Welcome to Consumer Direct Care Network (CDCN)! Please see the instructions below for filling out the Attendant Enrollment Packet. Images are included as examples for how to correctly fill out each document. Fields highlighted yellow are required in order to complete your enrollment.

1. Attendant Data Form (Figure 1).

Attendant Information Section

Name – enter the Attendant's First, Middle, and Last Name as shown on Social Security Card.

Physical Address – enter the Attendant's physical address.

Mailing Address – enter the Attendant's mailing address if it is different than the physical address.

Phone – enter if the Attendant has one.

Email – enter the Attendant's email address.

Date of Birth and Social Security Number – enter both.

Attendant Relationship to Consumer Questions – check yes or no to each question. If the Attendant checks yes to either question, the Attendant is not eligible to work under this program.

Employer Information Section

Name of EOR – enter EOR's full name.

EOR Phone and Email – enter both.

Name of Consumer – enter Consumer's full name.

Consumer Medicaid ID # - enter Consumer's 12-digit Medicaid ID number.

Age of Consumer – check whether the Consumer is an adult or minor.

Signature Section

Attendant and EOR sign and date the bottom of the form.

2. Payroll Tax Exemptions Determination (Figure 2).

Enter the Attendant's name, EOR's name, and Consumer's name in the boxes at the top of the form.

Check one Attendant-EOR relationship.

If you are the Parent of the EOR, check any additional statements that apply.

If you are the Child of the EOR, check one age description.

Attendant and EOR sign and date the bottom of the form.

3. Attendant-Consumer Live-in Determination (Figure 3).

Enter the Attendant's name, EOR's name, and Consumer's name in the boxes at the top of the form.

Check one living arrangement that best describes your situation.

If you live full time with the Consumer, also confirm your Difficulty of Care tax exemption status and provide proof of address.

Attendant and EOR sign and date the bottom of the form.

4. USCIS I-9 Employment Eligibility Verification

Section 1 (Figure 4).

- **Employee:** Complete Section 1 of Form I-9. This must be done no later than your first day of work for pay. Please print clearly, and sign and date when you are finished. Refer to figure 3 for detailed explanations.
- **Employer:** Review Section 1, ensuring your employee has completed it properly.

Section 2 (Figure 5).

- **Employee:** Present original, unexpired documents to your employer to verify your identity and authorization to work in the United States. The LIST OF ACCEPTABLE DOCUMENTS is found after the Form I-9.
- **Employer:** Examine the documents your employee provides and record them in Section 2. The employee must be present while you examine them. Refer to figure 4 for detailed explanations.

5. W-4 Employee's Withholding Allowance Certificate (Figure 6).

Step 1a – enter Attendant's first name, middle initial, last name, and physical address including city, state, and zip code

Step 1b – enter Attendant's social security number.

Step 1c – check your anticipated filing status. Leave blank if you are claiming exempt.

Steps 2 through 4 – complete only if they apply to you. Please reference the federal instructions starting on page 9 for additional information.

Step 5 – Attendant signs and dates.

6. VA-4 Employee's Virginia Income Tax Withholding Exemption Certificate (Figure 7).

Your Social Security Number – enter Attendant's social security number.

Name – enter Attendant's full name.

Street Address City, State, Zip Code – enter Attendant's full physical address.

Line 1 – complete only if the Attendant is subject to withholding. Use the Personal Exemptions Worksheet to identify the total number of exemptions that apply to the Attendant. Enter the total exemptions on Line 1c.

Line 2 – if the Attendant wants to have additional taxes withheld, enter the amount.

Line 3 – check the box only if the Attendant is not subject to Virginia withholding. A new Form VA-4 must be filed for each year for which the Attendant claims exemption from Virginia withholding.

Line 4 – check box if the Attendant qualifies for exemption under the Servicemember Civil Relief Act. If claiming this exemption, attach a copy of your spousal military identification card.

Note: One option must be completed for Line 1c, 3, and 4.

7. Pay Selection Form (Figure 8).

Enter the Attendant's name at the top of the form.

Select the preferred direct deposit option.

If the Attendant selects Direct Deposit to an Existing Account, enter the bank name, account type, and attach a bank-issued document that contains the routing and account numbers.

Attendant signs and dates bottom of the form.

8. Employment Agreement (Figure 9).

Enter the Attendant's name and EOR's name in the boxes at the top of the form.

Upon reading the Agreement, the Attendant and EOR sign and date the 3rd page.

9. Criminal History Record Name Search Request (Figure 10).

Name Information to be Searched Section

Last, First, Middle, and Maiden Name (if applicable) – enter Attendant information.

Race, Sex, Date of Birth, and Social Security # – complete all fields

Note: DMAS will pay for the search fee.

Affidavit for Release of Information Section

Signature – Attendant signs here.

Remainder of Section – have a notary fill out.

10. Child Protective Services Central Registry Release of Information Form (Figures 11 and 12).

Complete this form only if the Consumer is under the age of 18.

Part I – Attendant enters all applicable information including:

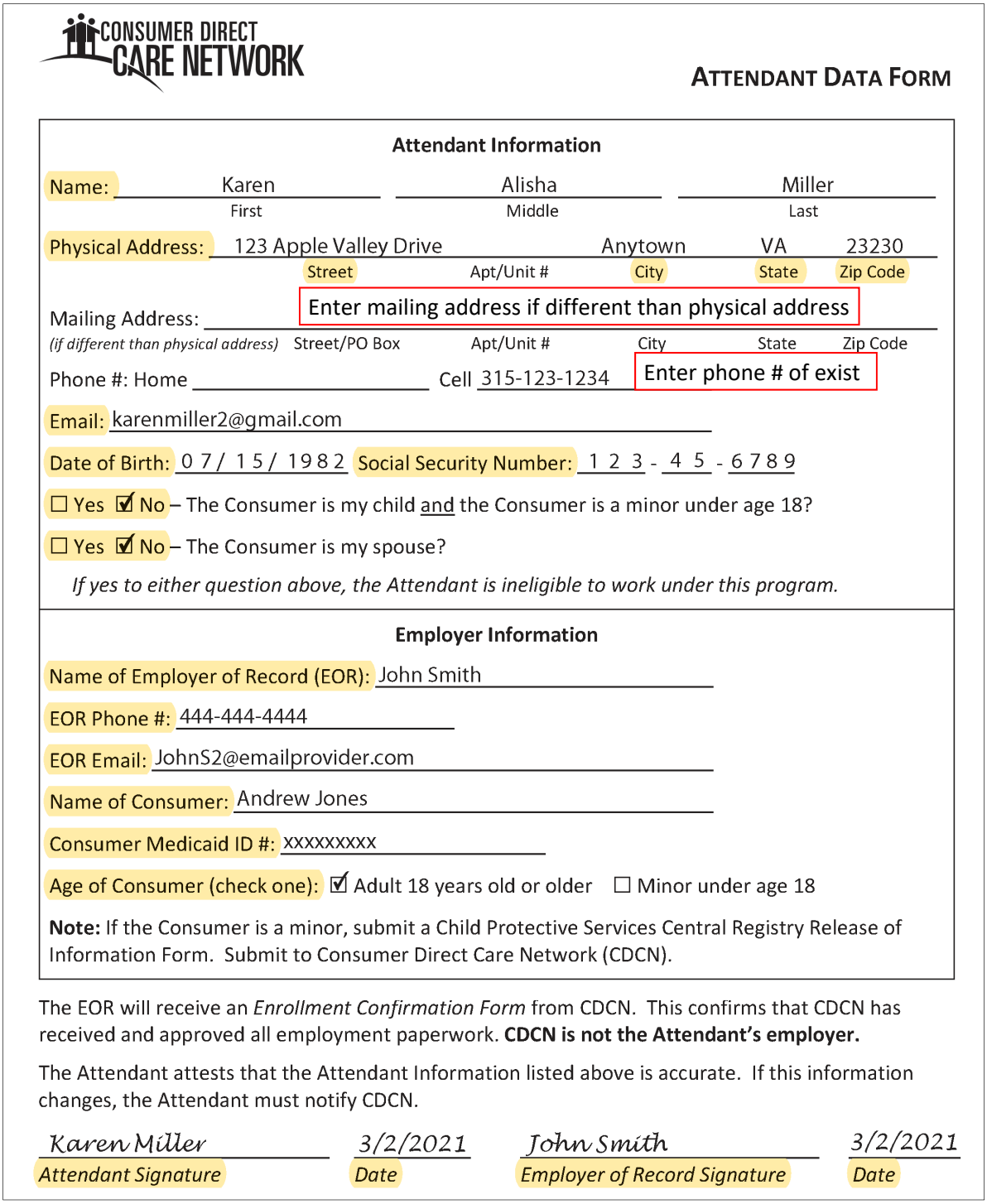
- Last name, first name, middle name, maiden name (if applicable).
- Sex, date of birth, race, driver's license/ID number, social security number, other names used.
- Current physical address including street, city, state, and zip.
- Prior Addresses – list all prior addresses that the Attendant resided at and include street address, city, state, zip code and the dates that the Attendant resided in that location.
- Marital Status – check the box that best defines the Attendant's current marital status. List all of the Attendant's current and previous spouse(s) and include each spouse's last name, first name, middle name, maiden name, race, sex, and date of birth.
- List all of the Attendant's children including the child's last name, first name, middle name, relationship, sex, and date of birth.

Part II – Attendant signs in the presence of a notary

Part III – Attendant has Notary complete all fields within this section.

Note: DMAS will pay for the search fee. **The original, notarized form must be mailed to CDCN;** submitting a photocopy of the release will delay enrollment.

Figure 1. Sample Attendant Data Form. Mandatory



CONSUMER DIRECT CARE NETWORK

ATTENDANT DATA FORM

Attendant Information

Name: Karen (First) Alisha (Middle) Miller (Last)

Physical Address: 123 Apple Valley Drive (Street) Anytown (City) VA (State) 23230 (Zip Code)

Mailing Address: Enter mailing address if different than physical address
(if different than physical address) Street/PO Box Apt/Unit # City State Zip Code

Phone #: Home _____ Cell 315-123-1234 Enter phone # of exist

Email: karenmiller2@gmail.com

Date of Birth: 07/15/1982 Social Security Number: 123-45-6789

☐ Yes ☑ No – The Consumer is my child and the Consumer is a minor under age 18?

☐ Yes ☑ No – The Consumer is my spouse?

If yes to either question above, the Attendant is ineligible to work under this program.

Employer Information

Name of Employer of Record (EOR): John Smith

EOR Phone #: 444-444-4444

EOR Email: JohnS2@emailprovider.com

Name of Consumer: Andrew Jones

Consumer Medicaid ID #: xxxxxxxxx

Age of Consumer (check one): ☑ Adult 18 years old or older ☐ Minor under age 18

Note: If the Consumer is a minor, submit a Child Protective Services Central Registry Release of Information Form. Submit to Consumer Direct Care Network (CDCN).

The EOR will receive an *Enrollment Confirmation Form* from CDCN. This confirms that CDCN has received and approved all employment paperwork. **CDCN is not the Attendant's employer.**

The Attendant attests that the Attendant Information listed above is accurate. If this information changes, the Attendant must notify CDCN.

Karen Miller — *Attendant Signature* | 3/2/2021 — *Date* | John Smith — *Employer of Record Signature* | 3/2/2021 — *Date*

Figure 2. Sample Payroll Tax Exemptions Determination Form Mandatory

CONSUMER DIRECT CARE NETWORK

PAYROLL TAX EXEMPTIONS DETERMINATION

Karen A Miller	John Smith	Andrew Jones
Attendant Name	Employer of Record (EOR) Name	Consumer Name

Background: Employees providing domestic services may be exempt from some payroll taxes. This is based on the Attendant's age and relationship to the Employer of Record (EOR). Consumer Direct Care Network (CDCN) will apply any exemptions based on the relationships identified below. **Incorrectly filling this form out may result in inaccurate tax withholdings.**

Note: If the Attendant and EOR qualify for tax exemptions, they must be taken. Exemptions cannot be waived. If the Attendant's earnings are exempt from these taxes, they may not qualify for related benefits. An example is unemployment insurance.

Attendant-Employer Relationship

*Attendant select **one** relationship below.*

☐ **I am the spouse of the Employer.** *Exempt from FICA[1], FUTA[2], and SUTA[3].*

☐ **I am the parent of the Employer.**

If parent checked, check any of the following that apply:

- ☐ I provide care for the EOR's child or stepchild that lives in the home.
- ☐ The EOR's child or stepchild is less than 18 years old or requires personal care of an adult for at least 4 straight weeks in 3 months.
- ☐ The EOR is a v…ut the spouse has a physical or medical condition that prevents them from caring for the child at least 4 straight weeks in 3 months.

Check each box that applies if you are the EORs parent.

Exempt from FUTA and SUTA. Subject to FICA if all three boxes checked above; else FICA exempt.

☐ **I am the child of the Employer.**

If child checked, check one option below:

Check one box for your age if you are the EOR's child.

- ☐ I am 21 years of age or older. *Subject to FICA, FUTA, and SUTA.*
- ☐ I am less than 21 years old. *Exempt from FICA, FUTA, and SUTA.*

☑ **I am not related to the Employer or my relationship is not described above.** *Subject to FICA, FUTA, and SUTA.*

Acknowledgement: The Attendant and EOR attest the exemptions listed above are accurate. If this information changes, the Attendant must notify CDCN. If CDCN is not notified of changes, the Attendant may have to pay back money that should have been withheld from pay.

Karen Miller	3/2/2021	John Smith	3/2/2021
Attendant Signature	*Date*	*Employer of Record Signature*	*Date*

Figure 3. Sample Attendant-Consumer Live-in Determination Form. Mandatory

CONSUMER DIRECT CARE NETWORK

ATTENDANT-CONSUMER LIVE-IN DETERMINATION

Karen A Miller	John Smith	Andrew Jones
Attendant Name	Employer of Record Name	Consumer Name

Attendant Care Workers may be exempt from overtime pay requirements and exempt from paying income taxes. Consumer Direct Care Network (CDCN) will apply exemptions based on your answers below.

Attendant-Consumer Live-in Status

*Attendant select **one** living arrangement below.*

1. ☐ **I live full time in the same house as the Consumer and have the same physical address.**

   If Checked Above:

   If you live full time with the Consumer, send proof of residence to CDCN and check Yes or No to declare your Difficulty of Care status.

   - **Send proof of resid**
     bank statement, credit card statement, utility bill, or phone bill.
   - ☐ Yes ☐ No **I attest that I qualify for IRS Difficulty of Care income tax exclusion**. *State and Federal income taxes will not be withheld from my pay. For more information please refer to https://www.irs.gov/pub/irs-drop/n-14-07.pdf*

   Note: Payroll withholding changes are applied at the beginning of the pay period following the processing of your request.

2. ☐ **I live temporarily, but for extended periods with the Consumer (at least 120 hours per week or 5 consecutive days or nights per week).**

3. ☑ **I live at a separate residence than the Consumer.**

Live-in Attendants *(1 or 2 above)*: You will be paid at the regular hourly rate for all hours worked. You are exempt from the overtime payment rate. You may submit time worked by Electronic Visit Verification (EVV) mobile application, Interactive Voice Response (IVR) or web portal.

Non Live-in Attendants *(3 above)*: Overtime hours worked will be paid at 1.5 times the regular pay rate. You must submit time worked through an approved EVV method.

Acknowledgement: The Attendant and Employer of Record agree the statements above are accurate. If living arrangements change, the Attendant must notify CDCN immediately as overtime and tax status will also change.

Karen Miller	3/2/2021	John Smith	3/2/2021
Attendant Signature	*Date*	*Employer of Record Signature*	*Date*

Figure 4. Sample Form I-9 Section 1. Mandatory

Employee (steps 1-9)

① Print your full legal name: Last, First and Middle Initial. Provide any other names used, such as maiden name. Enter "N/A" if you have never had another name.

② Print your physical address. Entering a PO Box is not allowed. Enter "N/A" if you have no apartment number.

③ Print your date of birth (mm/dd/yyyy).

④ Print your Social Security Number.

⑤ Print your email address or print "N/A" if you choose to not provide it.

⑥ Print your telephone number or print "N/A" if you choose to not provide it.

⑦ Check the one box that best describes your citizenship or immigration status in the United States.

⑧ Sign and print the date you completed the form. **No later than first day of work for pay.**

⑨ Check the box that indicates whether or not you were assisted by a preparer or translator.

Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►**START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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	Other Last Names Used *(if any)*
① Miller	Karen	A	N/A

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code
② 123 Apple Valley Drive		Anytown	VA	23230

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
③ 07/15/1982	④ 123-45-6789	⑤ karenmiller2@gmail.com	⑥ 315-123-1234

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

⑦
- [x] 1. A citizen of the United States
- [ ] 2. A noncitizen national of the United States *(See instructions)*
- [ ] 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____
- [ ] 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
  Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

⑧ Signature of Employee	Today's Date *(mm/dd/yyyy)*
Karen Miller	03/02/2021

Preparer and/or Translator Certification (check one):

⑨ [x] I did not use a preparer or translator. [ ] A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

Figure 5. Sample Form I-9 Section 2. Mandatory

Employer (steps 1-10)

① Print employee's name from Section 1: Last, First, and Middle Initial.

② Print citizenship/immigration status from Section 1.

③ Examine each document and note the details in the appropriate List column.

<u>one document from List A</u>

OR

<u>one from List B and one from List C</u>

Only accept unexpired, original documents (no photocopies).

④ Print the date of the employee's first day of work.

⑤ Sign the form.

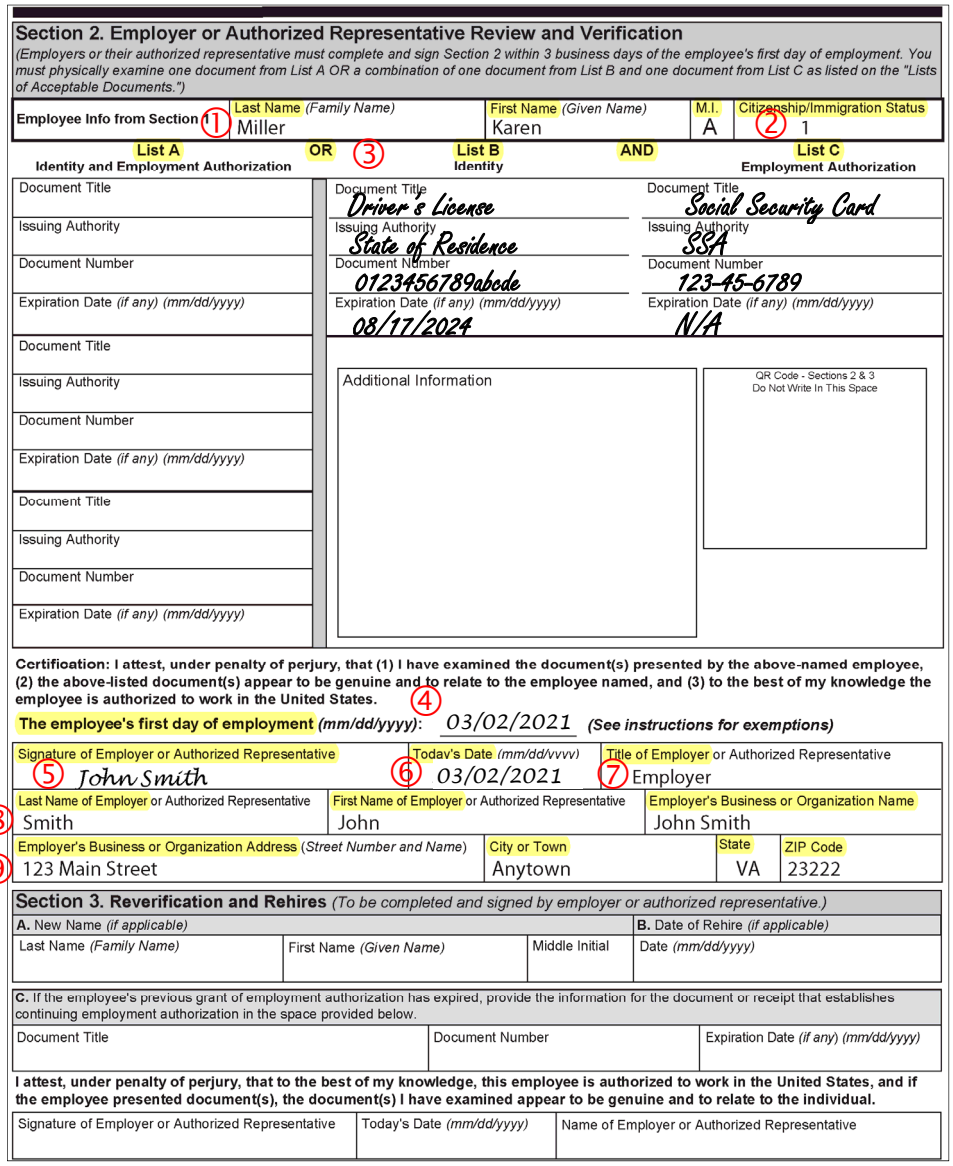
⑥ Print the date you signed the form. **Must be completed and signed within 3 days of employee's first day of work.**

⑦ Print your title as "Employer."

⑧ Print your last then first name.

⑨ Print your first and last name.

⑩ Print your physical address, city, state, and zip code.



Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
	① Miller	Karen	A	② 1

List A Identity and Employment Authorization	OR ③ List B Identity	AND List C Employment Authorization
Document Title	Document Title: Driver's License	Document Title: Social Security Card
Issuing Authority	Issuing Authority: State of Residence	Issuing Authority: SSA
Document Number	Document Number: 0123456789abcde	Document Number: 123-45-6789
Expiration Date (if any) (mm/dd/yyyy)	Expiration Date (if any) (mm/dd/yyyy): 08/17/2024	Expiration Date (if any) (mm/dd/yyyy): N/A
Document Title	Additional Information	QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority		
Document Number		
Expiration Date (if any) (mm/dd/yyyy)		
Document Title		
Issuing Authority		
Document Number		
Expiration Date (if any) (mm/dd/yyyy)		

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear 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.

④ **The employee's first day of employment** *(mm/dd/yyyy)*: 03/02/2021 ***(See instructions for exemptions)***

⑤ Signature of Employer or Authorized Representative	⑥ Today's Date (mm/dd/yyyy)	⑦ Title of Employer or Authorized Representative
John Smith	03/02/2021	Employer

⑧ Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
Smith	John	John Smith

⑨ Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code
123 Main Street	Anytown	VA	23222

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	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 document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

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

Figure 6. Sample W-4 Employee's Withholding Certificate. Mandatory

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

▶ 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

2021

Step 1: Enter Personal Information

(a) First name and middle initial: Karen, A
Last name: Miller
(b) Social security number: 123-45-6789

Address: 123 Apple Valley Drive
City or town, state, and ZIP code: Anytown VA, 23230

▶ **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 widow(er)**
☐ **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.)

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, when to use the estimator at *www.irs.gov/W4App*, and privacy.

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 co[illegible] from all of these jobs.

Complete steps 2 – 4 only if applicable.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **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 accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ▶ ☐

TIP: To be accurate, submit a 2021 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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 Dependents

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

Multiply the number of qualifying children under age 17 by $2,000 ▶ $

Multiply the number of other dependents by $500 . . . . ▶ $

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): 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. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

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

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.

Karen Miller
Employee's signature (This form is not valid unless you sign it.)

3/2/2021
Date

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

For Privacy Act and Paperwork Reduction Act Notice, see page 3. Cat. No. 10220Q Form **W-4** (2021)

Figure 7. Sample VA-4 Virginia Employee's Withholding Exemption Certificate. Mandatory

FORM VA-4

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF TAXATION

PERSONAL EXEMPTION WORKSHEET

(See back for instructions)

1. If you wish to claim yourself, write "1" 1
2. If you are married and your spouse is not claimed on his or her own certificate, write "1" .....
3. Write the number of dependents you will be allowed to claim on your income tax return (do not include your spouse) 0
4. Subtotal Personal Exemptions (add lines 1 through 3) 1
5. Exemptions for age
   - (a) If you will be 65 or older on January 1, write "1" .....
   - (b) If you claimed an exemption on line 2 and your spouse will be 65 or older on January 1, write "1" .....
6. Exemptions for blindness
   - (a) If you are legally blind, write "1" .....
   - (b) If you claimed an exemption on line 2 and your spouse is legally blind, write "1" .....
7. Subtotal exemptions for age and blindness (add lines 5 through 6) 0
8. Total of Exemptions - add line 4 and line 7 1

Detach here and give the certificate to your employer. Keep the top portion for your records

FORM VA-4 EMPLOYEE'S VIRGINIA INCOME TAX WITHHOLDING EXEMPTION CERTIFICATE

Your Social Security Number	Name	
123-45-6789	Karen A Miller	
Street Address		
123 Apple Valley Drive		
City	**State**	**Zip Code**
Anytown	VA	23230

COMPLETE THE APPLICABLE LINES BELOW

1. If subject to withholding, enter the number of exemptions claimed on:
   - (a) Subtotal of Personal Exemptions - line 4 of the Personal Exemption Worksheet 1
   - (b) Subtotal of Exemptions for Age and Blindness line 7 of the Personal Exemption Worksheet 0
   - (c) Total Exemptions - line 8 of the Personal Exemption Worksheet 1

Complete lines 1 – 4 as applicable.

2. Enter the amount of additional withholding requested (see instructions) 0
3. I certify that I am not subject to Virginia withholding. I meet the conditions set forth in the instructions ..... (check here) ☐
4. I certify that I am not subject to Virginia withholding. I meet the conditions set forth Under the Service member Civil Relief Act, as amended by the Military Spouses Residency Relief Act ..... (check here) ☐

Karen Miller — Signature

03/02/2021 — Date

Figure 8. Sample Pay Selection Form. Mandatory

CONSUMER DIRECT CARE NETWORK

PAY SELECTION FORM

Attendant Name: Karen A Miller Date of Birth: 07/15/1982

Consumer Direct Care Network (CDCN) issues pay by direct deposit. This is to a bank account or a pay card. Direct deposits avoid all possible delays from mail delivery. That helps you access your pay on pay day. Pay stubs (summaries) are available online through our secure web portal, DirectMyCare.com.

CDCN offers the following pay options. Please check one option below.
No selection will result in automatic enrollment in the Wisely Card option.

☐ **Direct Deposit to a Wisely Pay Card Account.** I authorize CDCN to issue me a Wisely Pay card. The card will be tied to my identification on file. CDCN will make payroll deposits to my card account. I will receive the card in about two weeks.

☑ **Direct Deposit to an Existing Checking, Savings or Pay Card Account.** I authorize CDCN to initiate payroll deposits to my bank or financial institution. Enter bank name and account type, if applicable.

The Name of my bank is: Farmers Bank

The Account Type is (check one): ☑ Checking. ☐ Savings. ☐ Pay Card.

AN ATTACHMENT IS REQUIRED.

For a Checking Account. Please attach a voided check. This is preferred.
A bank-issued direct deposit form or bank letter* is ok too.

For a Savings Account or Pay Card. Please attach a bank-issued direct deposit form or bank letter.*

**Do not submit a deposit slip*. *The routing numbers differ from direct deposit routing numbers.*

Acknowledgement. I authorize CDCN to process my selected method of pay. I understand that:

- CDCN reserves the right to refuse any direct deposit request.
- I am responsible to confirm that each deposit has occurred. I must pay any fees caused by overdrafts on my account.
- All direct deposits are made through an Automated Clearing House (ACH). Processing is subject to ACH terms. The terms of my bank also apply.
- If funds are deposited to my account in error, I authorize CDCN to debit my account to correct the error. If my account cannot be debited due to closure or insufficient balance, then CDCN may withhold future payments until the erroneous deposited amounts are repaid.
- I may receive a paper check while my selected method of pay is being set up.
- I must submit a new Pay Selection Form to CDCN if I wish to change my Direct Deposit option.

Karen Miller 3/2/2021

Attendant Signature *Date*

10601

Figure 9. Sample Employment Agreement. Mandatory

CONSUMER DIRECT CARE NETWORK

EMPLOYMENT AGREEMENT

Karen A Miller	John Smith
Attendant Name	Employer of Record Name

This Agreement is between the Attendant and Employer of Record (EOR) named above. It establishes the responsibilities of the parties to each other.

This Agreement will be effective when it is signed by both parties. Either party may terminate this Agreement. Notice to the EOR can be made orally or in writing. Notice must also be supplied to Consumer Direct Care Network Virginia (CDCN). The EOR must send a *Notice of Discontinued Employment Form*.

Attendant Acknowledgements

As the Attendant, I acknowledge the following:

Attestation

By signing below, the parties attest and agree that they:

- Have read and understand all program rules and responsibilities.
- Understand what is being requested.
- Must sign and return this Agreement.
- Will abide by the terms and conditions of this Agreement.

John Smith	John Smith	3/2/2021
Employer of Record, Printed Name	*Signature*	Date
Karen A Miller	Karen Miller	3/2/2021
Attendant, Printed Name	*Signature*	Date

Figure 10. Sample Criminal History Record Name Search Request. Mandatory

SP-167 (Revised 12-01-2012)

CRIMINAL HISTORY RECORD NAME SEARCH REQUEST

PURPOSE OF THIS REQUEST (Check only one):

☐ DOMESTIC ADOPTION ☐ INTERNATIONAL ADOPTION _____ (COUNTRY)

☐ VISA (INTERNATIONAL TRAVEL) ☑ OTHER (please specify) Employment Screening

NAME INFORMATION TO BE SEARCHED:

LAST NAME	FIRST NAME	MIDDLE NAME	MAIDEN NAME
Miller	Karen	Alisha	

RACE	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER
White	F	07/15/1982 (MM/DD/YYYY)	123-45-6789

AFFIDAVIT FOR RELEASE OF INFORMATION:

I hereby give consent and authorize the Virginia State Police to search the files of the Central Criminal Records Exchange for a criminal history record and report the results of such search to the agent or individual authorized in this document to receive same.

Sign here in front of a Notary Public

_____
Signature

State of _____ ☐ County ☐ City of _____; to wit: Subscribed and sworn to before me on: _____ (MM/DD/YYYY)

_____ My commission expires: _____ My registration # is: _____
Signature of Notary Public

SIGNATURE OF PERSON MAKING REQUEST:

As provided in Section 19.2-389, Code of Virginia, I hereby request the criminal history record of the individual named above and swear or affirm I have the consent of the individual to obtain their record and will not further disseminate the information received, except as provided by law.

_____
Signature of Individual Making Request

State of _____ ☐ County ☐ City of _____; to wit: Subscribed and sworn to before me on: _____ (MM/DD/YYYY)

_____ My commission expires: _____ My registration # is: _____
Signature of Notary Public

NAME AND MAILING ADDRESS OF AGENCY, INDIVIDUAL OR AUTHORIZED AGENT MAKING REQUEST:

Mail Reply To:

NAME: Consumer Direct Care Network Virginia, LLC
ATTENTION: Virginia Consumer-Directed Services Program
ADDRESS: 6802 Paragon Place, Suite 430
CITY: Richmond STATE: VA ZIP CODE: 23230

FEES FOR SERVICE:

☑ $15.00 CRIMINAL HISTORY SEARCH
☐ $20.00 COMBINATION CRIMINAL HISTORY & SEX OFFENDER SEARCH

* FEES For Volunteers with Non-Profit Organizations:
☐ $8.00 CRIMINAL HISTORY SEARCH
☐ $16.00 COMBINATION CRIMINAL HISTORY & SEX OFFENDER SEARCH

* To be entitled to reduced price, services must be on volunteer basis for a non-profit organization with a tax exempt number. Attach documentation to form which supports volunteer status and include organization's name, address, and the tax exempt identification number.

METHOD OF PAYMENT: (Note: Personal Checks Not Accepted)

☐ Business or Certified check or Money order (payable to Virginia State Police)

CHARGE CARD: ☐ MasterCard OR ☐ Visa

Account Number: ____ - ____ - ____ - ____ Expiration: ____/____

Signature of Cardholder: _____

☐ Virginia State Police Charge Account Number: _____

Mail Request To:

Virginia State Police
Central Criminal Records Exchange – NF
P. O. Box 85076
Richmond, Virginia 23261-5076

ATTN: NEW FORM

FOR STATE POLICE USE ONLY – DO NOT WRITE BELOW THIS LINE

Response based on comparison of name information submitted in request against a master name index maintained in the Central Criminal Records Exchange only.

☐ No Conviction Data – Does Not Preclude the Existence of an Arrest Record
☐ No Criminal Record – Name Search Only ☐ No Criminal Record – Fingerprint Search
☐ No Sex Offender Registration Record ☐ Criminal Record Attached

Date: _____ By CCRE/ _____

Purpose code: ☐ C ☐ N ☐ O

Figure 11. Sample Child Protective Services Central Registry Release of Information. (Part I) Mandatory

VA Department of Social Services
Office of Background Investigations – Search Unit
801 East Main Street, 6th Floor, Richmond, VA 23219-2901

Central Registry Release of Information Form

Search Fee $10.00

Purpose of Search, Check one: ☐ Adam Walsh Law ☐ Adoptive Parent ☐ Babysitter/Family Day Care ☐ CASA ☐ Children's Residential Facility ☐ Custody Evaluation ☐ Day Care Center ☐ Foster Parent ☐ Institutional Employee ☑ Other Employment ☐ School Personnel ☐ Volunteer ☐ Other

MAIL SEARCH RESULTS TO: Agency, Individual or Authorized Agent Requesting Search

Name	Consumer Direct Care Network Virginia, LLC
Address	6802 Paragon Place, Suite 430
City / State / Zip	Richmond / VA / 23230
Contact Name / Tel.#	CDCN Representative / 888-444-8182Ext
Contact E-Mail	InfoCDVA@ConsumerDirectCare.com

Payment/FIPS Code (Use only if assigned by OBI-CRU)
B11226
Mandatory if agency code has been assigned

PART I: DETAILS OF INDIVIDUAL WHOSE NAME MUST BE SEARCHED

Last Name	First Name	Full Middle Name – (given at birth) - No initials (if middle name is an initial, indicate "Initial Only")
Miller	Karen	Alisha

Maiden Name (last name before marriage)	Sex	Date of Birth (MM/DD/YYYY)	Race
Smith	☐ Male ☑ Female	07/15/1982	White

Driver's License Number or ID #	Social Security Number	Other names used; nicknames, legal names (refer to instruction page)
12345678910111213	123-45-6789	Karen Johnson

Current Address (Include Street # and Apt #)	City	State	Zip
123 Apple Valley Drive	Anytown	VA	23230

Applicant's Prior Addresses

Include Street # and Apt #	City	State	Zip	Start Date (MM/YY)	End Date (MM/YY)
456 Orange Valley Drive	Anytown	VA	23230	01/2000	01/2010

Marital Status ☐ Single ☑ Married ☐ Divorced ☐ Widowed ☐ Partner

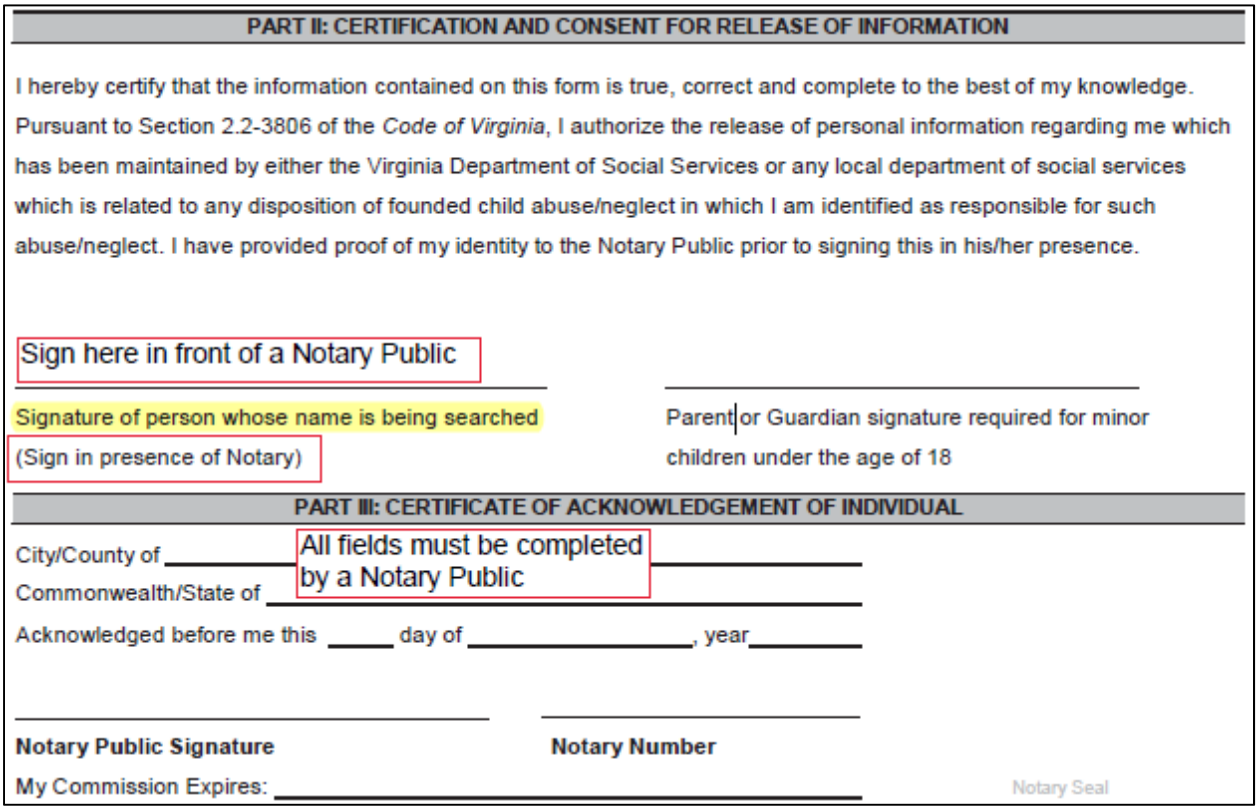
If married, list current spouse. If previously married, list all previous spouses. If you have never been married, write 'N/A'.

Last Name	First Name	Full Middle Name (given at birth)	Maiden Name	Race	Sex	Date of Birth (MM/DD/YYYY)
Miller	Tom	Timothy	N/A	White	☑ Male ☐ Female	1/1/1980
Johnson	Anthony	Alex	N/A	White	☑ Male ☐ Female	3/3/1985
					☐ Male ☐ Female	

List all of your children. If you have none, write **'N/A'.** Include all adult children, step and foster children not living with you.

Last Name	First Name	Full Middle Name (given at birth)	Relationship	Sex	Date of Birth (MM/DD/YYYY)
Miller	Alex	Brady	Son	☑ Male ☐ Female	1/1/2009
				☐ Male ☐ Female	
				☐ Male ☐ Female	

Figure 12. Sample Child Protective Services Central Registry Release of Information. (Part II & III) Mandatory



PART II: CERTIFICATION AND CONSENT FOR RELEASE OF INFORMATION

I hereby certify that the information contained on this form is true, correct and complete to the best of my knowledge. Pursuant to Section 2.2-3806 of the *Code of Virginia*, I authorize the release of personal information regarding me which has been maintained by either the Virginia Department of Social Services or any local department of social services which is related to any disposition of founded child abuse/neglect in which I am identified as responsible for such abuse/neglect. I have provided proof of my identity to the Notary Public prior to signing this in his/her presence.

Sign here in front of a Notary Public

Signature of person whose name is being searched (Sign in presence of Notary)

Parent or Guardian signature required for minor children under the age of 18

PART III: CERTIFICATE OF ACKNOWLEDGEMENT OF INDIVIDUAL

All fields must be completed by a Notary Public

City/County of _____

Commonwealth/State of _____

Acknowledged before me this _____ day of _____, year _____

Notary Public Signature **Notary Number**

My Commission Expires: _____ Notary Seal