

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** _____ **Zip** _____ **County** _____

Phone _____
 Home

_____ **Email** _____
 Cell

We may reach out to you via SMS/Text Messaging concerning your services with CDCN. Please note that CDCN will never request sensitive personal information, such as your Social Security Number, banking details, address, or date of birth through text messages. If you receive an SMS message from CDCN and would like to opt-out from future SMS messages, please respond to the initial message with "STOP"

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** _____





Dear future Employer,

Welcome to Consumer Direct Care Network Virginia (CDCN). CDCN is the Fiscal/Employer Agent (F/EA) for the consumer's enrolled in Consumer-Directed Services Programs. 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, CDCN will send you additional instructions to:

1. Log into our web portal. 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 CareAttend Mobile App or 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 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

CDCN Customer Service Center

DMAS Services.....1-888-444-8182

Aetna Better Health of Virginia Services.....1-888-444-2418

Sentara Health Plans Services.....1-888-444-2419

Molina.....1-888-444-2717

Phone

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/>



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 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. Recruit, interview, hire, train, manage and dismiss employees. Resources are available in the *Consumer-Directed Employer of Record Manual* to help me with these responsibilities.
4. For each employee, I will:
 - Send new hire paperwork to CDCN.
 - Make sure they only work approved hours. I am liable for paying all wages and expenses for shifts that:
 - Exceed the amount approved in the Consumer's plan of care
 - Result in an employee working unapproved overtime; and/or
 - Are not submitted according to the 30 day shift submission rule.
 - Make sure they do not work when the Consumer is in a hospital or nursing home.
 - Make sure they do not work more than 16 hours within one day.
 - Make sure they clock-in and clock-out for each shift worked using the CareAttend app or Interactive Voice Response (IVR).
 - Make sure they document daily tasks performed during each shift regardless of live in status.
 - Make sure they submit shifts with 30 calendar days from the date of service.
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 Attendant lives with the Consumer.

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

10598



Application for Employer Identification Number

(For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.)

See separate instructions for each line. Keep a copy for your records.

Go to www.irs.gov/FormSS4 for instructions and the latest information.

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. <table><tr><td>Agricultural</td><td>Household</td><td>Other</td></tr><tr><td>0</td><td>0</td><td>0</td></tr></table>		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 will generally be \$1,000 or less if you expect to pay \$5,000 or less, \$6,536 or less if you're in a U.S. territory, in total wages.) If you don't check this box, you must file Form 941 for every quarter. ☐
Agricultural	Household	Other						
0	0	0						
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. ☐ Construction ☐ Rental & leasing ☐ Transportation & warehousing ☐ Health care & social assistance ☐ Wholesale—agent/broker ☐ Real estate ☐ Manufacturing ☐ Finance & insurance ☐ Accommodation & food service ☐ Wholesale—other ☐ Retail ☒ 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 Madison Haynes Address and ZIP code 100 Consumer Direct Way, Suite 304, Missoula, MT 59808	Designee's telephone number (include area code) 406-532-8502 ext. 8 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.		Applicant's telephone number (include area code)						
Name and title (type or print clearly) Home Care Service Recipient		Applicant's fax number (include area code)						
Signature _____		Date _____						



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

(Rev. December 2024) Department of the Treasury — Internal Revenue Service

OMB No. 1545-0029

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're 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 isn't effective until we approve your request. See the instructions for more information.

- If you're 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're 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)**

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

--

3 Trade name (if any)

--

4 Address

Number	Street	Suite or room number
City	State	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, Employer's Annual Federal Unemployment (FUTA) Tax Return* (all 940 series)	☐	☐
Form 941, Employer's QUARTERLY Federal Tax Return (all 941 series)	☐	☐
Form 943, Employer's Annual Federal Tax Return for Agricultural Employees (all 943 series)	☐	☐
Form 944, Employer's ANNUAL Federal Tax Return (all 944 series)	☐	☐
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 can't appoint an agent to report, deposit, and pay tax reported on Form 940, unless you're a home care service recipient.

- ☐ Check here if you're 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.

Sign your name here

--

Print your name here

--

Print your title here

--

Date

/	/
---	---

Best daytime phone

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Now give this form to the agent to complete.

2025 Payroll Calendar



Symbol Key:



Pay Day



Postal and Bank Holiday

JANUARY							FEBRUARY							MARCH						
Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1	2	3	4							1							1
5	6	7	8	9	10	11	2	3	4	5	6	7	8	2	3	4	5	6	7	8
12	13	14	15	16	17	18	9	10	11	12	13	14	15	9	10	11	12	13	14	15
19	20	21	22	23	24	25	16	17	18	19	20	21	22	16	17	18	19	20	21	22
26	27	28	29	30	31		23	24	25	26	27	28		23	24	25	26	27	28	29
														30	31					
APRIL							MAY							JUNE						
Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1	2	3	4	5					1	2	3	1	2	3	4	5	6	7
6	7	8	9	10	11	12	4	5	6	7	8	9	10	8	9	10	11	12	13	14
13	14	15	16	17	18	19	11	12	13	14	15	16	17	15	16	17	18	19	20	21
20	21	22	23	24	25	26	18	19	20	21	22	23	24	22	23	24	25	26	27	28
27	28	29	30				25	26	27	28	29	30	31	29	30					
JULY							AUGUST							SEPTEMBER						
Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1	2	3	4	5						1	2		1	2	3	4	5	6
6	7	8	9	10	11	12	3	4	5	6	7	8	9	7	8	9	10	11	12	13
13	14	15	16	17	18	19	10	11	12	13	14	15	16	14	15	16	17	18	19	20
20	21	22	23	24	25	26	17	18	19	20	21	22	23	21	22	23	24	25	26	27
27	28	29	30	31			24	25	26	27	28	29	30	28	29	30				
							31													
OCTOBER							NOVEMBER							DECEMBER						
Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1	2	3	4							1		1	2	3	4	5	6
5	6	7	8	9	10	11	2	3	4	5	6	7	8	7	8	9	10	11	12	13
12	13	14	15	16	17	18	9	10	11	12	13	14	15	14	15	16	17	18	19	20
19	20	21	22	23	24	25	16	17	18	19	20	21	22	21	22	23	24	25	26	27
26	27	28	29	30	31		23	24	25	26	27	28	29	28	29	30	31			
							30													

2025 Bank & Post Office Holidays

*Consumer Direct Care Network office closures

***New Year's Day** - Wednesday, January 1

***Martin Luther King, Jr. Day** - Monday, January 20

Presidents Day - Monday, February 17

***Memorial Day** - Monday, May 26

***Juneteenth** - Thursday, June 19

***Independence Day** - Friday, July 4

***Labor Day** - Monday, September 1

Indigenous Peoples Day - Monday, October 13

***Veterans Day** - Tuesday, November 11

***Thanksgiving Day** - Thursday, November 27

***Christmas Day** - Thursday, December 25

00540





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	
Start Date	End Date	Deadline	Pay Date
Thursday	Wednesday	Friday	Friday
12/12/2024	12/25/2024	12/27/2024	1/3/2025
12/26/2024	1/8/2025	1/10/2025	1/17/2025*
1/9/2025	1/22/2025	1/24/2025	1/31/2025
1/23/2025	2/5/2025	2/7/2025	2/14/2025*
2/6/2025	2/19/2025	2/21/2025	2/28/2025
2/20/2025	3/5/2025	3/7/2025	3/14/2025*
3/6/2025	3/19/2025	3/21/2025	3/28/2025
3/20/2025	4/2/2025	4/4/2025	4/11/2025*
4/3/2025	4/16/2025	4/18/2025	4/25/2025
4/17/2025	4/30/2025	5/2/2025	5/9/2025*
5/1/2025	5/14/2025	5/16/2025	5/23/2025
5/15/2025	5/28/2025	5/30/2025	6/6/2025*
5/29/2025	6/11/2025	6/13/2025	6/20/2025
6/12/2025	6/25/2025	6/27/2025	7/3/2025*
6/26/2025	7/9/2025	7/11/2025	7/18/2025
7/10/2025	7/23/2025	7/25/2025	8/1/2025*
7/24/2025	8/6/2025	8/8/2025	8/15/2025
8/7/2025	8/20/2025	8/22/2025	8/29/2025*
8/21/2025	9/3/2025	9/5/2025	9/12/2025
9/4/2025	9/17/2025	9/19/2025	9/26/2025*
9/18/2025	10/1/2025	10/3/2025	10/10/2025
10/2/2025	10/15/2025	10/17/2025	10/24/2025*
10/16/2025	10/29/2025	10/31/2025	11/7/2025
10/30/2025	11/12/2025	11/14/2025	11/21/2025*
11/13/2025	11/26/2025	11/28/2025	12/5/2025
11/27/2025	12/10/2025	12/12/2025	12/19/2025*
12/11/2025	12/24/2025	12/26/2025	1/2/2026

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

Web: www.ConsumerDirectVA.com

Email: InfoCDVA@ConsumerDirectCare.com

DMAS: 888.444.8182

Aetna: 888.444.2418

Sentara Health Plans: 888.444.2419

Molina: 888.444.2717

Fax: 877-747-7764

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