keep confidential, sensitive information to which I have access. This includes but is not limited to confidential information, that is pertinent to students and student records/files, employee and employee records/files, applicants for employment, donors and donor records/files, candidates for admission to the College, financial records/files and financial/budgets, grants, College strategic plans, Board of Trustee minutes and documents, academic program development and other such information, that if released to unauthorized individuals may be harmful to the interests of the College and/or individual persons.

I understand and agree to not divulge or publish to unauthorized persons inside and/or outside the College any confidential information obtained from observation, conversation, correspondence, surveys and/or other written records (to include electronic files) that are the property of the College.

I understand that in some cases I may be required to divulge confidential information in order to comply with governmental laws and regulations, or to conduct College business with individuals who have a right and need to know such information, or to comply with court ordered/subpoenaed requests for information.

I agree to review and abide by other confidential related policies and procedures of the College which include my assigned Department., Human Resources and Information Technology Departments, and to abide by applicable privacy protection laws and regulations.

I agree to defer to my assigned supervisor for guidance in situations when I am not confident as to the proper protocol or course of action relative to release of confidential information.

I understand that my failure to comply with this agreement may result in disciplinary action up to and including termination of employment, and/or criminal or civil prosecution. Student workers may also be subject to the College's judicial process.

I understand that this agreement is valid throughout my term of employment with the College and need not be renewed annually.

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Employee's Signature

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Date

**MOUNT ALOYSIUS COLLEGE**

**ACKNOWLEDGEMENT OF RECEIPT—WORKERS' COMPENSATION**

I have received a copy of the REPORTING OF ACCIDENTS POLICY & PROCEDURE and the attached PHYSICIAN PANEL LIST and acknowledge that I understand the provisions of said policy and procedure.

NAME \_\_\_\_\_

DEPARTMENT \_\_\_\_\_

DATE \_\_\_\_\_

SIGNATURE \_\_\_\_\_

*This signed and dated form must be returned to the Financial Aid Office.*

# MOUNT ALOYSIUS COLLEGE

## REPORTING OF ACCIDENTS

EFFECTIVE DATE: July 1, 2003

SUPERCEDES POLICY DATED: 7-1-02

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### **POLICY**

1. All employee on-the-job accidents must be reported. See procedure section on how to report an on-the-job accident. Students working for the College at the time of the accident are also required to report accidents using the same procedure.
2. Enclosed is the Injury/Illness Report Form that is used to report an accident and for further investigation of the accident.
3. Individuals requiring medical care are encouraged to do so. See procedure section on how to obtain medical care.
4. The Security Department is responsible to investigate all accidents and complete the corresponding section of the form, as well as completing the required OSHA logs.
5. The HR Department is responsible to submit accident reports to the College's designated workers' compensation insurance company.
6. If in the event an employee loses work time wages and/or sought medical attention, a claim will be processed. The insurance carrier is responsible to determine if the claim will be approved. The HR Department will provide assistance to the employee with all aspects of claims administration.
7. All new employees will be required to read and sign an acknowledgement form which includes information from the Pennsylvania Worker's Compensation Law about employee's rights and duties under section 306 (f.1(1)(i). New employees will also received a copy of this policy & procedure and a list of the medical providers. The HR Department is responsible to coordinate the distribution and filing of the acknowledgement form and to provide a copy of the same to the employee.
8. Many on-the-job accidents require only first aid treatment. If a first aid kit is not available in the department, one is available in the Security Department – first floor, St. Gertrude Hall, or the Student Health Services Department – second floor, St. Joseph's Hall.

### **PROCEDURE**

#### REPORTING OF ACCIDENTS:

1. Once an accident has occur the employee having the accident must immediately notify the Security Department at 886-6327. If the employee is not able to personally make contact, a fellow employee or supervisor, etc. is responsible to assist the employee and call Security.
2. A Security Officer will give the individual a form to complete and will investigate the accident, and/or assist in the completion of the form if the employee is not able to do so.
3. The Security Department then forwards the form to the HR Department.  
(Continued)

4. If a fatality has occurred, the employee's supervisor must notify the Security Department immediately in order for the College to report this to OSHA as required by law.

*OBTAINING MEDICAL ATTENTION:*

1. When an employee needs medical treatment, he/she must visit one of the physicians or health care providers on the list of designated panel providers (see enclosure), for up to a period of 90 days when necessary from the first visit to the physician or health care provider. The insurance company will NOT pay for services if the employee takes it upon him/herself to go to a non-designated panel provider without referral by a designated provider during the first 90-days from the date of the first of treatment.
2. After a 90 day period, if further treatment is necessary, the employee may choose to seek treatment from another licensed physician who is not on the panel.
3. In emergency situations, the employee should seek initial treatment at the nearest facility regardless of whether the facility is on the panel provider list.
4. The injured employee is responsible to keep the Human Resources Department informed of medical progress every two weeks until return to duty.

July 16, 2003

**MOUNT ALOYSIUS COLLEGE****NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES**

\*\*\*If you sustain an injury at work, you must report the injury to your employer immediately.

**FOR ASSISTANCE IN SCHEDULING APPOINTMENTS, PLEASE CALL  
SMARTCOMP TOLL FREE AT 1-877-362-3391**

<b>Name</b>	<b>Address</b>	<b>Phone #</b>	<b>Specialty</b>
Health Force Medicine	2613 Eighth Ave.-Ste. 1A Altoona, PA 16602 Location # 1-814-949-4244	1-877-362-3391	Occupational
Corporate Care Service- Dr.Alan MedicineStein	1450 Scalp Ave. Johnstown, PA 15904 Location # 1-814-266-8466	1-877-362-3391	Occupational
Western PA Orthopedics & Sports	2 Celeste Drive Johnstown, PA 15905 Location # 1-814-255-6781	1-877-362-3391	Orthopedics
Blair Orthopedic Associates- Drs. Gurman, Rowe, Welker, Harvey, Fulchiero, Port, Jenter, & Singer	3000 Fairway Drive Altoona, PA 16602 Location # 1-814-942-1166	1-877-362-3391	Orthopedics
Ophthalmic Associates	120 Main St. Johnstown, PA 15901 Location # 1-814-536-5343	1-877-362-3391	Ophthalmology
Dr. Richard Capriotti	1223 13 <sup>th</sup> Avenue Altoona, PA 16601 Location # 1-814-942-9081	1-877-362-3391	Ophthalmology
Dr. Ikram Haque	132 Walnut St. Johnstown, PA 15901 Location # 1-814-536-7194	1-877-362-3391	Neurosurgery
Central PA Neurosurgery Associates –Dr. Michael Moncman	1701 12 <sup>th</sup> Ave. Altoona, PA 16601 Location # 1-814-944-7810	1-877-362-3391	Neurosurgery
SmartComp PT Network	Call for Closest Location	1-877-362-3391	Physical Therapy
SmartComp MRI Network	Call for Closest Location	1-877-362-3391	MRI's
SmartComp Chiro Network	Call for Closest Location	1-877-362-3391	Chiropractic

**Employee's Rights and Duties under Section 306 (f.1(i))**

1. The employee has the duty to obtain treatment for work-related injuries and illnesses from one or more of the designated health care providers for 90 days from the date of the first visit to a designated provider.
2. The employee has the right to have all reasonable medical supplies and treatment related to the injury paid for by the employer as long as treatment is obtained from a designated provider during the 90-day period.
3. The employee has the right, during this 90-day period, to switch from one health care provider on the list to another provider on the list, and that all treatment shall be paid for by the employer.
4. The employee has the right to seek treatment from a referral provider if the employee is referred to him by a designated provider, and the employer shall pay for the treatment rendered by the referral provider.
5. The employee has the right to seek emergency medical treatment from any provider, but that subsequent non-emergency treatment shall be by a designated provider for the remainder of the 90-day period.
6. The employee has the right to seek treatment or medical consultation from a non-designated provider during the 90-day period, but that these services shall be at the employee's expense for the applicable 90 days.
7. The employee has the right to seek treatment from any health care provider after the 90-day period has ended, and that treatment shall be paid for by the employer, if it is reasonable and necessary.
8. The employee has the duty to notify the employer of treatment by a non-designated provider within five (5) days of the first visit to that provider. The employer may not be required to pay for treatment rendered by a non-designated provider prior to receiving this notification. However, the employer shall pay for these services once notified, unless the treatment is found to be unreasonable by a URO, under Subchapter C (relating to medical treatment review).
9. The employee has the right to seek an additional opinion from any health care provider of the employee's choice when a designated provider prescribes invasive surgery for the employee. If the additional opinion differs from the opinion of the designated provider and the additional opinion provides a specific and detailed course of treatment, the employee shall determine which course of treatment to follow. If the employee opts to follow the course of treatment outlined by the additional opinion, the treatment shall be performed by one of the health care providers on the employer's designated list for 90 days from the date of the first visit to the provider of the additional opinion.

**\*\*\*IN CASE OF MEDICAL EMERGENCY\*\*\***

Seek care at the closest hospital emergency room. In such situation, you or an immediate member must contact your supervisor or workers' compensation carrier as soon as possible.