CONSUMER DIRECT CARE NETWORK

ATTENDANT DATA FORM

Clear Form

Attendant Information

Name: _____ _____ _____
First Middle Last

Physical Address: _____
Street Apt/Unit # City State Zip Code

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

Phone #: Home _____ Cell _____

Email: _____

Date of Birth: ___/___/_____ Social Security Number: _____ - _____ - _____

☐ 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): _____

EOR Phone #: _____

EOR Email: _____

Name of Consumer: _____

Consumer Medicaid ID #: _____

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

Note: If the Consumer is a minor, the Attendant must complete a Dept of Social Services background check form. The form will be sent to the Attendant in an email from Virginia DSS on behalf of Consumer Direct. The email will be from CDVADSS@ConsumerDirectCare.com with subject line "*Virginia Central Registry Search Authorization*". The attendant needs to complete the form in one sitting. Click on the link in the email to begin filling out the DSS background check form.

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.

_____ _____ _____ _____
Attendant Signature *Date* *Employer of Record Signature* *Date*

CONSUMER DIRECT CARE NETWORK

Dear future Attendant,
Welcome to Consumer Direct Care Network Virginia (CDCN). CDCN provides financial management services for individuals, "Consumers", enrolled in certain Medicaid programs. This packet contains information and forms, to establish you as an employee. CDCN will pay and file payroll taxes on your behalf.

Once you have received notice from CDCN that your enrollment documents have been received and approved:

1. Register for online services. Our web portal is www.DirectMyCare.com. Here you can review pay stubs, adjust time records, etc.

2. Sign up for Electronic Visit Verification (EVV). All attendants are required to clock-in and clock-out using an approved EVV method for each shift.

Please review training materials and instructions regarding the CDCN web portal and EVV at https://www.consumerdirectva.com/training-materials/.

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

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/

CONSUMER DIRECT CARE NETWORK

Checklist of Attendant Enrollment Packet Forms to Submit to CDCN

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

(Some forms are completed by the Attendant, and some forms are completed by both the Attendant and the Employer.)

1. ☐ **Attendant Data Form**
   - *Attendant completes the Attendant Information section of the form.*
   - *Attendant completes the Attendant/Consumer Relationship section of the form.*
   - *Employer completes the Employer Information section of the form.*
   - *Both Attendant and Employer sign and date the form.*

2. ☐ **Payroll Tax Exemptions Determination**
   - *Enter the Attendant's, Employer's and Consumer's name on the top of the form.*
   - *Attendant checks one relationship.*
   - *If Attendant is the Employer's parent or child, check additional descriptions that apply.*
   - *Both Attendant and Employer sign and date the form.*

3. ☐ **Attendant-Consumer Live-in Determination**
   - *Enter the Attendant's, Employer's and Consumer's name on the top of the form.*
   - *Attendant checks one living arrangement.*
   - *If Attendant lives full time with the Consumer:*
     - *Send proof of address to CDCN, and*
     - *Check Yes or No for Difficulty of Care income tax exclusion.*
   - *Both Attendant and Employer sign and date the form.*

4. ☐ **USCIS I-9 Employment Eligibility Verification** – Full I-9 instructions are found on the forms page of the CDCN Virginia website.
   - *Attendant completes and signs Section 1.*
   - *Attendant provides identity documents to Employer for review.*
   - *Employer completes and signs Section 2.*
   - *Employer must review and verify the Attendant's identity documents. Enter the details of the identity document(s) in appropriate column (List A or Lists B and C).*
   - *Employer completes the Certification section with Employee's first day of employment, Employer's name and title (title can simply be "Employer"), Business name (the EOR's name), and Business address (Consumer's home address – where services are provided).*

5. ☐ **W-4 Employee's Withholding Allowance Certificate** – A complete W-4 with instructions and worksheets is found on the forms page of the CDCN Virginia website.
   - *Attendant completes steps 1-4 as needed.*

00540

- *Attendant signs and dates step 5.*

6. ☐ **VA-4 Virginia Employee's Tax Withholding Exemption Certificate** – A complete VA-4 with instructions is found on the forms page of the CDCN Virginia website.
   - *Attendant completes the demographic section (name, SSN, address).*
   - *Attendant completes lines 1 through 4, as applicable, depending on withholding status.*
   - *Attendant signs and dates the form.*

7. ☐ **Pay Selection Form –** Wisely Card information and fee schedule is found on the forms page of the CDCN Virginia website.
   - *Enter the Attendant's name on the top of the form.*
   - *Choose one of the two direct deposit pay options.*
   - *For an existing bank account (1) Enter the bank's name, (2) Check the account type, and (3) Upload a voided check or other document with exact routing numbers.*
   - *Attendant signs and dates the bottom of the form.*

8. ☐ **Employment Agreement**
   - *Enter the Attendant's and Employer's name on the top of the form.*
   - *Attendant and Employer review the Agreement.*
   - *Both Attendant and Employer sign and date the Agreement to acknowledge their understanding.*

9. ☐ **Criminal History Record Name Search Request** – A background check required by state law.
   - *Attendant completes the Name Information To Be Searched section.*
   - *Attendant signs the form in the presence of a Notary Public.*
   - *Attendant submits form to CDCN with Notary seal.*
   - CDCN will submit the completed form to the Virginia State Police. The search fee will be paid by the Consumer's Medicaid program.

10. ☐ **Department of Social Services Central Registry Form** – A background check required by state law only if the Consumer is a minor (under age 18).
    - *The Attendant receives the form in an email from CDVADSS@ConsumerDirectCare.com The subject line will be "Virginia Central Registry Search Authorization".*
    - *Attendant clicks on the link in the email. The Attendant then completes the background check form online. CDCN will process the completed form.*
    - *All associated background check costs will be paid by the Consumer's Medicaid program.*

CONSUMER DIRECT CARE NETWORK

PAYROLL TAX EXEMPTIONS DETERMINATION

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 widow, widower, divorced or married and lives with a spouse, but the spouse has a physical or medical condition that prevents them from caring for the child at least 4 straight weeks in 3 months.

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:

- ☐ 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.

Attendant Signature	*Date*	*Employer of Record Signature*	*Date*

[1]FICA – Federal Insurance Contributions Act (Social Security and Medicare)
[2]FUTA – Federal Unemployment Tax Act
[3]SUTA – State Unemployment Tax

CONSUMER DIRECT CARE NETWORK

ATTENDANT-CONSUMER LIVE-IN DETERMINATION

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:

   - **Send proof of residence to CDCN**. *We will accept a driver's license, voter registration card, 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.

Attendant Signature	*Date*	*Employer of Record Signature*	*Date*

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No.1615-0047
Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number
/ /			

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

Signature of Employee	Today's Date (mm/dd/yyyy)

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
Employer		

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/i-9-central. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	**OR**	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on I-9 Central for more information.

Supplement A,
Preparer and/or Translator Certification for Section 1

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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

2024

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	**(b) Social security number**
Address		**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*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **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, and when to use the estimator at *www.irs.gov/W4App*.

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 correct amount of withholding depends on income earned from all of these jobs.

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). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **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 generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

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 Dependent and Other Credits

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 for qualifying children and other dependents. You may add to this the amount of any other credits. 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.

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

Employers Only

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

02227

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" ..... _____
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) ..... _____
4. Subtotal Personal Exemptions (add lines 1 through 3) ..... _____
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) ..... _____
8. Total of Exemptions - add line 4 and line 7 ..... _____

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	
Street Address		
City	State	Zip Code

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 ..... _____
   - (b) Subtotal of Exemptions for Age and Blindness line 7 of the Personal Exemption Worksheet ..... _____
   - (c) Total Exemptions - line 8 of the Personal Exemption Worksheet ..... _____
2. Enter the amount of additional withholding requested (see instructions) ..... _____.___
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) ☐

Signature Date

EMPLOYER: Keep exemption certificates with your records. If you believe the employee has claimed too many exemptions, notify the Department of Taxation, P.O. Box 1115, Richmond, Virginia 23218-1115, telephone (804) 367-8037. Note: Employers may establish a system to electronically receive Forms VA-4 from employees, provided the system meets Internal Revenue Service requirements as specified in § 31.3402(f)(5)-1(c) of the Treasury Regulations (26 CFR).

2601064 Rev. 08/11

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CONSUMER DIRECT CARE NETWORK

PAY SELECTION FORM

Attendant Name: _____ Date of Birth: ___/___/_____
(please print)

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.

☐ **Direct Deposit to a Wisely Pay Card Account.** I authorize CDCN to issue me a Wisely Pay Card and make payroll deposits to my card account. It is mailed to me by ADP in an unmarked envelope about 2 weeks after my enrollment paperwork is approved.

☐ **Direct Deposit to an Existing Checking, Savings or Pay Card Account.** I authorize CDCN to initiate payroll deposits to my bank or financial institution.

The Name of my bank is: _____

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:

- I will be issued a Wisely Pay Card if I do not select a Direct Deposit option above or I fail to provide an attachment with routing numbers for bank deposits.
- I may receive a paper check for my first two pay periods during account set up.
- 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, or an improper payment is made, 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 must submit a new Pay Selection Form to CDCN if I wish to change my Direct Deposit option.

_____ _____
Attendant Signature *Date*

CONSUMER DIRECT CARE NETWORK

EMPLOYMENT AGREEMENT

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:

- I am at least 18 years old.
- I have a valid Social Security Number. I am authorized to work in the United States.
- I am an employee receiving payments under a state Medicaid Home and Community-Based Services program. I will not be paid by CDCN for services performed if the Consumer is not authorized for services.
- I am an employee of the EOR. I am not an employee of CDCN.
- My hourly pay rate is set by the Virginia General Assembly. The rate is based on the Consumer's physical address.
- This Agreement does not guarantee me employment or payment of wages for any time period.
- I will keep information about the Consumer confidential.
- I will carry out assigned duties and tasks. These will be explained by the Consumer or EOR. Approved tasks are outlined in the Consumer's Plan of Care.
- I must report to the Dept. of Social Services:
  - Neglect or abuse of a Consumer.
  - Misuse of funds or property of a Consumer.
- 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.
- Federal and state taxes will be withheld from my wages, as applicable. Garnishments, support orders, and liens may also apply. I will submit to CDCN:
  - *IRS Form W-4.*
  - *Virginia Form VA-4.*
  - *CDCN Payroll Tax Exemptions Determination*.
  - *CDCN Attendant-Consumer Live-In Determination.*

- I cannot be paid if:
  - The Consumer is no longer authorized for services
  - I work more hours than what the Consumer is authorized.
- I must notify CDCN of changes in my information on file. Such as name, address, contact information and tax withholdings.
- I am classified as a "domestic service employee" under Virginia law. I am not covered by Workers' Compensation Insurance.

EOR Acknowledgements

As the EOR, I acknowledge the following:

- I am responsible for completing the *USCIS Form I-9*. I will keep a copy for my record and send a copy to CDCN.
- I will hire, dismiss, and train the attendant.
- I will submit to CDCN a *Notice of Discontinued Employment* form when an Attendant is no longer employed.

Background Check Requirements

- The Attendant is subject to background checks prior to hire. These include:
  - Criminal History Record Name Search. This is by the Virginia State Police.
  - List of Excluded Individuals/Entities (LEIE). This is by the U.S. Dept. of Health and Human Services; Office of Inspector General.
  - Child Abuse and Neglect Central Registry Records Check. This is by the Virginia Dept. of Social Services. *This is only required if the Consumer is a minor (under the age of 18).*
- Attendant authorizes CDCN to proceed with required background checks. Results cannot be released for any other purpose without Attendant's written consent. The results of background and LEIE checks are made available to CDCN, the EOR, and the clients Medicaid program.
- Background checks are paid for by the clients Medicaid program.
- The Attendant may be hired on a temporary basis for no more than thirty (30) days. This is pending results of all background and LEIE checks.
- An Attendant who fails a background or LEIE check is not allowed to work or be paid under this program upon or after discovery of failed results.

Time Records and Payment

- The Attendant must clock-in and clock-out for each shift worked using an approved Electronic Visit Verification (EVV) method.
- Use the EVV exception process only as needed. The reasons an Attendant 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.
- Attendant wages are paid biweekly by CDCN. Payment is through Electronic Funds Transfer. Payment is to a bank account or pay card.
- CDCN will not pay for services provided when:
  - They are not authorized.
  - They exceed the service authorization.
  - The Consumer has lost program eligibility.
  - Time records are submitted more than one (1) year from the date of service.
- If the Consumer is responsible for any "Patient Pay" amount, CDCN will deduct the amount from the Attendant's net pay. The Consumer pays the Attendant the Patient Pay amount shown on the pay stub.

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.

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

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

RACE	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER
		/ / (MM/DD/YYYY)	

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.

_____
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
300 Arboretum Place, Suite 410

CITY Richmond STATE VA ZIP CODE 26236

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

Purpose code: ☐ C ☐ N ☐ O

Date: _____ By CCRE/ _____

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