This PDF document is optimized for use in Adobe Acrobat. Completion in a browser such as Chrome, Firefox, or Edge is not recommended.

This document is designed for single-sided paper printing.

CONSUMER DIRECT CARE NETWORK

Reset/clear all fields > Clear Form

CONSUMER DATA FORM

Consumer Information

Name in Program _____ _____ _____
First *Middle* *Last*

Consumer Physical Address _____
(Street address only. No PO Box. This is where service will be provided.)

City _____ **State** VA **Zip** _____ **County** _____

Phone _____ _____ **Email** _____
Home *Cell*

Medicaid ID _____ **Gender** ☐ Male ☐ Female

Date of Birth _____ **Social Security #** ____ - ____ - ____

Prior Fiscal Agent: ☐ Yes ☐ No – Is Consumer switching services to CDCN from another Fiscal Agent?

If yes, Agent Name: _____

Prior Employer of Record (EOR)?

☐ Yes ☐ No – Is Consumer switching their EOR? If yes, previous EOR name: _____

New Employer of Record (EOR) Information

EOR Relationship to Consumer ☐ Consumer (self) ☐ Other (describe): _____

Name on Social Security Card _____ _____ _____
First *Middle* *Last*

EOR Physical Address _____
(Street address only. No PO Box. This is where service will be provided.)

City _____ **State** _____ **Zip** _____ **County** _____

EOR Mailing Address *(Street or PO Box.)* _____

City _____ **State** _____ **Zip** _____

Phone _____ _____ _____
Home *Cell* *Fax*

Date of Birth _____ **Social Security #** ____ - ____ - ____ **Email** _____

Prior Accounts: ☐ Yes ☐ No – Does EOR have an existing Sole Proprietor or Household Employer business with established accounts? If yes, provide confirmation of your Employer Identification Number from the IRS (EIN Certification Letter 147C or EIN Confirmation Letter CP575).

Services Facilitator

Name _____

Phone _____ **Email** _____

CONSUMER DIRECT CARE NETWORK

Dear future Employer,

Welcome to Consumer Direct Care Network Virginia (CDCN). CDCN is the Fiscal/Employer Agent (F/EA) for the Virginia Department of Medical Assistance Services (DMAS), Fee-for- Service, Consumer-Directed Services Program. This packet contains information and forms, to establish you as an Employer. You will serve as the Employer of Record (EOR) for the attendants you hire. CDCN will pay and file payroll taxes for your attendants.

Once you complete the Enrollment Packet, please follow the steps below:

1. Register for online services. Our web portal is www.DirectMyCare.com. Here you manage payroll activities, approve time, and can view service authorizations.

2. Review Electronic Visit Verification (EVV) procedures. EVV is how your Attendants clock-in and clock-out for each shift they work. They must use an approved EVV method – the CellTrak Mobile App or Cell Trak IVR system.

   For EVV and DirectMyCare.com instructions and user guides, please visit https://www.consumerdirectva.com/training-materials/.

3. Hire Attendants. Each attendant must submit a New Hire Packet to CDCN. The electronic packet is available on the Forms Page of our website.

Questions? We are happy to help! Please call us at 1-888-444-8182 Monday-Friday from 8:00 a.m. to 6:00 p.m. and Saturday from 9:00 a.m. to 1:00 p.m., excluding federal holidays or email us at infocdva@consumerdirectcare.com

Important Contact Information

Phone

CDCN Customer Service Center	1-888-444-8182
Virginia Medicaid Fraud Hotline	1-800-371-0824
Adult Protective Services Hotline	1-888-832-3858
Child Protective Services Hotline	1-800-552-7096
CDCN Fax (Forms)	1-877-747-7764
CDCN Email (Forms/Correspondence)	InfoCDVA@consumerdirectcare.com
CDCN Web (Forms/Packets/Instructions/Training Materials)	www.ConsumerDirectVA.com
CDCN Web Portal (Pay Information/Time Approval)	https://DirectMyCare.com/

CONSUMER DIRECT CARE NETWORK

Checklist of Employer Enrollment Packet Forms to Submit to CDCN

(Forms are listed in the order they appear in the packet)

1. ☐ **Consumer Data Form**
   - *Consumer Information - Complete all fields.*
   - *Prior Employer of Record (EOR) - Check yes or no as to whether the Consumer is switching who serves as their EOR. If yes, enter the prior EOR's name.*
   - *New EOR Information - Complete all fields.*
   - *Services Facilitator Information - Enter Services Facilitator's name and contact information.*

2. ☐ **Employer of Record Attestation**
   - *Enter the Consumer's and EOR's name in the boxes on the top of the form.*
   - *EOR reads, signs and dates the Attestation form.*

3. ☐ **IRS Form SS-4**
   - *Line 1 - First Name, Middle Initial and Last Name followed by "HCSR". Example: John F Smith HCSR.*
   - *Line 5a and b - Enter physical address where the EOR lives. Not mailing address.*
   - *Line 6 - Enter County and State where the EOR lives.*
   - *Line 7a and b - Enter name as shown on Social Security Card. Enter Social Security number.*
   - *Line 11 - Enter the same date as signature date on bottom of form.*
   - *Line 18 - Check NO if you do not have an FEIN. If you do, check YES and enter the number.*
   - *Name and Title - Print name the same as line 1. Follow your name with the title of: "Home Care Service Recipient". Example: John F Smith Home Care Service Recipient.*
   - *Signature and Date - Sign your name and enter today's date at the bottom of the form. Signature must include First Name, Middle Initial and Last Name.*
   - *Applicant's telephone number - Enter your telephone number.*

4. ☐ **IRS Form 2678**
   - *Line 1 - If you have an existing FEIN, enter it on line 1. If you do not, leave line 1 blank.*
   - *Line 2 - First Name, Middle Initial and Last Name followed by "HCSR". Example: John F Smith HCSR.*
   - *Line 3 through 5 - No action required.*
   - *Sign your name here - Sign your name at the bottom of the form. Signature must include First Name, Middle Initial and Last Name.*
   - *Date - Enter date of signature.*
   - *Print your name here - First Name, Middle Initial and Last Name.*
   - *Print your title here - Enter title as "HCSR - Household Employer".*
   - *Best daytime phone - Enter your preferred telephone number.*

CONSUMER DIRECT CARE NETWORK

EMPLOYER OF RECORD ATTESTATION

Consumer Name	Employer of Record Name

Acknowledgements

As the Employer of Record (EOR), I will do the following:

1. Fill out all the forms required by Consumer Direct Care Network Virginia (CDCN).
2. Obtain a Federal Employer Identification Number. CDCN will help me with this.
3. Hire, train, and dismiss employees.
4. For each employee, I will:
   - Send new hire paperwork to CDCN.
   - Make sure they only work approved hours.
   - Make sure they do not work when the Consumer is in a hospital or nursing home.
   - Make sure they clock-in and clock-out for each shift worked using an approved Electronic Visit Verification (EVV) method.
5. Use the approved EVV manual exception process only as needed. The reasons an employee would need to adjust or correct a shift include:
   - The Attendant clocked-in or clocked-out at the wrong time.
   - The Attendant forgets to clock-in or clock-out.
   - The Attendant's phone or tablet was not working.
   - The Attendant did not have their phone or tablet.
   - The mobile app was not working.
   - The Consumer had an emergency.
   - The Attendant was a new enrollee and worked prior to being setup in CDCN's system.

   The manual exception process is not EVV compliant.
6. Report abuse, neglect, or exploitation of a Consumer to the Department of Social Services.
7. Wages are from federal and state funds. I can report suspected Medicaid fraud to the Virginia Medicaid Fraud Hotline. Reporting contact information is available on the CDCN website under the Resources/Fraud Prevention tab.

I understand that CDCN will serve as my fiscal agent for the purpose of payroll and payroll tax filing. I authorize CDCN to set up and manage tax accounts on my behalf with state and federal agencies. If needed, I authorize CDCN to make corrections to my SS-4 and 2678 forms prior to submitting them to the IRS. Corrections would be made based off of information provided on the Data Form or notification sent to CDCN by me.

Employer of Record, Printed Name	*Signature*	Date

Form **SS-4**
(Rev. December 2019)
Department of the Treasury
Internal Revenue Service

Application for Employer Identification Number

(For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.)
► Go to *www.irs.gov/FormSS4* for instructions and the latest information.
► See separate instructions for each line. ► Keep a copy for your records.

OMB No. 1545-0003

EIN

Type or print clearly.

1 Legal name of entity (or individual) for whom the EIN is being requested
HCSR

2 Trade name of business (if different from name on line 1)

3 Executor, administrator, trustee, "care of" name

4a Mailing address (room, apt., suite no. and street, or P.O. box)
100 Consumer Direct Way, Suite 303-VA

5a Street address (if different) (Don't enter a P.O. box.)

4b City, state, and ZIP code (if foreign, see instructions)
Missoula, MT 59808

5b City, state, and ZIP code (if foreign, see instructions)

6 County and state where principal business is located

7a Name of responsible party

7b SSN, ITIN, or EIN

8a Is this application for a limited liability company (LLC) (or a foreign equivalent)? . . . . . ☐ Yes ☑ No

8b If 8a is "Yes," enter the number of LLC members . . . . . ► **0**

8c If 8a is "Yes," was the LLC organized in the United States? . . . . . ☐ Yes ☑ No

9a **Type of entity** (check only one box). **Caution:** If 8a is "Yes," see the instructions for the correct box to check.

- ☐ Sole proprietor (SSN) _____
- ☐ Partnership
- ☐ Corporation (enter form number to be filed) ► _____
- ☐ Personal service corporation
- ☐ Church or church-controlled organization
- ☐ Other nonprofit organization (specify) ► _____
- ☑ Other (specify) ► **HCSR**
- ☐ Estate (SSN of decedent) _____
- ☐ Plan administrator (TIN) _____
- ☐ Trust (TIN of grantor) _____
- ☐ Military/National Guard ☐ State/local government
- ☐ Farmers' cooperative ☐ Federal government
- ☐ REMIC ☐ Indian tribal governments/enterprises

Group Exemption Number (GEN) if any ►

9b If a corporation, name the state or foreign country (if applicable) where incorporated | State | Foreign country

10 **Reason for applying** (check only one box)

- ☐ Started new business (specify type) ► _____
- ☐ Hired employees (Check the box and see line 13.)
- ☐ Compliance with IRS withholding regulations
- ☑ Other (specify) ► **HCSR**
- ☐ Banking purpose (specify purpose) ► _____
- ☐ Changed type of organization (specify new type) ► _____
- ☐ Purchased going business
- ☐ Created a trust (specify type) ► _____
- ☐ Created a pension plan (specify type) ► _____

11 Date business started or acquired (month, day, year). See instructions.

12 Closing month of accounting year **December**

13 Highest number of employees expected in the next 12 months (enter -0- if none). If no employees expected, skip line 14.

Agricultural	Household	Other
0	**0**	**0**

14 If you expect your employment tax liability to be $1,000 or less in a full calendar year **and** want to file Form 944 annually instead of Forms 941 quarterly, check here. (Your employment tax liability generally will be $1,000 or less if you expect to pay $5,000 or less in total wages.) If you don't check this box, you must file Form 941 for every quarter. ☐

15 First date wages or annuities were paid (month, day, year). **Note:** If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year) . . . . . ► **N/A**

16 Check **one** box that best describes the principal activity of your business.

☐ Health care & social assistance ☐ Wholesale-agent/broker
☐ Construction ☐ Rental & leasing ☐ Transportation & warehousing ☐ Accommodation & food service ☐ Wholesale-other ☐ Retail
☐ Real estate ☐ Manufacturing ☐ Finance & insurance ☑ Other (specify) ► **HCSR**

17 Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided.
HCSR

18 Has the applicant entity shown on line 1 ever applied for and received an EIN? ☐ Yes ☑ No
If "Yes," write previous EIN here ►

Third Party Designee

Complete this section **only** if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.

Designee's name: **Leigha Clairmont**
Designee's telephone number (include area code): **406-203-9877**
Address and ZIP code: **100 Consumer Direct Way, Suite 304, Missoula, MT 59808**
Designee's fax number (include area code): **406-532-8588**

Under penalties of perjury, I declare that I have examined this application, and to the best of my knowledge and belief, it is true, correct, and complete.
Name and title (type or print clearly) ► **Home Care Service Recipient**
Applicant's telephone number (include area code)
Applicant's fax number (include area code)
Signature ► Date ►

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 16055N Form **SS-4** (Rev. 12-2019)
05151

Form **2678** **Employer/Payer Appointment of Agent**

(Rev. August 2014) Department of the Treasury — Internal Revenue Service

OMB No. 1545-0748

Use this form if you want to request approval to have an agent file returns and make deposits or payments of employment or other withholding taxes or if you want to revoke an existing appointment.

- If you are an employer or payer who wants to request approval, complete Parts 1 and 2 and sign Part 2. Then give it to the agent. Have the agent complete Part 3 and sign it.

  Note. This appointment is not effective until we approve your request. See the instructions for filing Form 2678 on page 3.

- If you are an employer, payer, or agent who wants to revoke an existing appointment, complete all three parts. In this case, only one signature is required.

For IRS use:

Part 1: Why you are filing this form...

(Check one)

☑ You want to **appoint** an agent for tax reporting, depositing, and paying.

☐ You want to **revoke** an existing appointment.

Part 2: Employer or Payer Information: Complete this part if you want to appoint an agent or revoke an appointment.

1 Employer identification number (EIN) ☐☐ – ☐☐☐☐☐☐☐

2 Employer's or payer's name (not your trade name) HCSR

3 Trade name (if any)

4 Address

100 Consumer Direct Way (Number Street) Suite 303-VA (Suite or room number)

Missoula (City) MT (State) 59808 (ZIP code)

Foreign country name / Foreign province/county / Foreign postal code

5 Forms for which you want to appoint an agent or revoke the agent's appointment to file. (*Check all that apply.*)

	For ALL employees/ payees/payments	For SOME employees/ payees/payments
Form 940, 940-PR (Employer's Annual Federal Unemployment (FUTA) Tax Return)*	☐	☑
Form 941, 941-PR, 941-SS (Employer's QUARTERLY Federal Tax Return)	☐	☑
Form 943, 943-PR (Employer's Annual Federal Tax Return for Agricultural Employees)	☐	☐
Form 944, 944(SP) (Employer's ANNUAL Federal Tax Return)	☐	☐
Form 945 (Annual Return of Withheld Federal Income Tax)	☐	☐
Form CT-1 (Employer's Annual Railroad Retirement Tax Return)	☐	☐
Form CT-2 (Employee Representative's Quarterly Railroad Tax Return)	☐	☐

*Generally you cannot appoint an agent to report, deposit, and pay tax reported on Form 940, Employer's Annual Federal Unemployment (FUTA) Tax Return, unless you are a home care service recipient.

☑ Check here if you are a home care service recipient, and you want to appoint the agent to report, deposit, and pay FUTA tax for you. See the instructions.

I am authorizing the IRS to disclose otherwise confidential tax information to the agent relating to the authority granted under this appointment, including disclosures required to process Form 2678. The agent may contract with a third party, such as a reporting agent or certified public accountant, to prepare or file the returns covered by this appointment, or to make any required deposits and payments. Such contract may authorize the IRS to disclose confidential tax information of the employer/payer and agent to such third party. If a third party fails to file the returns or make the deposits and payments, the agent and employer/payer remain liable.

X **Sign your name here**

Print your name here

Print your title here HCSR - Household Employer

Date / /

Best daytime phone

Now give this form to the agent to complete.

CONSUMER DIRECT CARE NETWORK

2023 Payroll Calendar

Symbol Key: (◯) Pay Day (△) Postal and Bank Holiday

JANUARY

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	△2	3	4	5	◯6	7
8	9	10	11	12	13	14
15	△16	17	18	19	◯20	21
22	23	24	25	26	27	28
29	30	31				

FEBRUARY

Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1	2	◯3	4
5	6	7	8	9	10	11
12	13	14	15	16	◯17	18
19	△20	21	22	23	24	25
26	27	28				

MARCH

Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1	2	◯3	4
5	6	7	8	9	10	11
12	13	14	15	16	◯17	18
19	20	21	22	23	24	25
26	27	28	29	30	◯31	

APRIL

Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1
2	3	4	5	6	7	8
9	10	11	12	13	◯14	15
16	17	18	19	20	21	22
23	24	25	26	27	◯28	29
30						

MAY

Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1	2	3	4	5	6
7	8	9	10	11	◯12	13
14	15	16	17	18	19	20
21	22	23	24	25	◯26	27
28	△29	30	31			

JUNE

Sun	Mon	Tue	Wed	Thu	Fri	Sat
				1	2	3
4	5	6	7	8	◯9	10
11	12	13	14	15	16	17
18	△19	20	21	22	◯23	24
25	26	27	28	29	30	

JULY

Sun	Mon	Tue	Wed	Thu	Fri	Sat
						1
2	3	△4	5	6	◯7	8
9	10	11	12	13	14	15
16	17	18	19	20	◯21	22
23	24	25	26	27	28	29
30	31					

AUGUST

Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1	2	3	◯4	5
6	7	8	9	10	11	12
13	14	15	16	17	◯18	19
20	21	22	23	24	25	26
27	28	29	30	31		

SEPTEMBER

Sun	Mon	Tue	Wed	Thu	Fri	Sat
					◯1	2
3	△4	5	6	7	8	9
10	11	12	13	14	◯15	16
17	18	19	20	21	22	23
24	25	26	27	28	◯29	30

OCTOBER

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2	3	4	5	6	7
8	△9	10	11	12	◯13	14
15	16	17	18	19	20	21
22	23	24	25	26	◯27	28
29	30	31				

NOVEMBER

Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1	2	3	4
5	6	7	8	◯9	△10	11
12	13	14	15	16	17	18
19	20	21	22	△23	◯24	25
26	27	28	29	30		

DECEMBER

Sun	Mon	Tue	Wed	Thu	Fri	Sat
					1	2
3	4	5	6	7	◯8	9
10	11	12	13	14	15	16
17	18	19	20	21	◯22	23
24	△25	26	27	28	29	30
31						

2023 Bank & Post Office Holidays

*Consumer Direct Care Network office closures

- ***New Year's Day** - Monday, January 2
- ***Martin Luther King, Jr. Day** - Monday, January 16
- **Presidents Day** - Monday, February 20
- ***Memorial Day** - Monday, May 29
- ***Juneteenth** - Monday, June 19
- ***Independence Day** - Tuesday, July 4
- ***Labor Day** - Monday, September 4
- **Columbus Day** - Monday, October 9
- ***Veterans Day** - Friday, November 10
- ***Thanksgiving Day** - Thursday, November 23
- ***Christmas Day** - Monday, December 25

CONSUMER DIRECT CARE NETWORK

Work weeks are Thursday through Wednesday. You must submit time daily using Electronic Visit Verification (EVV). Corrections are due by the correction deadline. Late time or time with mistakes may result in late pay. Thank you!

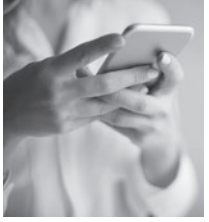
Two Week Pay Period		EVV Time Correction	Pay Date
Start Date	End Date	Deadline	
Thursday	Wednesday	Friday	Friday
12/15/2022	12/28/2022	12/30/2022	1/6/2023
12/29/2022	1/11/2023	1/13/2023	1/20/2023*
1/12/2023	1/25/2023	1/27/2023	2/3/2023
1/26/2023	2/8/2023	2/10/2023	2/17/2023*
2/9/2023	2/22/2023	2/24/2023	3/3/2023
2/23/2023	3/8/2023	3/10/2023	3/17/2023*
3/9/2023	3/22/2023	3/24/2023	3/31/2023
3/23/2023	4/5/2023	4/7/2023	4/14/2023*
4/6/2023	4/19/2023	4/21/2023	4/28/2023
4/20/2023	5/3/2023	5/5/2023	5/12/2023*
5/4/2023	5/17/2023	5/19/2023	5/26/2023
5/18/2023	5/31/2023	6/2/2023	6/9/2023
6/1/2023	6/14/2023	6/16/2023	6/23/2023*
6/15/2023	6/28/2023	6/30/2023	7/7/2023
6/29/2023	7/12/2023	7/14/2023	7/21/2023*
7/13/2023	7/26/2023	7/28/2023	8/4/2023
7/27/2023	8/9/2023	8/11/2023	8/18/2023*
8/10/2023	8/23/2023	8/25/2023	9/1/2023
8/24/2023	9/6/2023	9/8/2023	9/15/2023*
9/7/2023	9/20/2023	9/22/2023	9/29/2023
9/21/2023	10/4/2023	10/6/2023	10/13/2023*
10/5/2023	10/18/2023	10/20/2023	10/27/2023
10/19/2023	11/1/2023	11/3/2023	11/09/2023*†
11/2/2023	11/15/2023	11/17/2023	11/24/2023
11/16/2023	11/29/2023	12/1/2023	12/8/2023
11/30/2023	12/13/2023	12/15/2023	12/22/2023*
12/14/2023	12/27/2023	12/29/2023	1/5/2024

*If applicable, Patient Pay amount is subtracted from pay on these dates.

†Thursday.

Web: www.ConsumerDirectVA.com
Email: InfoCDVA@ConsumerDirectCare.com
Phone: 888-444-8182
Fax: 877-747-7764

CONSUMER DIRECT CARE NETWORK VIRGINIA



GETTING STARTED **WITH** Web Portal Registration

Q What is the name of the Consumer Direct Care Network web portal?

Direct My Care

Q Who needs to register?

Participants, Attendants, Designated Representatives, Employers of Record, and Service Facilitators

Q What does the web portal do?

DirectMyCare.com is your secure online website. It has payroll and management tools. Employers can use the web portal to approve submitted time and view reports.

Web portal time approval reasons:

- EOR was not available to sign the mobile app at the end of the shift.
- The shift was recorded using the CellTrak IVR.

Video tutorials on how EORs approve time can be found at **www.ConsumerDirectVA.com/training-materials.**

Q How do I register?

1. Open internet browser.
2. Go to DirectMyCare.com
3. Click on the **Register** button to open the registration page.
4. Enter your email address and click the **Send Verification Code** button.
5. Check your email for the verification code.
6. Enter the code into the verification box on the registration page.
7. Create a password.
8. Retype the same password.
9. Enter your first and last name into the boxes.
10. Select your role.
11. Choose VA for the state where service is provided.
12. Enter phone number.
13. Enter the last four digits of your Social Security Number.
14. Click the **Create** button to finish the registration process.

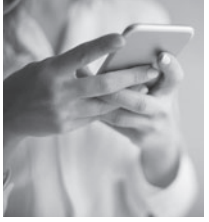
Q What if I need more help?

Go to www.ConsumerDirectVA.com/training-materials for step-by-step instructions.
Email Consumer Direct Care Network Virginia at infocdva@consumerdirectcare.com

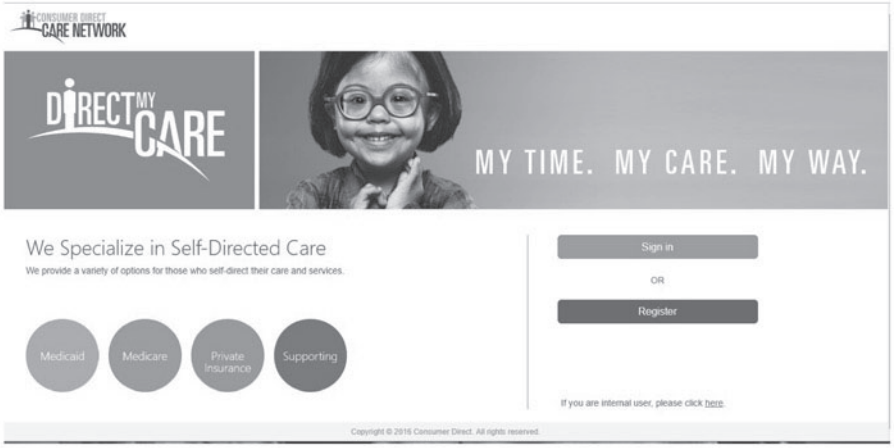
00540

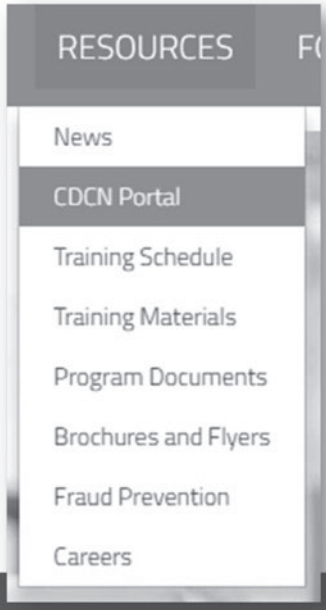
For additional information, please visit our training materials page at **www.ConsumerDirectVA.com/training-materials**

CONSUMER DIRECT CARE NETWORK VIRGINIA

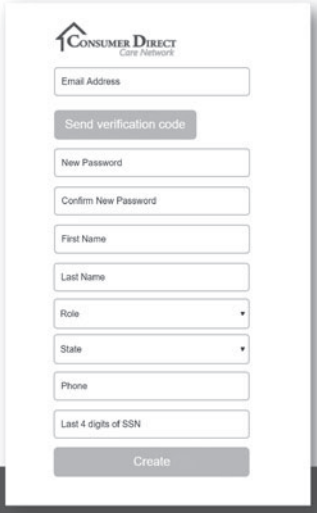


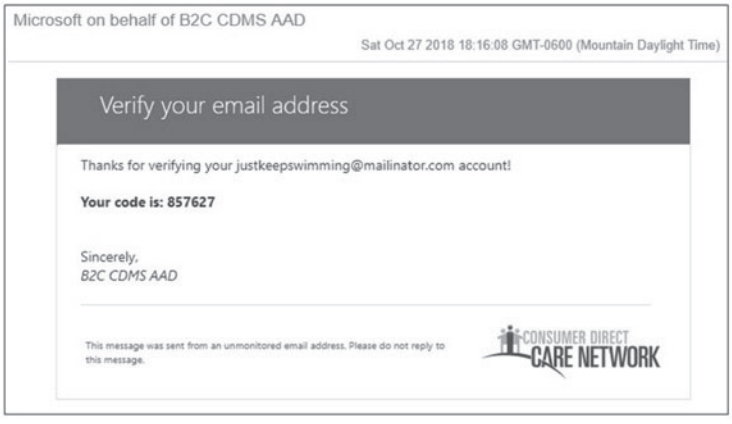
Web Portal Registration





Web Portal Registration Cont.





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For additional information, please visit our training materials page at **www.ConsumerDirectVA.com/training-materials**

CONSUMER DIRECT CARE NETWORK VIRGINIA

GETTING STARTED **WITH THE**

Mobile Application

FOR ELECTRONIC VISIT VERIFICATION

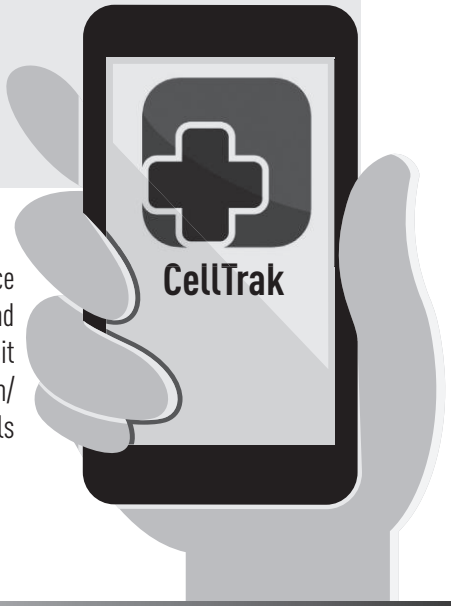
Q What is Electronic Visit Verification?

Electronic Visit Verification (EVV) is a way to record the date, time, and place that Attendants provide services.

Q Who should download the EVV mobile application?

Anyone can download the EVV mobile application. CellTrak requires an Attendant to be registered to only one device. If an Attendant provides service to multiple Participants at different addresses it is recommended that the Attendant use their own device.

Q What EVV mobile application does Consumer Direct Care Network use?



For a list of common device registration error codes and resolutions please visit www.ConsumerDirectVA.com/training-materials

Q How do I register?

1. Download CellTrak on your mobile device from the Apple App Store or Google Play Store. Type CellTrak in the search bar. When searching for CellTrak, you will see two applications: CellTrak and CellTrak 1.7.
   Download the application titled CellTrak.
2. Once downloaded, open the application to begin registration.
3. Enter following items for the initial steps:
   a. License ID: 200458
   b. Authentication Code: 740083
   c. Your mobile device's phone number
4. Once entered, click the **Acquire License** button at the bottom of the screen. This will bring you to the register user screen.
5. You will need your Consumer Direct Care Network ID for the next steps.
   a. Enter "CDVA-E-" followed by the attendant's 7-digit Consumer Direct Care Network ID (It looks like CDVA-E-3001234).
6. Enter your last name, a password, and select two challenge questions.
7. Click the **Register User** button at the bottom of the screen to complete the registration process.
8. To add multiple Attendants to one device:
   a. Click the three dots in the upper right corner of the screen.
   b. Click **Add Account.**
   c. Begin step three above to register your second Attendant.

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