CONSUMER DIRECT CARE NETWORK

CONSUMER DATA FORM

Consumer Information

Name on Social Security Card Required (First) If applicable (Middle) Required (Last)

Consumer Name in Program Required (First) If applicable (Middle) Required (Last)

Street Address Required

(Physical address where services will be provided. No PO Box.)

City Required **State** Req **Zip** Req **County** Required

Phone If applicable (Home) If applicable (Cell) If applicable (Fax)

Medicaid ID Required **Gender** ☐ Male ☐ Female ← Check One

Date of Birth Required **Social Security #** Required **Email** If applicable

Employer of Record (FEIN Holder) Information

Relationship to Consumer ☐ Consumer (self) ☐ Parent of minor ☐ Legal Guardian ☐ Other: If "Other" checked ← Check One

Name Required (First) If applicable (Middle) Required (Last)

Street Address Required

City Required **State** Req **Zip** Req **County** Required

Phone If applicable (Home) _____ (Cell) _____ (Fax)

Date of Birth Required **Social Security #** Required **Email** _____

☐ Yes ☐ No - Will a guardian sign enclosed Federal and State tax forms on the FEIN holder's behalf? If yes, enter guardian name; AND **attach court-appointed guardianship paperwork**.

Check One ↑

Guardian Name If Yes checked (First) ___ (MI) If Yes checked (Last)

Service Facilitator

Service Facilitator Name Required ID Number _____

Phone _____ Email _____

Prior Relationships/Business Accounts

1. ☐ Yes ☐ No – Is Consumer switching FEIN holders? If yes, previous FEIN holder name: If Yes checked
2. ☐ Yes ☐ No – Are Prior Business Accounts established? If yes, enter account information:

Check One Each ↑

___ - If Yes these fields are recommended if information is known.
(FEIN) (VA Business Acct #) (VA Unemployment Acct #) (SUTA Rate)

3. **Budget/Auth Start Date or Reactivation Start Date:** Required

CONSUMER DIRECT CARE NETWORK

CONSUMER DATA FORM

Enrollment Questions

Please answer the questions below. Consumer Direct Care Network will setup federal and state accounts in your name. Please be sure to answer the questions correctly. If you are unsure of the answer, please write "unknown" or "unsure".

Question for the Consumer named on page 1 of this form.

1. Have you ever been enrolled in a Medicaid program with another Fiscal Agent/Provider?
   ☐ Yes ☐ No ← Check One
   a. If yes:
      i. Name of the Fiscal Agent/Provider: If Yes checked _____
      ii. When were you with the Fiscal Agent/Provider: If Yes checked _____

Questions for the Employer of Record (FEIN holder) named on page 1 of this form.

1. Name on your most recently received Social Security Card: Required _____
2. Number on your most recently received Social Security Card: Required _____
3. Have you gone by any other name(s) in the past which aren't shown on your current Social Security Card?
   ☐ Yes ☐ No ← Check One
   a. If yes, please list your other name(s): If Yes checked _____
   _____
   b. Please list when your other name(s) were used: If Yes checked _____
   _____
4. Were you ever previously assigned an Federal Employer Identification Number (FEIN) by the IRS for any business previously operated/owned?
   ☐ Yes ☐ No ← Check One
   a. If yes and known:
      i. Please list the previously assigned FEIN: If Yes checked _____
      ii. What was the business for? If Yes checked _____
      iii. Is the business still active? ☐ Yes ☐ No ← If Yes checked above, Check One

Employer of Record Signature: Required _____ Date: Required _____

The Consumer-Directed Services Program does not discriminate against any person on the basis of race, religion, color, gender, sexual orientation, age, national origin, disability, veteran status or any other status or condition protected by law.

CONSUMER DIRECT CARE NETWORK

CONSUMER ENROLLMENT CHECKLIST

Required	Required
Consumer Name	Employer of Record (EOR) Name

Welcome to Consumer Direct Care Network (CDCN)!

Please complete the forms in the lists below. All forms need to be completed. Check off each item upon completion. If you would like a paper copy of these forms, please let us know and we will return copies to you.

CDCN and Tax Forms

1. ☐ Consumer Data Form
2. ☐ Consumer Enrollment Checklist (this form)
3. ☐ Employer of Record Attestation
4. ☐ SS-4 Application for Employer Identification Number (EIN)
5. ☐ 2678 Employer/Payer Appointment of Agent
6. ☐ PAR 101 Virginia Power of Attorney and Declaration of Representation
7. ☐ Unemployment Insurance Account Authorization
8. ☐ Authorized Representative Agreement and Signatory Authority *(Optional)*

Supplements *(Discuss and keep for future use)*

- Notice of Privacy Practices
- Employer Packet Instructions
- Payroll Calendar
- Notice of Discontinued Employment
- Information Change Forms

I have reviewed and verified the above forms for completeness and all forms are readable.

CONSUMER DIRECT CARE NETWORK

EMPLOYER OF RECORD ATTESTATION

Required	Required
Consumer Name	Employer of Record (EOR) Name

Acknowledgement – I acknowledge that I will do the following:

1. Fill out all the forms required by Consumer Direct Care Network Virginia (CDCN). Packets may result in a delay of services if I fail to note needed Federal Employer Identification Number (FEIN) information; and/or do not submit a complete packet.
2. Read the Consumer-Directed Waiver Services Employer Manual.
3. Obtain an FEIN; CDCN will help me with this process.
4. Ensure prospective employees have filled out all required paperwork. Paperwork must be sent to CDCN to be officially hired.
5. Ensure payments made to attendants will be made only when there is a valid approved services authorization based on the number of hours approved for the time period.
6. Dismiss an employee if their name is on the Office of Inspector General List of Excluded Individuals/Entities (LEIE). CDCN runs the LEIE check each month on all employees.
7. Recruit, interview, hire, train, manage, and dismiss employees.
8. Establish performance evaluation criteria for each employee.
9. Create the work schedules and tasks for each employee.
10. Maintain record of services provided by the Employee.
11. Ensure employees do not provide services while the Consumer is in a hospital, nursing home or other Medicaid-reimbursed facility.
12. Ensure employees only work the approved number of hours. I am liable for paying all wages and expenses that:
    a. Exceed the amount approved in the Consumer's plan of care; and/or
    b. Result in an employee working unapproved overtime.
13. Review and approve employee time records. Time records must be sent to CDCN in a timely manner; please see CDCN's payroll schedule. I can be held liable if I approve fraudulent records that result in over-billing Medicaid.
14. Let CDCN know of any changes in the EOR's or the Consumer's name, address, or phone number.
15. Inform CDCN right away if the Consumer is hospitalized.
16. Inform CDCN right away if an employee is dismissed.
17. Read CDCN's Notice of Privacy Practices. It describes the Consumer's rights under CDCN's privacy rules. The rules follow federal privacy regulations (HIPAA). CDCN's Privacy Officer can be reached toll-free at: 1-877-532-8530
18. Immediately Report:
    a. Any possible Medicaid fraud to the CDCN Fraud Hotline: 1-877-532-8530

b. Abuse, neglect and exploitation to the appropriate authorities.

19. Maintain a backup plan. The plan should be used if a scheduled employee does not show up for work.

Additional Agreement Terms and Conditions

1. This Attestation is subject to change. Changes may occur if any portion of this Attestation:
   a. Does not apply to CDCN and me; or
   b. Is found to be illegal or invalid.

   If a or b above are found, the relevant part(s) of the Attestation will be changed. The change(s) will be made to give the Attestation its intended effect and/or meaning. All other parts of the Attestation shall continue in full force and effect.
2. I agree that if CDCN and I have a dispute, we will try to resolve the dispute within thirty (30) days. If the dispute has not been resolved within thirty (30) days, CDCN and I, together, will choose someone to help us settle the dispute. This person:
   a. Will be from the American Arbitration Association;
   b. Is called an independent arbitrator; and
   c. Will help work out the dispute.

   The cost of the person chosen will be paid by CDCN and me; we will share the cost equally. The arbitrator may not reach a decision that is accepted by either party; in this case, a judge may be used to reach a verdict.
3. I understand and consent that all actions under this Attestation are governed by the laws of Virginia without regard to its conflict of laws rules. I agree that the courts in the Judicial District in which the Consumer's primary state office sits shall have exclusive jurisdiction; this will be with respect to any controversy or dispute arising out of or relating to this Attestation and not resolved pursuant to the terms of this Attestation.
4. I agree to communicate with CDCN in a timely way. Any notice will be given immediately.
5. Any changes to the terms of this Attestation must be in a separate writing. I must sign and date such changes. CDCN must approve such changes.
6. All actions related to this Attestation shall adhere to state and federal privacy laws and regulations; this includes HIPAA and regulations issued thereunder, 45 C.F.R. Parts 160 – 164.
7. CDCN can choose to not serve the Consumer. This will happen if I do not follow policies and procedures or if the Consumer's health and safety needs cannot be met with the self-directed program. CDCN and I will discuss any concerns with the Authorizing Agency. If necessary, the Consumer's service facilitator will assist the Consumer with transitioning services within thirty (30) days.

Required	Required	Required
Employer of Record, Printed Name	*Signature*	Date

Form **SS-4**
(Rev. December 2017)
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
Required 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) (Do not enter a P.O. box.)
Required

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

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

6 County and state where principal business is located
Required

7a Name of responsible party
Required

7b SSN, ITIN, or EIN
Required

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.
Required - Must match Signature Date

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 $4,000 or less in total wages.) If you do not 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 ← Check One
If "Yes," write previous EIN here ▶ If Yes

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

Designee's telephone number (include area code)
406-532-1900

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) ▶ Required

Applicant's telephone number (include area code)
Required

Applicant's fax number (include area code)

Signature ▶ Required

Date ▶ Required

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 16055N

Form **SS-4** (Rev. 12-2017)

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 a and paying.

☐ You want to **revoke** an e

Enter EIN if applicant has established prior business account.

Part 2: Employer or Pa art 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) Required HCSR

3 **Trade name** (if any)

4 **Address**

100 Consumer Direct Way — Suite 303-VA

Number Street — Suite or room number

Missoula — MT — 59808

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, 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 instructio

If EIN holder signing form enter: "HCSR Household Employer"

If Guardian signing form enter: "HCSR Guardian"

I am authorizing the IRS to disclose agent relating to the authority granted under this appointment, including disclosures ay contract with a third party, such as a reporting agent or certified public a ed by this appointment, or to make any required deposits and payments. Such cont ntial tax information of the employer/payer and agent to such third party. If a third sits and payments, the agent and employer/payer remain liable.

✗ **Sign your name here** Required

Date Required

Print your name here Required

Print your title here Required

Best daytime phone Required

Now give this form to the agent to complete.

Form PAR 101
Virginia Power of Attorney and Declaration of Representative

Virginia Tax
P. O. Box 1115
Richmond, VA 23218-1115
Individual fax: (804) 254-6113
Business fax: (804) 254-6111

This is a legal document.

If this Form PAR 101, Power of Attorney and Declaration of Representative is not signed and dated, lacks complete information, or is illegible, it will be denied.

Asterisks denote required fields. Read the instructions carefully before completing this form.

1. Taxpayer Information

Taxpayer Name (Individual, Business, or Fiduciary)*			SSN, ITIN, or FEIN*
Required			Required
Spouse Name (For joint representation only. See instructions.)			Spouse SSN or ITIN
If applicable			If applicable
Address*			Daytime Telephone Number
Required			( ) Required
Address			Alternative Telephone Number ( )
City*	State*	ZIP Code*	Email Address
Required	Req	Req	

2. Maintain or Revoke Prior Authorization

☐ **Maintain authorization for the agent listed below.** This form automatically revokes all earlier powers of attorney on file with Virginia Tax for the same tax matters covered by this form.

(Specify agent name, address, ZIP Code, and date granted. Attach copy of the power of attorney form.)

☐ **Revoke prior authorization(s).** To revoke a prior power of attorney without naming another representative, send a copy of the power of attorney form to Virginia Tax at the address above and write "REVOKE" across the top. If you do not have a copy of the power of attorney form, provide the agent's name, address, ZIP Code, and date granted:

3. Tax Matters – Taxable years or periods may not extend more than 3 years into the future. You must designate at least one tax type and taxable year period.*

Annual Income Taxes Only – Individual, Corporate, Pass-through Entity, Fiduciary, or Estate Tax Type

Tax Type	Taxable Years Do Not Enter "All Years" – Must be Specific

Business, Excise, Commodity, and Other Taxes

Tax Type	15-Character Virginia Tax Account Number REQUIRED: See Instructions	Do Not Enter "All Periods" – Must be Specific	
		Beginning Period (MM/YYYY)	Ending Period (MM/YYYY)
Income Tax Withholding			

4. Authorized Agent /Representative Information. Additional representatives should be listed on an attached list and may not receive copies of correspondence.

Primary Representative – Must be a person; cannot be a business

First Name*	Last Name*	
Alisha	Matt	
Address: 100 Consumer Direct Way, Suite 304		
Address:		
City: Missoula	State: MT	ZIP Code: 59808
Daytime Telephone Number: (406) 532-2917	Fax Number: (406) 532-8588	Email Address: taxdept@consumerdirectcare.com

Automatic Correspondence
An Authorized Agent will automatically be mailed copies of correspondence regarding the tax matters.

Authorized Agent Number
A - 05908467

☑ Do **NOT** mail copies of any correspondence to agent.

☑ Mail copies of email communications to agent.

Additional Representative – Must be a person; cannot be a business

First Name	Last Name	
Malcolm	Graham	
Address: 100 Consumer Direct Way, Suite 304		
Address:		
City: Missoula	State: MT	ZIP Code: 59808
Daytime Telephone Number: (406) 532-2916	Fax Number: (406) 532-1921	Email Address: taxdept@consumerdirectcare.com

Automatic Correspondence
An Authorized Agent will automatically be mailed copies of correspondence regarding the tax matters.

Authorized Agent Number
A - 05576878

☑ Do **NOT** mail copies of any correspondence to agent.

☑ Mail copies of email communications to agent.

5. Signature of Taxpayer(s) and Acknowledgment of Authorized Acts

By signing this form, I am granting the representative(s) listed in Section 4 the authority to:

- Receive and inspect my confidential tax information for the tax matters listed in Section 3,
- Perform all acts that I can perform with respect to the specified tax matters, and
- Represent me before Virginia Ta… …o assess tax and executing consents that agree to a tax adjustment.
- In addition, I understand that the… …or decrease my tax liabilities and legal rights.

The authority does not, however, inc… …bstitute another representative, request a copy of a tax return, sign certain retu… …ation.

For joint representation, both the tax… …ust sign and date this form. If this form is signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, or trustee on behalf of the taxpayer, they certify that they have the authority to execute this form on behalf of the taxpayer. This power of attorney will remain in effect until it is revoked by either the taxpayer or the agent.

If EIN holder signing form enter: "Household Employer"

If Guardian signing form enter: "Guardian"

Print Name*	Signature*	Title	Date*
Required	Required	Required	Required
Print Name	Signature	Title	Date

6. Representative Signature: *Under penalties of perjury, I declare I am authorized to represent the taxpayer(s) listed in Section 1.*

A.) Attorney B.) Certified Public Accountant C.) Enrolled Agent D.) Family member or Other (provide relationship below):
Relationship: _____

Representative	Designation Letter from Above List	Print Name *	Representative Signature*	Date*
Primary	D	Alisha Matt		1/1/2019
Additional	D	Malcolm Graham		1/1/2019

CONSUMER DIRECT CARE NETWORK

UNEMPLOYMENT INSURANCE ACCOUNT AUTHORIZATION FORM

Required	Required
Consumer Name	Employer of Record (EOR) Name

I hereby authorize Consumer Direct Care Network Virginia, LLC (CDCN) to act on my behalf as an agent with the Virginia Employment Commission (VEC). I give CDCN permission to obtain an Unemployment Account number for me. I give CDCN permission to act as the Third Party Administrator of my VEC account. This is for unemployment tax filing purposes.

Required _____ Required _____

Employer of Record Signature *Date*