**ARIS SOLUTIONS**
**White River Junction, VT 05001**
**Phone 866.970.3301**
**Fax 802.295.9812**
**veteranpayroll@arissolutions.org**

Financial & Payroll Services for the Nonprofit Sector

# Enrollment Forms for:

## VDC Program Employers

This packet contains the necessary forms and instructions that will authorize ARIS Solutions to act in your behalf as your Financial Management Service provider.

**BELOW FORMS MUST BE SIGNED/DATED AND RETURNED TO ARIS SOLUTIONS**

- ❑ Employer / Veteran Information Form
- ❑ Form SS-4 - Application for Employer Identification Number
  - ❖ Form SS-4 allows ARIS to request a Federal Employer Identification Number from the IRS for you.
- ❑ Workers Compensation Application (if applicable)
- ❑ Form 2678 - Employer/Payer Appointment of Agent
  - ❖ Allows ARIS to file your employment tax forms.
- ❑ Form 8821- Tax Information Authorization
  - ❖ Allows ARIS to receive & review copies of tax filings from the IRS.
- ❑ State Tax Forms
  - ❖ State Department of Revenue (if applicable)
  - ❖ State Department of Labor
- ❑ Employer/Authorized Representative Background Check Release Form
- ❑ Employer Confirmation of Receipt
- ❑ Fraud & Abuse Statement
- ❑ HIPAA Notice of Privacy Practices & Agreement
- ❑ Electronic Timesheet Submission: (2 different options)
  - ❖ Electronic Timesheets Application. Followed by instructions on Electronic Timesheets.
  - ❖ Timesheet Submission Portal and applicable information.

If you have questions contact the Veterans Department at 866.970.3301

**Return Packet to:** **ARIS Solutions-Veteran Program**

**PO Box 4409**
**White River Jct., VT 05001**
**Phone: 866.970.3301 (toll free)**
**Fax: 802.295.9812**
**Email: veteranpayroll@arissolutions.org**

# New Employer/Veteran Information

## You are now an Employer!

Welcome to the Veteran Directed Care Program employment model. You will now manage and direct the services you receive or the services the Veteran you represent receives. In this employer model you, or a representative who you appoint, are the employer and you direct the work of your employee.

## The Role of ARIS Solutions as Your Financial Management Services "FMS" Provider

ARIS Solutions will serve as your FMS Provider to support you and complete many of the administrative employer obligations. This means that ARIS will process your timesheets, conduct criminal background checks on potential employees manage your employer tax responsibilities on the federal and state level, apply for workers compensation insurance, and pay your employees.

## Roles and Responsibilities Chart

| **Your Role** *(as Employer)* | **Employee's Role** *(as Employee)* | **ARIS Solutions' Role** *(as FMS Provider)* |
|---|---|---|
| Select and hire an employee<br><br>Schedule employees (staying within your authorized budget)<br><br>Train employees<br><br>Sign timesheets<br><br>Review employees job performance | Meet your requirements for hiring<br><br>Complete required employment paperwork<br><br>Submit a background check<br><br>Submit signed timesheets to ARIS | Assist with paperwork, as needed<br><br>Establish you as an employer<br><br>Establish your worker as your employee<br><br>Conduct criminal background checks |
| Dismiss employees<br><br>Establish clear boundaries<br><br>Let your employee know what the rules are and what their responsibilities are<br><br>Prevent fraud | Respect employer's boundaries, rules and responsibilities<br><br>Provide home care services to your employer as directed by your employer<br><br>Prevent fraud | Provide payroll services Prepare and disburse payroll checks<br><br>Pay employer taxes<br><br>Prepare year-end tax reports<br><br>Apply for and secure Workers Compensation insurance on behalf of the employer |

## Contact Information

You can remove this page from the packet and post it somewhere prominent so you always have the information you need to contact the Veterans Program team.

ARIS Solutions-Veteran Program staff are available for support Monday through Friday from 8:00 am to 4:00pm (EST) and can be reached at **866.970.3301** (toll free), our veteran dedicated email address: veteranpayroll@arissolutions.org or our Website at www.arissolutions.org

*ARIS Solutions is not open on state or federal holidays.*

Financial & Payroll Services for the Nonprofit Sector

ARIS SOLUTIONS

# Employer/Veteran Information Form

## NAME OF EMPLOYER

**Name** _____
(Last) (First) (Middle)

**Address** _____
(Street) (Apt) (City) (State) (Zip)

**Phone (_____)_____** **Email** _____

**DOB**____/____/____ **Social Security Number**_____-_____-_____

**GENDER** _____

**FEIN** (If previously issued)_____

**Relationship to Veteran** _____

**Veteran IS EMPLOYER** **YES** **NO**
*If yes please skip next section.*

**CASE MANAGER / OPTIONS COUNSELOR / CARE COORDINATOR :**

## NAME OF VETERAN

**Name** _____ **GENDER** _____

**Address** _____
(Street) (APT) (City) (State) (Zip)

**Phone (_____)_____**

**Date of Birth** _____

**Social Security Number** _____

VDC-EMPLOYER

Form **SS-4** (Rev. December 2019)

Department of the Treasury
Internal Revenue Service

# Application for Employer Identification Number

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

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

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

OMB No. 1545-0003

**EIN**

**Type or print clearly.**

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

| | |
|---|---|
| **2** Trade name of business (if different from name on line 1) | **3** Executor, administrator, trustee, "care of" name |
| **4a** Mailing address (room, apt., suite no. and street, or P.O. box)<br>ARIS Solutions PO Box 4409 | **5a** Street address (if different) (Don't enter a P.O. box.) |
| **4b** City, state, and ZIP code (if foreign, see instructions)<br>White River Jct., VT 05001 | **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 . . . . . ▶

**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) ▶ _____ Personal Care/Home Care
- ☐ Hired employees (Check the box and see line 13.)
- ☐ Compliance with IRS withholding regulations
- ☐ Other (specify) ▶
- ☐ 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 June

**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 |
|---|---|---|
| | | |

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

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

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

☐ Construction ☐ Rental & leasing ☐ Transportation & warehousing ☐ Health care & social assistance ☐ Accommodation & food service ☐ Wholesale-agent/broker ☐ Wholesale-other ☐ Retail
☐ Real estate ☐ Manufacturing ☐ Finance & insurance ☒ Other (specify) ▶ Home and community based personal care.

**17** Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided.
Home and Community Based personal care to veteran participant.

**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<br>ARIS Solutions Fiscal Agent | Designee's telephone number (include area code)<br>802.280.1911 |
| Address and ZIP code<br>PO Box 4409 White River Jct., VT 05001 | Designee's fax number (include area code)<br>802.295.9812 |

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) ▶

Applicant's fax number (include area code)

Signature ▶ Date ▶

## Worker's Compensation Insurance

*Information on Worker's Compensation Insurance/frequently asked questions:*

- *All employers are required to obtain Worker's Compensation insurance before employees may begin to work.*
  - *Employers will be notified as soon as policy is in place.*
- *Worker's Compensation Insurance is an insurance policy which pays for the cost of an employee's medical expense and lost wages in the event of a work related injury.*
- *ARIS Solutions assists employers in obtaining a Worker's Compensation Policy.*
- *The cost for Worker's Compensation insurance can vary somewhat, most policies are atleast $1000 per year.*
  - *The exact cost is determined by the insurance company and depends upon the number of full or part time employees and the total annual wages to be paid in the year.*
  - *The cost of the policy is paid from the participant's budget and is broken down into equal monthly amounts.*
    - *ARIS Solutions pays the policy upfront and is repaid through the VA as billing is done each month.*

# VDC Indiana Workers' Compensation Form

| |
|---|
| Employer Legal Name:<br><br>Employer Date of Birth: |
| Veteran name (if different than Employer name): |
| Relationship to Veteran: ☐ Spouse ☐ Child ☐ Sibling ☐ Other (specify): |
| Employer FEIN # : |
| Employer Phone: |
| Street Address (where service is provided): |
| City, State, ZIP(where service is provided): |
| Estimated Number of Employees:<br><br>Full Time: _____ Part Time: _____ |
| Estimated Annual Payroll: |
| Effective Date of Coverage (start date):<br><br>Employer Signature and Date: |

VDC-EMPLOYER

## INDIVIDUALS INCLUDED/EXCLUDED

PARTNERS, OFFICERS, RELATIVES TO BE INCLUDED OR EXCLUDED. (Remuneration to be included must be part of rating information section.)

| # | NAME | DATE OF BIRTH | TITLE/ RELATIONSHIP | OWNER-SHIP % | DUTIES | INC/EXC | CLASS CODE | REMUNERATION |
|---|---|---|---|---|---|---|---|---|
| | | | Owner | 100% | | Excl | 8835 | 0 |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

## PRIOR CARRIER INFORMATION/LOSS HISTORY

PROVIDE INFORMATION FOR THE PAST 5 YEARS AND USE THE REMARKS SECTION FOR LOSS DETAILS ☐ LOSS RUN ATTACHED

| YEAR | CARRIER & POLICY NUMBER | ANNUAL PREMIUM | MOD | # CLAIMS | AMOUNT PAID | RESERVE |
|---|---|---|---|---|---|---|
| | CO: | | | | | |
| | POL #: | | | | | |
| | CO: | | | | | |
| | POL #: | | | | | |
| | CO: | | | | | |
| | POL #: | | | | | |
| | CO: | | | | | |
| | POL #: | | | | | |
| | CO: | | | | | |
| | POL #: | | | | | |

## NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS

GIVE COMMENTS AND DESCRIPTIONS OF BUSINESS, OPERATIONS AND PRODUCTS: MANUFACTURING-- RAW MATERIALS, PROCESSES, PRODUCT, EQUIPMENT. CONTRACTOR-- TYPE OF WORK, SUB-CONTRACTS. MERCANTILE--MERCHANDISE, CUSTOMERS, DELIVERIES. SERVICE--TYPE, LOCATION. FARM--ACREAGE, ANIMALS, MACHINERY, SUB-CONTRACTS.

Indiana Veterans Program

## GENERAL INFORMATION

| EXPLAIN ALL "YES" RESPONSES | YES | NO |
|---|---|---|
| 1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT/WATERCRAFT? | | ✓ |
| 2. DO/HAVE PAST, PRESENT OR DISCONTINUED OPERATIONS INVOLVE(D) STORING, TREATING, DISCHARGING, APPLYING, DISPOSING, OR TRANSPORTING OF HAZARDOUS MATERIAL? (e.g. landfills, wastes, fuel tanks, etc) | | ✓ |
| 3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET? | | ✓ |
| 4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER? | | ✓ |
| 5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS? | | ✓ |
| 6. ARE SUB-CONTRACTORS USED? (IF YES, GIVE % OF WORK SUBCONTRACTED) | | ✓ |
| 7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INS.? | | ✓ |
| 8. IS A WRITTEN SAFETY PROGRAM IN OPERATION? | | ✓ |
| 9. ANY GROUP TRANSPORTATION PROVIDED? | | ✓ |
| 10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE? | | ✓ |
| 11. ANY SEASONAL EMPLOYEES? | | ✓ |
| 12. IS THERE ANY VOLUNTEER OR DONATED LABOR? | | ✓ |
| 13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS? | | ✓ |
| 14. DO EMPLOYEES TRAVEL OUT OF STATE? | | ✓ |
| 15. ARE ATHLETIC TEAMS SPONSORED? | | ✓ |

| EXPLAIN ALL "YES" RESPONSES | YES | NO |
|---|---|---|
| 16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE? | | ✓ |
| 17. ANY OTHER INSURANCE WITH THIS INSURER? | | ✓ |
| 18. ANY PRIOR COVERAGE DECLINED/ CANCELLED/NON-RENEWED (Last 3 years)? NOT APPLICABLE IN MO | | ✓ |
| 19. ARE EMPLOYEE HEALTH PLANS PROVIDED? | | ✓ |
| 20. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS/SUBSIDIARY? | | ✓ |
| 21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS? | | ✓ |
| 22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME? | | ✓ |
| 23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST 5 YEARS? | | ✓ |
| 24. ANY UNDISPUTED AND UNPAID WORKERS COMPENSATION PREMIUM DUE FROM YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? IF YES, EXPLAIN INCLUDING ENTITIY NAME(S) AND POLICY NUMBERS(S). | | ✓ |

**CONTACT INFORMATION**

| | | |
|---|---|---|
| IN-SPECTION | PHONE: | 802-280-1191 |
| | NAME: | Theresa Towle |
| ACCTNG RECORD | PHONE: | 802-280-1191 |
| | NAME: | Theresa Towle |
| CLAIMS INFO | PHONE: | 802-280-1191 |
| | NAME: | Theresa Towle |

APPLICABLE IN TENNESSEE: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO ANY PARTY TO A WORKERS COMPENSATION TRANSACTION FOR THE PURPOSE OF COMMITTING FRAUD. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, HI, NE, OH, OK, OR, TN or VT; in DC, LA, ME and VA, insurance benefits may also be denied)

**REMARKS**

| | | | |
|---|---|---|---|
| Does insured have any locations outside of this state? | No | Are cancer treatments provided? | No |
| Is travel radius greater than 200 miles? | No | Do they give immunizations or shots? | No |
| Are operations 24 hours? | No | Do they take safety precautions with pregnant employees? | No |
| | | Do they have procedures for reporting unsafe conditions? | No |
| | | Are all clients/patients ambulatory (ie: able to walk on their own)? | No |

| APPLICANT'S SIGNATURE | DATE | PRODUCER'S SIGNATURE | NATIONAL PRODUCER NUMBER |
|---|---|---|---|
| | | | |

ACORD 130 (2002/09)

VDC-EMPLOYER

# Form 2678 Employer/Payer Appointment of Agent

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

OMB No. 1545-0748

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

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

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

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

**For IRS use:**

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

(Check one)

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

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

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

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

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

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

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

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

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

X **Sign your name here**

Print your name here

Print your title here HHCSR

Date / /

Best daytime phone

**Now give this form to the agent to complete.**

VDC-EMPLOYER

Form **8821**

(Rev. January 2021)

Department of the Treasury
Internal Revenue Service

# Tax Information Authorization

▶ **Go to *www.irs.gov/Form8821* for instructions and the latest information.**
▶ **Don't sign this form unless all applicable lines have been completed.**
▶ **Don't use Form 8821 to request copies of your tax returns or to authorize someone to represent you. See instructions.**

OMB No. 1545-1165

**For IRS Use Only**
Received by:
Name
Telephone
Function
Date

**1 Taxpayer information.** Taxpayer must sign and date this form on line 6.

| Taxpayer name and address | Taxpayer identification number(s) |
|---|---|
| | Daytime telephone number / Plan number (if applicable) |

**2 Designee(s).** If you wish to name more than two designees, attach a list to this form. **Check here if a list of additional designees is attached ▶** ☐

| Name and address | |
|---|---|
| ARIS Solutions<br>PO Box 4409<br>White River Jct., VT 05001 | CAF No. 0313-84964R<br>PTIN<br>Telephone No. 866.970.3301<br>Fax No. 802.295.9812 |
| **Check if to be sent copies of notices and communications** ☐ | Check if new: Address ☐ Telephone No. ☐ Fax No. ☐ |
| Name and address | CAF No.<br>PTIN<br>Telephone No.<br>Fax No. |
| **Check if to be sent copies of notices and communications** ☐ | Check if new: Address ☐ Telephone No. ☐ Fax No. ☐ |

**3 Tax information.** Each designee is authorized to inspect and/or receive confidential tax information for the type of tax, forms, periods, and specific matters you list below. See the line 3 instructions.

☒ By checking here, I authorize access to my IRS records via an Intermediate Service Provider.

| (a) Type of Tax Information (Income, Employment, Payroll, Excise, Estate, Gift, Civil Penalty, Sec. 4980H Payments, etc.) | (b) Tax Form Number (1040, 941, 720, etc.) | (c) Year(s) or Period(s) | (d) Specific Tax Matters |
|---|---|---|---|
| Employment | 941, 940, 941R, 941X, W2, W3, W2C, SS4 | 2023-2026 | Tax Liability |
| Authority to obtain existing FEIN | SS4, 8821 | 2023-2026 | Tax Liability |
| | | | |

**4 Specific use not recorded on the Centralized Authorization File (CAF).** If the tax information authorization is for a specific use not recorded on CAF, check this box. See the instructions. If you check this box, skip line 5 . . . . . ▶ ☐

**5 Retention/revocation of prior tax information authorizations.** If the line 4 box is checked, skip this line. If the line 4 box isn't checked, the IRS will automatically revoke all prior tax information authorizations on file unless you check the line 5 box and **attach a copy** of the tax information authorization(s) that you want to retain . . . . . ▶ ☐
To revoke a prior tax information authorization(s) without submitting a new authorization, see the line 5 instructions.

**6 Taxpayer signature.** If signed by a corporate officer, partner, guardian, partnership representative (or designated individual, if applicable), executor, receiver, administrator, trustee, or individual other than the taxpayer, I certify that I have the legal authority to execute this form with respect to the tax matters and tax periods shown on line 3 above.

**▶ IF NOT COMPLETED, SIGNED, AND DATED, THIS TAX INFORMATION AUTHORIZATION WILL BE RETURNED.**

**▶ DON'T SIGN THIS FORM IF IT IS BLANK OR INCOMPLETE.**

Signature | Date

HCSR

Print Name | Title (if applicable)

VDC-EMPLOYER

# SUTA ACCOUNT NUMBER APPLICATION & DISCLOSURE STATEMENT

State Form 2837 (R9 / 3-15)
INDIANA DEPARTMENT OF WORKFORCE DEVELOPMENT
10 N Senate Ave RM SE 202
Indianapolis, IN 46204-2277
Confidential record pursuant To IC 4-1-16, IC 22-4-19-6

* This agency is requesting disclosure of Social Security Numbers (SSNs) in accordance with IC 4-1-8-1; disclosure is mandatory and this record cannot be processed without it.

IMPORTANT: Employer registration should be submitted on-line at https://uplink.in.gov/ESS/ESSLogon.htm on or before the due date of the employer's first quarterly report. If the employer is unable to submit an on-line application and disclosure statement, a copy of this form, SF 2837, must be attached to the employer's first quarterly contribution report (UC1S). Failure to timely register an account or to complete the application and disclosure statement accurately may result in civil penalties as described in IC 22-4-11.5-9 being assessed to the Employer and / or to the non-employer Agent. Please go to www.in.gov/dwd/SUTA.htm for additional information or clarification.

## SECTION ONE – IDENTIFICATION OF THE REGISTRANT

What is the FEIN number to be used by this business to issue the IRS W2 or 1099 to workers or contractors?

What is the FEIN or SSN* to be used by this business to report business income to the IRS? *Leave blank if not required to report.*

What is the complete, legal name of the business as registered with the Indiana Secretary of State?
*Leave blank if not required to register. IDWD must be able to verify registration with the Indiana Secretary of State.*

Date registered with the Indiana Secretary of State? / /

If not required to register with the Indiana Secretary of State, what is the legal name of the business used to secure the EIN from the IRS?

At what address will work be physically performed ***in Indiana?*** *If registering for Tele-work or similar activity, provide the worker's address.*
***Do not use a PO Box. The state for this address defaults to Indiana. If no work is performed in Indiana, there is no Indiana SUTA liability.***

Street

City

ZIP - Complete SF48812, Indiana Business Location Report, for additional locations.

What is the address at which legal notices are to be served (mailing address for the business)?
***Do not use a third party agent address.***

Street

City State

ZIP - US Canada Mexico Other

What is the telephone number for the business? ***Do not use a third party agent phone number.***

Telephone - - Ext or Name

Fax - -

Please provide an email address where IDWD may contact a responsible party for the business. *Leave blank if not applicable.*

## SECTION THREE – DISCLOSURES AND CERTIFICATION OF INFORMATION

Provide the name of the person in this organization that should be notified in the event of an audit or investigation. ***Not a third party provider***

First Name | Last Name

What is this person's Social Security Number?* *Mandatory disclosure*

Does this business share ownership, management, or control with any current or former Indiana Business? ☐ Yes ☑ No

Please identify the related business: SUTA # FEIN

Name

IMPORTANT: If you have additional business relationships to disclose, please complete the related business disclosure form SF 28804.

What is the NAICS that best describes this entity? NAICS codes can be found at http://www.census.gov/eos/www/naics/

Code: 812990 Key Word(s) / Description: other pers

Additional Keywords: care services

Provide the name and contact information for the person who prepared this form for signature.

First Name: EMILIE Last Name: DONKA

Telephone: 802 - 280 - 1911 Agent: ✓ Employee:

Preparer's Signature: _____ Date: / /

Provide the name of the person who is the responsible party for registration of this entity. ***Do not identify a third party Agent.***

First Name | Last Name

Telephone - - Title: HHCSR

Responsible Party's Signature: _____ Date: / /

IMPORTANT: By signing this form, you are certifying that the information contained herein is true and accurate to the best of your knowledge and belief. You further affirm that you are a person of sufficient authority with regard to the named entity to file this document and to bind the business by the information provided including all required attachments and disclosures as indicated.

***Third party providers***: This form should not contain third party provider information for any required response except the preparer signature, if applicable. Employers can designate correspondence agents or external authorized users for Indiana SUTA purposes only via ESS as described in 646 IAC 5-2-15. Third party providers are hereby notified that submitting this form or any ESS registration where the agent self identifies as the responsible party for the employer is specifically prohibited and is a violation of the Act as described in IC 22-4-11.5-9.

Mail completed forms to: IDWD – Employer Status Reports
10 N Senate Ave Rm SE 202
Indianapolis, IN 46204-2277

Fax: 317-233-2706
Questions: 800-437-9136 (2)
Handbook: www.in.gov/dwd

VDC-EMPLOYER

**POA - 1**
State Form 49357
(R6 / 11-14)

**Indiana Department of Revenue**
# POWER OF ATTORNEY

**1. Taxpayer Information**

| ∗Taxpayer(s) Name(s) | DBA Name(s) (if applicable) | |
|---|---|---|
| Address ☐ New Address? | | |
| City | State | Zip Code |
| Telephone Number | | |

**2. Identification Numbers**

∗Indiana Taxpayer Identification Number (10 digits) | or | Employer Identification Number

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |

– 

Social Security Number

| | | |
|---|---|---|
| | | |

Spouse's Social Security Number

| | | |
|---|---|---|
| | | |

Hereby appoint(s) the following:

**3. Representative Information**

| ∗Individual Representative Name | | | Additional Individual Representative Name | | |
|---|---|---|---|---|---|
| Address | | | Address | | |
| City | State | Zip Code | City | State | Zip Code |
| Telephone Number | Email | | Telephone Number | Email | |
| Additional Individual Representative Name | | | Additional Individual Representative Name | | |
| Address | | | Address | | |
| City | State | Zip Code | City | State | Zip Code |
| Telephone Number | Email | | Telephone Number | Email | |

**4. Firm/Vendor Information**

| Firm/Vendor Name (∗if applicable)<br>ARIS SOLUTIONS | | |
|---|---|---|
| Address<br>PO BOX 4409 | | |
| City<br>WHITE RIVER JUNCTION | State<br>VT | Zip Code<br>05001 |
| Telephone Number<br>1-802-280-1911 | Email | |

VDC-EMPLOYER

If firm or vendor, list representative(s) name, telephone number and email.

| Representative(s) Name | Telephone Number | Email |
|---|---|---|
| THERESA | 866-970-3301 | THERESAD@ARISSOLUTIONS.ORG |
| EMILIE | 866-970-3301 | EMILIED@ARISSOLUTIONS.ORG |
| | | |
| | | |

**5. General Authorization**

☑ I authorize the listed representative(s), in addition to anything otherwise authorized on this form, to represent me regarding any matters with the Indiana Department of Revenue regardless of tax years or income periods. I understand that this authority will expire 5 years from the date this POA is signed or a written and signed notice is filed revoking this authorization.

**6. Tax Type(s)** (Not applicable if box is checked in question 5 above)

| ∗Type of Tax (Income, Withholding, Sales, etc.) | ∗Year(s)/Period(s) ☐ Current Year ☑ Specify |
|---|---|
| ALL | 2023-2026 |
| | |
| | |

I acknowledge that the designated representative has the authority to receive confidential information and full power to perform on behalf of the taxpayer in tax matters related to this Power of Attorney. This authority does not include the power to receive refund checks.

I acknowledge that actions taken by the designated representative are binding, even if the representative is not an attorney. Proceedings cannot later be declared legally defective because the representative was not an attorney.

If I am a corporate officer, partner, or fiduciary acting on behalf of the taxpayer, I certify that I have authority to execute this Power of Attorney on behalf of the taxpayer.

**7. Authorizing Signature**

∗Signature _____ ∗Date _____

∗Printed Name _____ Title HHCSR

∗Telephone Number _____ Email _____

**∗Required fields - if not complete, this form will be returned to sender.**

# PROGRAM INTEGRITY and FRAUD PREVENTION

Maintaining and improving program integrity is one of the most important aspects of the Veteran Directed Program. Program integrity including fraud prevention is critical to sustaining this program model. Participants, authorized representatives, and providers are vital to preventing fraud and maintaining program integrity.

Fraud and abuse with funds from the Veteran's Administration can cost billions of dollars each year, diverting funds that could otherwise be used for additional services or to assist more people that need care. As a participant, authorized representative, care provider or recipient of funds, you must comply with all State and Federal laws and prevent misuse or fraud of any funds within this programs. Honesty and integrity are expected of all who participate in the Veteran Directed Program.

## *Examples of Fraud and Abuse Include*

- Submitting timesheets for services not actually provided
- Approving/authorizing hours that employees didn't actually work
- Recording more time or stating different times than you actually work
- Changing hours on a timesheet after it has been approved
- Not providing the services the veteran needs
- Falsifying a worker's compensation claim
- Falsifying or misrepresentation on applications or documentation
- Billing for services while in the hospital or other care facility
- Submitting twice for the same service
- Requiring an employee to "share" their paycheck with the employer

### Results

Fraud is a felony conviction that can lead to substantial penalties, including imprisonment of up to ten years, or a fine of up to $1,000 or an amount equal to twice the amount of assistance or benefits wrongfully obtained, or both. If convicted of fraud you may be excluded for a minimum of five years from any employment with a program or facility that receives Medicaid funding.

### *REPORTING*

If you suspect or know of fraud or abuse occurring, it is your duty and responsibility to report this immediately to the Area Agency on Aging and the Veteran's Administration. Or call ARIS Solutions at 866.970.3301 and the proper people will be contacted.

# Employer/Authorized Representative Background Checks

Effective February 1, 2024 any new Employer of Record or Authorized Representative whom is other than the Veteran, are required to undergo and pass a background check in accordance with the Veterans Administration (VA) and state polices as specified by the VDC provided to be designated as a Veteran's representative.

Per VA policy, any representative candidate who has a felony for fraud, abuse or exploitation for an individual may be not authorized as a representative for a Veteran.

Examples of Disqualifying Events as a Result of a Background Check would include:

1. A misdemeanor conviction against any individual that involves:

   a. Physical or sexual assault;
   b. Violence or exploitation;
   c. Child pornography;
   d. Threatening or reckless conduct;
   e. Theft;
   f. Fraud;
   g. Driving under the influence of drugs or alcohol;
   h. Any other conduct that represents evidence of behavior that could endanger the safety or well-being of an individual.

2. A conviction of a felony against an individual.

3. Additional factors considered in determining suitability may include, but not limited to:

   a. Relevance of the crime to the position sought;
   b. The nature of the work and/or activity to be performed;
   c. Time elapsed since the conviction;
   d. Age of the candidate at the time of the offense;
   e. The number of offenses;
   f. Whether the individual has pending charges;
   g. Any relevant evidence of rehabilitation or lack thereof;
   h. Any other relevant information, including information submitted by the individual or requested by the hiring authority.

# Employer/Authorized Representative Background Check Release Form

Veteran Directed Care Program

Care Coordinator _____AAA_____

| Veteran Demographic Information | | |
|---|---|---|
| Last Name: | First Name: | |
| Home Phone: | Cell Phone: | ID # (Last 4 SS#): |
| Is Veteran using a Representative? Yes____ No____ **(If no, skip Authorized Representative Information)** | | |

| Authorized Representative Demographic Information | | |
|---|---|---|
| Full Name (**If also a POA please attach documentation**): | | |
| Alias/Maiden Name (if more than one): | | |
| Home Phone Number: | Cell Phone: | Work Phone: |
| Address: | | |
| Address outside of state within 5 years: | | |
| Date of Birth: | Full Social Security Number: | |

By signing below, I am consenting to reviewing the list of excluded convictions, substantiations, and findings. I understand that ARIS Solutions will conduct background checks on behalf of the Veteran. I understand that the Veteran will be made aware of all findings and that any finding on the list of program background check exclusions will eliminate me from consideration as the Veteran's employer or Authorized Representative.

As so, I authorize ARIS Solutions to perform the following background check(s) on behalf of the Veteran. The cost of these background check(s) will be an expense to the Veterans budget.

* Indiana Criminal History Information Check *Office of Inspector General Check

**Signatures:**

Employer/Authorized Representative: _____ Date: _____

Veteran: _____ Date: _____

# Employer Confirmation of Receipt

I, _____, have read the "Program Integrity and Fraud Prevention" documents provided by ARIS Solutions.

I understand and accept my role or my designated representative's role as an employer in the Veteran Directed Program employment model.

I acknowledge that I am the employer of any employee I may choose to hire to provide home health care service in the Veteran Directed Program employment model.

I understand I am responsible for hiring, firing, training, and supervising my employees, as well as, maintaining program integrity by preventing and reporting fraud.

I understand and acknowledge that as a FMS Provider, ARIS Solutions, **will not** act as the employer of any employee I may choose to hire through this program.

Signed,

_____ _____

Signature of Employer Date

# FRAUD & ABUSE STATEMENT

**Fraud** is defined as **recklessly or purposefully** making false statements or representations to obtain some benefit or payment that you would not be entitled to without those statements or facts. These acts may be committed either for the person's own benefit or for the benefit of someone else. In other words, fraud includes the obtaining of something of value through misrepresentation or concealment of facts. Fraud is committed when a person or business deceives or distorts facts or information to get something they would not be otherwise entitled to. Fraud can range from a solo act to a broad-based operation by an institution or a group. Anyone can commit fraud.

**Examples of Medicaid/Veteran Administration Fraud include, but are not limited to**:

- Knowingly and/or purposefully filling out an employee timesheet incorrectly for hours or services that were not provided during the times listed or on the day listed;
- Knowingly and/or purposefully allowing the Vendor F/EA FMS-Support Broker entity to bill Medicaid/Veteran Administration for services that were not provided;
- Knowingly and/or purposefully using the Veteran's budget for any other purpose than what has been approved in the Veteran's service plan.
- Knowingly and/or purposefully allowing an employee to document services or hours that were not provided.
- Knowingly and/or purposefully submitting invoices to the Vendor F/EA FMS-Support Broker entity for goods and services that were not provided.
- Knowingly and/or purposefully having the Vendor F/EA FMS-Support Broker entity pay an employee or vendor for goods and/or services actually provided by someone else. (This is also tax fraud.)
- Knowingly and/or purposefully making a "side deal" with an employee to split their pay check with the Veteran or his/her representative. (This is also tax fraud).
- Knowingly or purposefully withholding information from authorities during an investigation
- Knowingly and/or purposely having the Vendor F/EA FMS-Support Broker entity pay for an approved good included in the Veteran's budget, and then return the approved good to get the cash or use it for something else that has not been approved.

Abuse is defined as practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to Medicaid/Veteran Administration and other programs, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medicaid/Veteran Administration program.

Examples of Medicaid/Veteran Administration Abuse include:

- Making errors when filling out the employee's timesheet and not immediately reporting the error to the Vendor F/EA FMS-Support Broker entity to remedy the situation.

- Being late in handing in Veteran/representative-employer related paperwork to the Vendor F/EA FMS-Support Broker entity.

The difference between Fraud and Abuse

Fraud is anything intentionally, purposefully or recklessly done to get something for your own benefit that you normally would not be entitled to. Abuse is anything that wasn't done intentionally or purposefully but was still completed incorrectly for your own benefit and not immediately reported.

Medicaid/Veteran Administration Fraud and Abuse is a crime against all taxpayers and is both a state and federal offense. All reports or allegations of fraud and abuse within the Veteran Directed Home and Community Based Services Program will be referred to the Veteran's Administration for possible criminal investigation. Veteran's suspected of Medicaid/Veteran Administration Fraud or Abuse also face termination from the Veteran Directed Home and Community Based Services Program.

_____

Veteran's Signature Date

_____

Authorized Representative Signature Date

_____

FMS Provider Signature Date

# HIPAA NOTICE OF PRIVACY PRACTICES & AGREEMENT

**This notice describes how medical information about you may be used and disclosed and how we may obtain access to this information. *Please review it carefully & keep for your records*.**

## DEFINITION OF MEDICAL INFORMATION

**When ARIS Solutions/ VDC Program refers to medical information, we mean protected health information (PHI). PHI is information that is individually identifiable health information including demographic information collected.**

## USES AND DISCLOSURES OF PHI

**Health Care Operations- Your medical information may be used and disclosed in connection with our health care operational including:**

- *Case management and care coordination.*
- *Quality assessment and improvement activities and protocol assessment.*
- *Reviewing the competence or qualifications of health care professionals, evaluating provider performance, conducting training programs, accreditation, certification activities, and credentialing activities.*
- *Conducting legal services, compliance programs, fraud and abuse detection*
- *Business planning and development.*

**Additional disclosures-PHI may be disclosed;**

- *To another entity that has relationship with the organization for their health care operations relating to quality improvement and assessment activities, reviewing competence or qualifications of health care professionals.*
- *To other entities that assist us in conducting our health care operations.*

***We will not disclose your medical information to those persons or entities unless they agree to keep it protected.***

**HIPAA NOTICE OF PRIVACY PRACTICES & AGREEMENT**
**continued...**

## For the Public Benefit- as authorized by law for the following purposes:

- *As required by law*
- *For public health activities, including disease and vital statistic reporting, FDA oversight, and for work related illness or injury*
- *To health oversight agencies*
- *In response to court and administrative orders*
- *To avert a serious threat to health and human safety*

*Your written authorization is required for all other uses and disclosures of your PHI. You may revoke your authorization at any time. However, your revocation will not affect any use or disclosure you permitted to your revocation.*

### *YOUR RIGHTS*

***Access to your information*** *— You have the right to inspect or obtain a copy of the medical information about you that is contained in a "designated record set". The organization may ask you to submit your request in writing.*

***Accounting of disclosures*** *– You have the right to receive a list of instances in which we or our associates disclosed your PHI for purposes other than health care operations or those authorized by you.*

***Confidential Communication*** *– You have the right to request that we communicate with you about your PHI by a different means or at a different location. You make this request in writing.*

***Amending your PHI*** *– You have the right to request that we amend your PHI contained in the "designated record set" if it is not correct or complete. We may require that this request be in writing.*

***Complaints*** *– You have the right to file a complaint if you believe your privacy rights have been violated. You may file this complaint with ARIS Solutions/ VDC Program and/or the Secretary of the Department of Health and Human Services. All complaints to ARIS Solutions/ VDC Program must be made in writing. We support your right to protect your PHI.*

***PLEASE KEEP THIS FOR YOUR RECORDS***

# HIPAA NOTICE OF PRIVACY PRACTICES & AGREEMENT

**PLEASE SIGN/DATE & RETURN TO ARIS SOLUTIONS**

*At ARIS Solutions/ VDC Program, we respect the confidentiality of your medical information and will protect information in a responsible manner. We have a privacy program in place that meets the requirements of HIPAA, the government legislation that sets standards for the privacy of medical information.*

*This notice will be effective for all medical information that we maintain, including medical information we created or received before* _____ (*date*)
_____(*initials*)

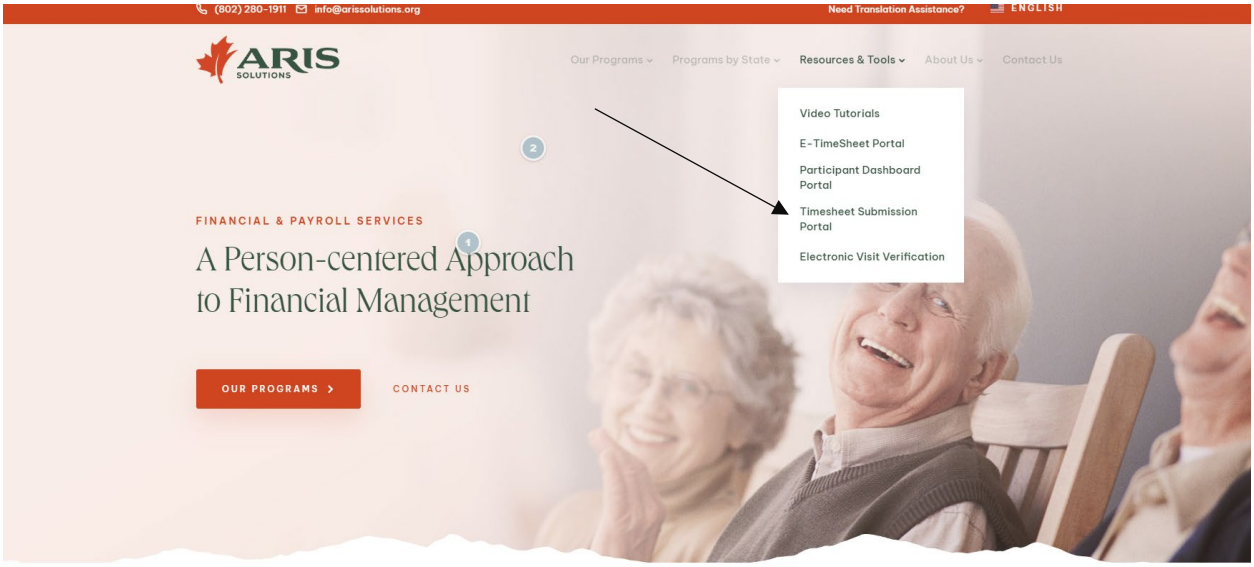
## *HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT AND CONSENT*

*I acknowledge that I have been provided with a notice of privacy practices and have been advised of how health information about me may be used and disclosed by ARIS Solutions/ VDHCBS Program and how may I obtain access to and control of this information.*

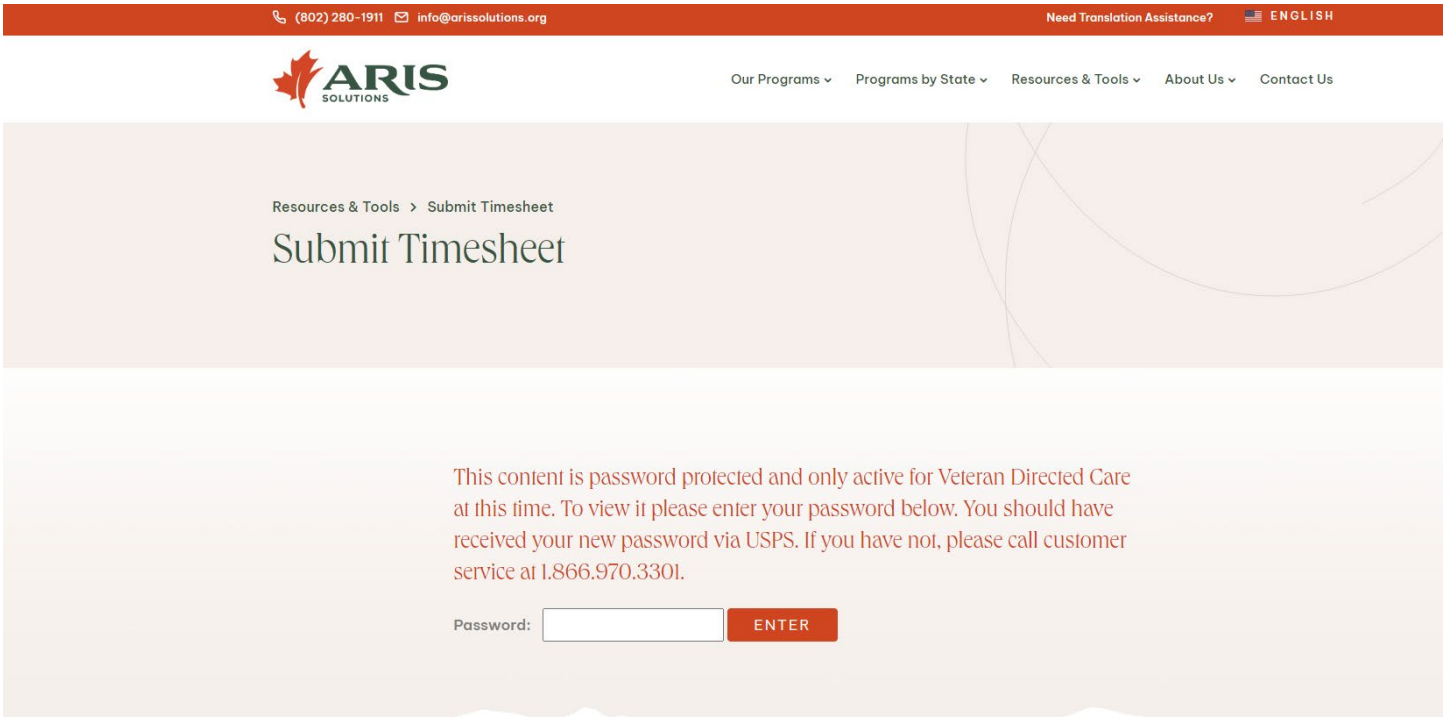
_____ _____

*Signature of Employer* *Date*

If you utilize the **Timesheet Submission Portal**, you can find it under the “Resources and Tools” tab on the home page. Please note it now requires a case sensitive password that we have provided below:




Once you click on “Timesheet Submission Portal” you will be brought to this screen:




Your password will be:

**ArisTime?4409**

Then, enter your first and last name and upload the timesheet file. You will receive a unique submission number for that timesheet. Record this number. If you are unsure if the file was successfully submitted, we can be reached at 1.866.970.3301.

# Electronic Timesheets Agreement

## I. About The Electronic Timesheets Module

a. The Electronic Timesheets Module is a web-based interface through which Consumers, Employers, Employees, and Fiscal Intermediary staff can respectively view relevant timesheet information.
b. Consumers, Employers and Employees will be able to use the system to both submit and approve timesheets electronically for payment by the Fiscal Intermediary.
c. A Consumer is not required to have an Employer in order to use the system. But in cases where a Consumer does have an Employer and the Consumer approves the Employer to have access to the Electronic Timesheets Submission Interface, both the Consumer and his/her Employer will have identical abilities to enter and approve timesheets for payment. If the Consumer does not feel comfortable with the electronic interface, the Employer has the ability to handle all of the Consumer's timesheet submission and approval responsibilities.

## II. Terms and Conditions

*By signing below, you are agreeing to the following Terms and Conditions:*

a. The Consumer and/or his/her Employer and the Employee must have valid e-mail addresses that they access frequently.
b. The Consumer, his/her Employer (if applicable) and the Employee agree to use the Electronic Timesheets Submission Interface as a method of submitting timesheets.
    i. Signing this Agreement does not require you to only use the Electronic Timesheets Submission Interface. Other methods of submitting time, such as faxing or mailing, are still acceptable.
c. A timesheet may not be submitted electronically if the Consumer and the Employee have not both signed and agreed to use the Electronic Timesheets Submission Interface via this Agreement.
    i. If the Consumer approves their Employer to use the system, then the Employer must also sign this Agreement.
d. An individual Electronic Timesheets Agreement is required for each Consumer/Employee relationship that chooses to use the Electronic Timesheets Submission Interface.
    i. This is true even if the Consumer or Employee is already using the Electronic Timesheets Submission Interface in another Consumer/Employee relationship.

Program: Veteran Direct Care

Veteran Name: _____ Veteran E-mail: _____

Employer Name: _____ Employer E-mail: _____

Employee Name: _____ Employee E-mail: _____

Veteran Signature: _____ Date: _____

Employer Signature: _____ Date: _____

Employee Signature: _____ Date: _____

** Note all fields in RED are required. Forms not completed in full will be returned.

**Please print very clearly and legibly, or processing could be delayed.**

## About the Electronic Timesheets Module

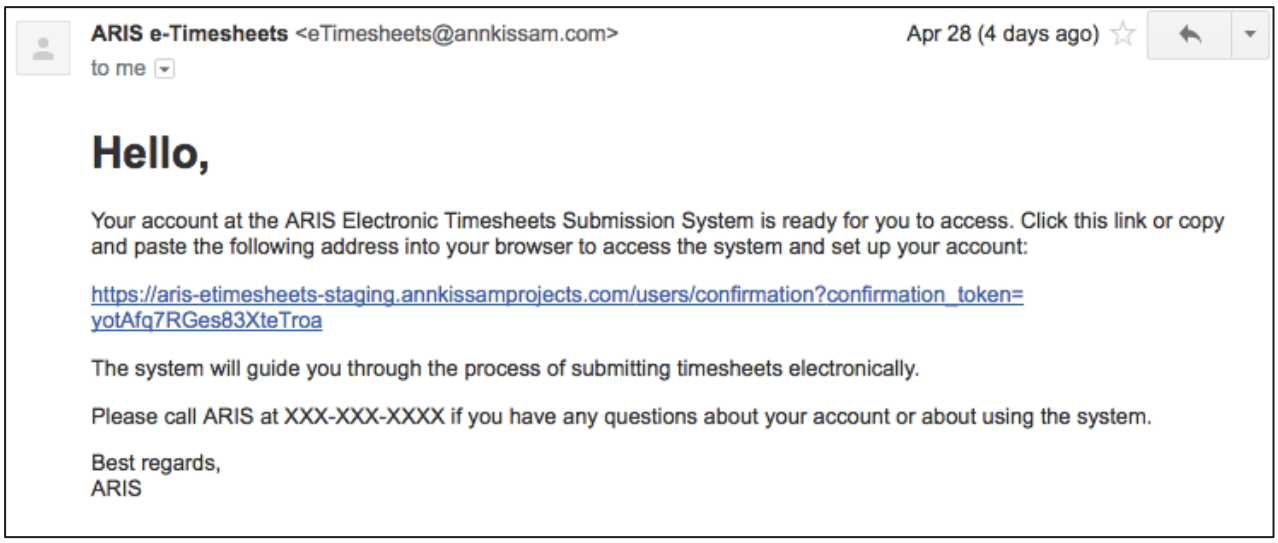
The Electronic Timesheets Module is a web-based interface through which Consumers, Employers, Representatives and Employees can respectively enter and view relevant timesheet information.

## Electronic Timesheets Agreement

In order to use the Electronic Timesheets Submission interface, a Consumer, their Representative or Employer (if applicable) and their Employee must sign an Electronic Timesheets Agreement which states that they both have valid e-mail addresses, and agree to use the electronic timesheets submission interface as a method of submitting time.

## Getting Started

1. An admin will create a user for the Consumer, Employer, Employee and Representative (if applicable).
2. The Consumer, Employer, Employee and Representative (if applicable) will each receive an e-mail alerting them that their account has been set up, and instructions for activating this account. Each user will click a one-time login link that expires after access to set up a password.



**ARIS e-Timesheets** <eTimesheets@annkissam.com> Apr 28 (4 days ago)

to me

**Hello,**

Your account at the ARIS Electronic Timesheets Submission System is ready for you to access. Click this link or copy and paste the following address into your browser to access the system and set up your account:

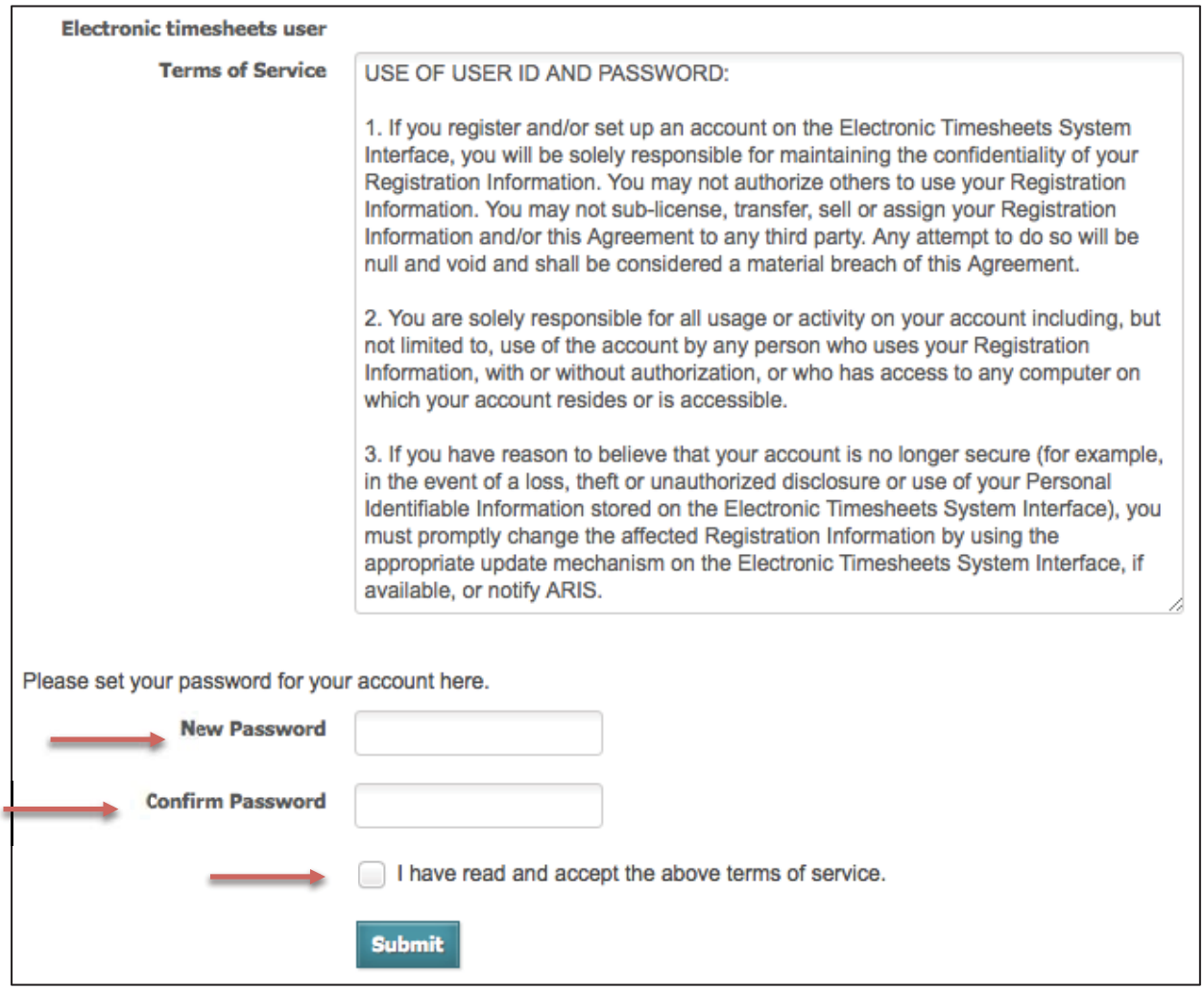
https://aris-etimesheets-staging.annkissamprojects.com/users/confirmation?confirmation_token=yotAfq7RGes83XteTroa

The system will guide you through the process of submitting timesheets electronically.

Please call ARIS at XXX-XXX-XXXX if you have any questions about your account or about using the system.

Best regards,
ARIS

3. Each user will be prompted to accept the Terms of Service, and set up a password for their account.




4. Once each user accepts the Terms of Service and creates a password, he or she may start using the system.

Time sheets are due on Mondays by 11:59pm Eastern Standard Time
Due dates do not change if they fall on a holiday.

## VDC- CO-IL-IN-ME-WI
## Time Sheet and Reimbursement Schedule 2024

| Pay Period | Pay Period Start Date | Pay Period End Date | Timesheet Submission Due Date | Payment Date |
|---|---|---|---|---|
| | | | | |
| **1** | **12/31/2023** | **1/13/2024** | **1/15/2024** | **1/19/2024** |
| 2 | 1/14/2024 | 1/27/2024 | 1/29/2024 | 2/2/2024 |
| **3** | **1/28/2024** | **2/10/2024** | **2/12/2024** | **2/16/2024** |
| 4 | 2/11/2024 | 2/24/2024 | 2/26/2024 | 3/1/2024 |
| **5** | **2/25/2024** | **3/9/2024** | **3/11/2024** | **3/15/2024** |
| 6 | 3/10/2024 | 3/23/2024 | 3/25/2024 | 3/29/2024 |
| **7** | **3/24/2024** | **4/6/2024** | **4/8/2024** | **4/12/2024** |
| 8 | 4/7/2024 | 4/20/2024 | 4/22/2024 | 4/26/2024 |
| **9** | **4/21/2024** | **5/4/2024** | **5/6/2024** | **5/10/2024** |
| 10 | 5/5/2024 | 5/18/2024 | 5/20/2024 | 5/24/2024 |
| **11** | **5/19/2024** | **6/1/2024** | **6/3/2024** | **6/7/2024** |
| 12 | 6/2/2024 | 6/15/2024 | 6/17/2024 | 6/21/2024 |
| **13** | **6/16/2024** | **6/29/2024** | **7/1/2024** | **7/5/2024** |
| 14 | 6/30/2024 | 7/13/2024 | 7/15/2024 | 7/19/2024 |
| **15** | **7/14/2024** | **7/27/2024** | **7/29/2024** | **8/2/2024** |
| 16 | 7/28/2024 | 8/10/2024 | 8/12/2024 | 8/16/2024 |
| **17** | **8/11/2024** | **8/24/2024** | **8/26/2024** | **8/30/2024** |
| 18 | 8/25/2024 | 9/7/2024 | 9/9/2024 | 9/13/2024 |
| **19** | **9/8/2024** | **9/21/2024** | **9/23/2024** | **9/27/2024** |
| 20 | 9/22/2024 | 10/5/2024 | 10/7/2024 | 10/11/2024 |
| **21** | **10/6/2024** | **10/19/2024** | **10/21/2024** | **10/25/2024** |
| 22 | 10/20/2024 | 11/2/2024 | 11/4/2024 | 11/8/2024 |
| **23** | **11/3/2024** | **11/16/2024** | **11/18/2024** | **11/22/2024** |
| 24 | 11/17/2024 | 11/30/2024 | 12/2/2024 | 12/6/2024 |
| **25** | **12/1/2024** | **12/14/2024** | **12/16/2024** | **12/20/2024** |
| 26 | 12/15/2024 | 12/28/2024 | 12/30/2024 | 1/3/2025 |
| **27** | **12/29/2024** | **1/11/2025** | **1/13/2025** | **1/17/2025** |
| 28 | 1/12/2025 | 1/25/2025 | 1/27/2025 | 1/31/2025 |

Time sheets, reimbursements, employee paperwork and check requests received by the ARIS Solutions office after the due dates posted above will be processed with the next pay period.

Send to:
ARIS Solutions
PO Box 4409
White River Junction, VT 05001
FAX: 1.802.295.9812

Questions?
Veterans Department
1.866.970.3301
https://arissolutions.org/submit-timesheet/

NATIONAL RESOURCE CENTER *for*
**PARTICIPANT-DIRECTED SERVICES**

VD-HCBS Resource January 2014

# WHAT EMPLOYERS NEED TO KNOW

*Author(s): Lucia Cucu, J.D.*

**Acknowledgements:** Lucia Cucu would like to acknowledge Merle Edwards-Orr and Mollie Murphy for their valuable contribution to this document. The detailed review and insightful comments they provided strengthened this resource.

*Special thanks to the Veterans Health Administration (Award #: VA244-P-1554) and Boston College for their generous sponsorship of this work.

# How to Protect Yourself and Your Worker: A Guide for Employers

Being an employer brings not only rights but also responsibilities. This guide describes a few important issues that every employer should know about.

## Maintaining a Safe Workplace

It is important to keep your home safe for your employee. Slips and falls are a common cause of injuries, so you should clean up or warn your employee of spills and wet surfaces, and keep stairs and flooring in good repair. If you have pets in your home, make sure they cannot bite or scratch your employee.

## Making Hiring and Firing Decisions

### Terminating Employees

Do not hesitate to terminate an employee who does not meet your needs. Most employment relationships are considered employment "at will," which means you can terminate an employee for any reason or no reason at all, so long as your reason is not discriminatory, retaliatory (see discussion below) or otherwise unlawful.

### Avoiding Promises about the Length of Employment

To avoid a claim for breach of contract, do not make any promises to your employee that you will keep him employed for a certain period of time or that you would only fire him for a specific reason. Remember that a contract does not always have to be in writing to be legally binding. Spoken statements and promises can sometimes create legal obligations.

### Avoiding Illegal Discrimination and Retaliation

In many states it is illegal to discriminate against employees based on certain factors, which can include race, color, religion, sex, national origin, marital status, sexual orientation. This means that you must not hire, fire, or harass employees based on such factors. While your employee is with you, be careful not to express any personal opinions that could be interpreted as discriminatory. Even if you are in your own home, the home is considered a workplace while your employee is there, and workplace discrimination and harassment are prohibited by law.

Do not allow friends or family to behave in ways that could be considered discriminatory or harassing towards your employee. As the employer, you could be held responsible for their behavior if you allow it to continue.

Sexual harassment is also illegal. It includes unwelcome sexual advances that can be physical or verbal, such as offensive comments or gestures that create a hostile environment. Remember that the harasser can be someone other than the employer, such as a guest visiting your home or someone who lives with you.

It is also illegal to fire employees in retaliation for reporting a crime or irregularity. For example, if an employee believes that an employer is misusing Medicaid funds and reports it to the authorities, it would be illegal to fire the employee in retaliation.

### Providing References for Former Employees

Be careful when talking about your reasons for terminating employees, because you could risk a claim of discrimination or defamation (saying things about the employee who harms them). If you are asked for a reference about a former employee and cannot provide a positive one, it is safest not to provide a reference at all.

## What Family Members and Authorized Representatives Need to Know

### Your Duty as Representative

In participant-directed programs, usually the participant (the person receiving services) is the employer. It is not unusual, however, for the participant to be unable or unwilling to serve as the employer. In those cases, the participant will designate a "representative" to serve as the employer. If you are designated as an authorized representative, you have a *fiduciary* duty to the participant. "Fiduciary" means you must always act in the best interest of the participant and not in your own interest. Program funds must always be spent for the participant's benefit, not your own benefit.

### Hiring and Training Employees

If the participant is likely to injure himself or others, you have a duty to warn employees of the risk and instruct them how to best handle it. Make sure to hire only employees who can deal with situations that arise. Ask them to confirm that they understand the risks and are willing and able to handle them.

If you are a parent, you must exercise reasonable care to control your minor child as best as you can, even if you are not listed as an authorized representative for the child. It is important to hire employees who are able to deal with any risks they may encounter when caring for your child. You should warn employees ahead of time of risks, and explain how to best handle situations that may to come up.

### Mandatory Reporter Duty

As an authorized representative, you may have a legal duty to report to the authorities if you suspect or notice that the participant is being abused by a family member, an employee, or some other person. Many states have "mandatory reporter" laws that could require you to report abuse of a child, an elderly adult or a person with a disability. You may have a duty to report the abuse even if the abuser is a member of your own family or the participant's family.

## Worker's Compensation Insurance

It is important to maintain a worker's compensation insurance policy, because such insurance will pay for claims if an employee is injured on the job.

If an employee is injured while at work, the employer is liable even if the injury is not the employer's fault. For example, if your employee drives to the grocery store on your behalf and is injured when a careless driver hits her car, the employee could ask you for compensation even though you could not have prevented the accident. This is because employers have to compensate employees for injuries sustained on the job. A worker's compensation insurance policy will pay for such claims.

## Liability Insurance

Worker's compensation will pay when your employee is injured, but what happens when someone else is injured? As an employer you may be liable when your employee injures someone else, even if the injury is not your fault. For example, if your employee causes a car accident while driving you to an appointment and injures a third party, the third party could sue you because your employee caused the accident while on the job.

Employment-related claims like wrongful termination, discrimination, or defamation are another source of liability that is not covered by worker's compensation insurance.

Some homeowner's, renter's, or liability insurance policies will cover such claims. However the terms of insurance policies vary, so you should read the terms and consult with an insurance agent before you start your participant direction program. You may consider an addition to your homeowner's or renter's policy, or a separate liability insurance policy, to be covered for liability risks related to domestic employees.