**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 ▶

ARIS Solutions

## 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* on *average cost around $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-EMPLOYER
ARIS Solutions

# VDC Maine 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

**AGENCY CUSTOMER ID:** _____

## GENERAL INFORMATION (continued)

| EXPLAIN ALL "YES" RESPONSES | Y / N |
|---|---|
| 17. ANY OTHER INSURANCE WITH THIS INSURER? | ✔ |
| 18. ANY PRIOR COVERAGE DECLINED / CANCELLED / NON-RENEWED IN THE LAST THREE (3) YEARS? (Missouri Applicants - Do not answer this question) | ✔ |
| 19. ARE EMPLOYEE HEALTH PLANS PROVIDED? | ✔ |
| 20. DO ANY EMPLOYEES PERFORM WORK FOR OTHER BUSINESSES OR SUBSIDIARIES? | ✔ |
| 21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS? | ✔ |
| 22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME? If "YES", # of Employees: _____ | ✔ |
| 23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST FIVE (5) YEARS? (If "YES", please specify) | ✔ |
| 24. ANY UNDISPUTED AND UNPAID WORKERS COMPENSATION PREMIUM DUE FROM YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? IF YES, EXPLAIN INCLUDING ENTITY NAME(S) AND POLICY NUMBER(S). | ✔ |

## SIGNATURE

Copy of the Notice of Information Practices (Privacy) has been given to the applicant. (Not required in all states, contact your agent or broker for your state's requirements.)

PERSONAL INFORMATION ABOUT YOU, INCLUDING INFORMATION FROM A CREDIT OR OTHER INVESTIGATIVE REPORT, MAY BE COLLECTED FROM PERSONS OTHER THAN YOU IN CONNECTION WITH THIS APPLICATION FOR INSURANCE AND SUBSEQUENT AMENDMENTS AND RENEWALS. SUCH INFORMATION AS WELL AS OTHER PERSONAL AND PRIVILEGED INFORMATION COLLECTED BY US OR OUR AGENTS MAY IN CERTAIN CIRCUMSTANCES BE DISCLOSED TO THIRD PARTIES WITHOUT YOUR AUTHORIZATION. CREDIT SCORING INFORMATION MAY BE USED TO HELP DETERMINE EITHER YOUR ELIGIBILITY FOR INSURANCE OR THE PREMIUM YOU WILL BE CHARGED. WE MAY USE A THIRD PARTY IN CONNECTION WITH THE DEVELOPMENT OF YOUR SCORE. YOU MAY HAVE THE RIGHT TO REVIEW YOUR PERSONAL INFORMATION IN OUR FILES AND REQUEST CORRECTION OF ANY INACCURACIES. YOU MAY ALSO HAVE THE RIGHT TO REQUEST IN WRITING THAT WE CONSIDER EXTRAORDINARY LIFE CIRCUMSTANCES IN CONNECTION WITH THE DEVELOPMENT OF YOUR CREDIT SCORE. THESE RIGHTS MAY BE LIMITED IN SOME STATES. PLEASE CONTACT YOUR AGENT OR BROKER TO LEARN HOW THESE RIGHTS MAY APPLY IN YOUR STATE OR FOR INSTRUCTIONS ON HOW TO SUBMIT A REQUEST TO US FOR A MORE DETAILED DESCRIPTION OF YOUR RIGHTS AND OUR PRACTICES REGARDING PERSONAL INFORMATION.
(Not applicable in AZ, CA, DE, KS, MA, MN, ND, NY, OR, VA, or WV. Specific ACORD 38s are available for applicants in these states.) **(Applicant's Initials):** _____

**Applicable in AL, AR, DC, LA, MD, NM, RI and WV:** Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD Only.

**Applicable in CO:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Applicable in FL and OK:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)*. *Applies in FL Only.

**Applicable in KS:** Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

**Applicable in KY, NY, OH and PA:** Any person who knowingly and with intent to defraud any insurance company or other 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 such person to criminal and civil penalties (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY Only.

**Applicable in ME, TN, VA and WA:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME Only.

**Applicable in NJ:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**Applicable in OR:** Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

**Applicable in PR:** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

**Applicable in UT:** Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

THE UNDERSIGNED IS AN AUTHORIZED REPRESENTATIVE OF THE APPLICANT AND REPRESENTS THAT REASONABLE INQUIRY HAS BEEN MADE TO OBTAIN THE ANSWERS TO QUESTIONS ON THIS APPLICATION. HE/SHE REPRESENTS THAT THE ANSWERS ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF HIS/HER KNOWLEDGE.

| APPLICANT'S SIGNATURE (Must be Officer, Owner or Partner) | DATE | PRODUCER'S SIGNATURE | NATIONAL PRODUCER NUMBER |
|---|---|---|---|
| | | | |

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

MAINE DEPARTMENT OF LABOR
Bureau of Unemployment Compensation
47 State House Station
Augusta ME 04333-0047

# POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS:

That _____ UI Account No. _____
(Business name)

having its principal office at _____ Federal ID No. _____
(Business mailing address)

_____ Telephone _____
(City) (State) (Zip Code)

hereby constitutes and appoints ARIS Solutions
(Designated authority)
PO Box 4409
(Designated authority mailing address)
White River Jct., VT 05001
(City) (State) (Zip Code)

its true and lawful attorney in fact with full power and authority to represent said company before the Maine Department of Labor, Bureau of Unemployment Compensation, effective immediately and until this authority has been superseded by another or has been revoked in writing in connection with any and all unemployment insurance matters as indicated below.

**Please check all that apply**

- [X] 1. Filing of completed forms, including claims for refund or account adjustments, assessments, liability or status determinations, contribution rate and wage record reports.
- [X] 2. Payment of contributions and any penalties and interest assessed on the account.
- [X] 3. Obtaining and discussion of all account information required and authorized by the Maine Employment Security Law.
- [X] 4. All matters affecting the experience record and contribution rate of the employer account.
- [X] 5. Employee wage and separation information and employer's appeal of benefit claims.

**Please confirm and provide the mailing address for Items 6 and/or 7 below.**

6. Send a copy of all mailings pertaining to unemployment **benefits** to:

| (C/O Name) | (Mailing Address) | (City) | (State) | (Zip Code) |
|---|---|---|---|---|
| ARIS Solutions Veterans Dept | PO Box 4409 | White River Jct., | VT | 05001 |

7. Send a copy of all mailings pertaining to unemployment **taxes** to:

| (C/O Name) | (Mailing Address) | (City) | (State) | (Zip Code) |
|---|---|---|---|---|
| ARIS Solutions Veterans Dept | PO Box 4409 | White River Jct., | VT | 05001 |

IN WITNESS WHEREOF, the said _____
(Signature of Owner, Officer or Member)

has caused this instrument to be duly attested by the signature of its duly qualified officer this _____ day of _____, 20____.

**This authorization cancels and supersedes all prior authorizations.**

| Printed Name of Owner, Officer or Member: | Title: HCSR |
|---|---|

**QUESTIONS ABOUT THIS NOTICE?**

Contact a Representative at (207) 621-5120, select option 3; Fax: (207) 287-3733;
TTY Users Call Maine Relay 711; E-mail address: division.uctax@Maine.gov

***Avoid missed mailings and potential late fees by notifying MDOL of any changes to your account.***

| FORM 2848-ME | **Power of Attorney** | **Maine Revenue Services**<br>**P.O. Box 1060**<br>**Augusta, ME 04332-1060** |
|---|---|---|

**READ INSTRUCTIONS** attached before completing this form. The filing of this form automatically revokes all earlier powers of attorney on file with Maine Revenue Services for the same tax type and years/periods.

If you previously submitted another Power of Attorney ("POA") and you **do not** want the prior POA revoked, check here and attach a copy of the POA you would like to remain in effect……☐

## *PART I: POWER OF ATTORNEY*

**1. Taxpayer information** *(taxpayer(s) must sign and date this form in Section 5 below)*

| Taxpayer's name | | Taxpayer ID Number (SSN or EIN) |
|---|---|---|
| Spouse's name *(if you filed a joint return and both spouses are appointing the same representative)* | | Spouse's SSN |
| Mailing address | | City, state, zip |
| Country *(if not United States)* | Telephone number | Email address (optional) |

**2. Representative information**

| Primary representative name<br>Emilie Donka | | Firm or company name<br>ARIS Solutions |
|---|---|---|
| Mailing address<br>PO Box 4409 | | City, state, zip<br>White River Jct., VT 05001 |
| Country *(if not United States)* | Telephone number<br>866.970.3301 | Email address (optional)<br>emilie.donka@arissolutions.org |
| Alternate representative name<br>Theresa Danforth | | Firm or company name<br>ARIS Solutions |
| Mailing address<br>PO Box 4409 | | City, state, zip<br>White River Jct., VT 05001 |
| Country *(if not United States)* | Telephone number<br>866.970.3301 | Email address<br>theresa.danforth@arissolutions.org |

**3. Notices and communications**

Maine Revenue Services may send copies of notices and other communications relating to the matters authorized in section 4 to the **primary representative** identified above.

**Please note:** This authorization does not *require* Maine Revenue Services to send notices to the representative. Many notices, particularly computer-generated notices, will be sent only to the taxpayer and not to the representative.

**4. Authority of representative(s)**

The taxpayers named in section 1 appoint the individuals named in section 2 to act as their representative(s) with **full authority** to receive confidential information and to perform **any and all acts** the taxpayers can perform in connection with the following matters, **except,** the representative(s) may not delegate their authority to another individual. If you wish to limit the authority granted by this POA, please describe the limitation: _____

Mark an **X** in all boxes that apply. The POA will not be valid if this section is left blank. See instructions for additional limitations.

| Tax Type | Specific Years/Periods | Tax Type | Specific Years/Periods |
|---|---|---|---|
| ☐ Individual Income Tax | | ☐ Other (*describe*) | |
| ☐ Corporate Income Tax | | | |
| ☒ Withholding | 2022-2025 | | |
| ☐ Sales and Use Tax | | | |

**5. Taxpayer signature**

I certify, under penalty of perjury, that I am the taxpayer identified in section 1 above, or if signing as a corporate officer, that I am a partner, member, manager, or fiduciary acting on behalf of the taxpayer, that I have the authority to execute this POA.

| Signature | Print name *(and title, if applicable)* | Date |
|---|---|---|
| Spouse's signature *(required if listed above)* | Print name | Date |

## *PART II: DECLARATION OF REPRESENTATIVE*

I certify, under penalty of perjury, that I am:

| Primary | Alternate | |
|---|---|---|
| ☐ | ☐ | A member in good standing of the bar of the highest court of the following jurisdiction: _____ |
| ☐ | ☐ | Duly qualified to practice as a certified public accountant in the following jurisdiction: _____ |
| ☐ | ☐ | An enrolled agent under U.S. Department of Treasury Circular 230 |
| ☐ | ☐ | A bona fide officer of the taxpayer's organization |
| ☐ | ☐ | A full-time employee of the taxpayer |
| ☐ | ☐ | A member of the taxpayer's immediate family |
| ☐ | ☐ | A fiduciary of the taxpayer |
| ☒ | ☒ | Other (explain): A full-time employee of a Fiscal Intermediary |

| Signature – Primary Representative | Print name *(and title, if applicable)* | Date |
|---|---|---|
| Signature – Alternate Representative | Print name *(and title, if applicable)* | Date |

**FORMS NOT SIGNED, DATED, OR OTHERWISE INCOMPLETE WILL NOT BE ACCEPTED.**

# Instructions

## General Information

Use Form 2848-ME to authorize an individual to represent you before Maine Revenue Services ("MRS"). Signing this Power of Attorney ("POA") form authorizes MRS to communicate with and provide your confidential information to the individual you name as your representative.

Unless you limit the authority (see section 4), your representative will be authorized to perform any and all acts you can perform, including, but not limited to: receiving your confidential information; agreeing to tax adjustments; signing settlement agreements; and making otherwise binding decisions on your behalf with regard to the tax matters covered by the POA.

### Limited Power of Attorney Form 2848-L

If you want your representative to communicate with and receive confidential information from MRS, but you do not want that person to act on your behalf, please fill out Form 2848-ME-L ("Limited Power of Attorney") instead.

## Revocation

Filing Form 2848-ME will automatically revoke any earlier POA's on file with MRS that cover the same tax types and same years/periods.

*Example 1:*

On 5/1/2017, you authorize Jane Doe to represent you for individual income tax for 2015. On 10/1/2017, you authorize Jim Jones to represent you for individual income tax for 2016. Both POA's are valid.

*Example 2:*

On 5/1/2017, you authorize Jane Doe to represent you for individual income tax for 2015. On 10/1/2017, you authorize Jim Jones to represent you for sales and use tax for 2015. Both POA's will be valid.

*Example 3:*

On 5/1/2017, you authorize Jane Doe to represent you for individual income tax for 2015. On 10/1/2017, you authorize Jim Jones to represent you for individual income tax for years 2015-2018. Filing the POA for Jim Jones will automatically revoke the POA for Jane Doe.

If you do not want a prior POA automatically revoked, you must check the box at the top of the form and attach a copy of the prior POA you would like to remain in effect.

Other requests to revoke a POA must be in writing and must be signed by the taxpayer.

## PART I – Power of Attorney

### *Section 1 – Taxpayer information*

The Taxpayer's identification number may be a social security number ("SSN") or employer identification number ("EIN") depending on the type of taxpayer. Please fill out the taxpayer information section accurately and completely. Note: By providing an email address, you authorize MRS to communicate your confidential information via email to the address provided.

### *Section 2 – Representative information*

Form 2848-ME allows you to authorize one or more representatives. Representatives must be individuals, i.e., you cannot name a firm as your representative but you can name a person or persons at the firm. Note: By providing an email address, you authorize MRS to communicate your confidential information via email to the address provided.

### *Section 3 – Notices and communications*

MRS may send copies of notices and other communications relating to the tax matters authorized in section 4 only to the primary representative. Many notices, particularly computer-generated notices, will be sent only to the taxpayer and not to the representative.

### *Section 4 – Authority of representatives*

This section allows you to specify which tax matters are covered by the POA and what authority you are granting your representative. By default, your representative will have full authority to receive your confidential information and to perform any and all acts you can perform in connection with the matters described in section 4. However, your authorized representative may not delegate their authority to another individual. If you wish to limit your representative's authority, please specifically describe the limitation.

For this form to be valid, you must select both the tax type and years/periods covered by the POA. If no tax type is selected, the POA will not be accepted.

You may list current, prior, or future years/periods. You must use specific periods. General references such as "All Years" will not be accepted.

Note: MRS will not accept a POA for future years/period which begin more than three years from the date the POA is received by MRS.

### *Section 5 – Taxpayer signature*

You must sign, print your name, and date the POA for it to be valid. If you filed a joint return and both spouses are appointing the same representative, both spouses must sign. POA forms must be hand-signed.

If you are signing on behalf of the taxpayer, please include your title—e.g., a "CEO" signing on behalf of a corporate taxpayer. You may be asked by MRS to verify your identity and/or provide evidence of authority to sign the POA.

## PART II – Declaration of Representatives

Your representative must indicate their relationship to you and sign and date the form. The POA must be signed by the representative to be valid.

## Submitting Completed POA Form

Completed POA forms should be mailed to MRS at the address at the top of the form. Completed POA forms may also be faxed or emailed to the MRS division responsible for the tax type covered by the POA. For fax/email contact info for the specific divisions, visit our website at: www.maine.gov/revenue/about/contact.

# 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.

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

*Agency of Human Services 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*)

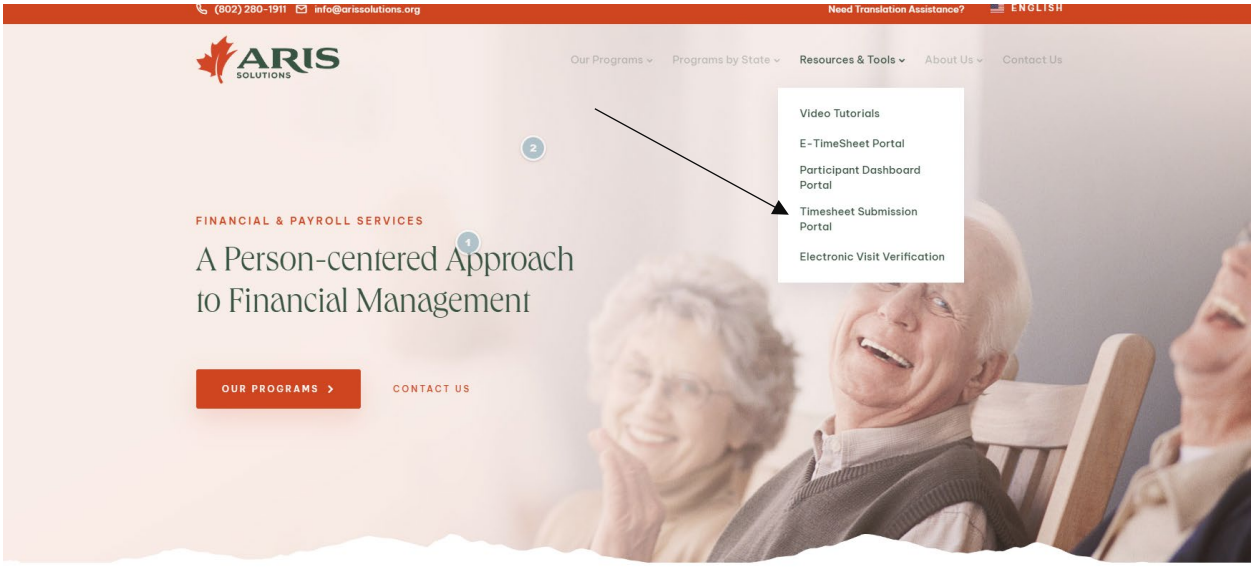
## *HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT AND CONSENT*

*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.*

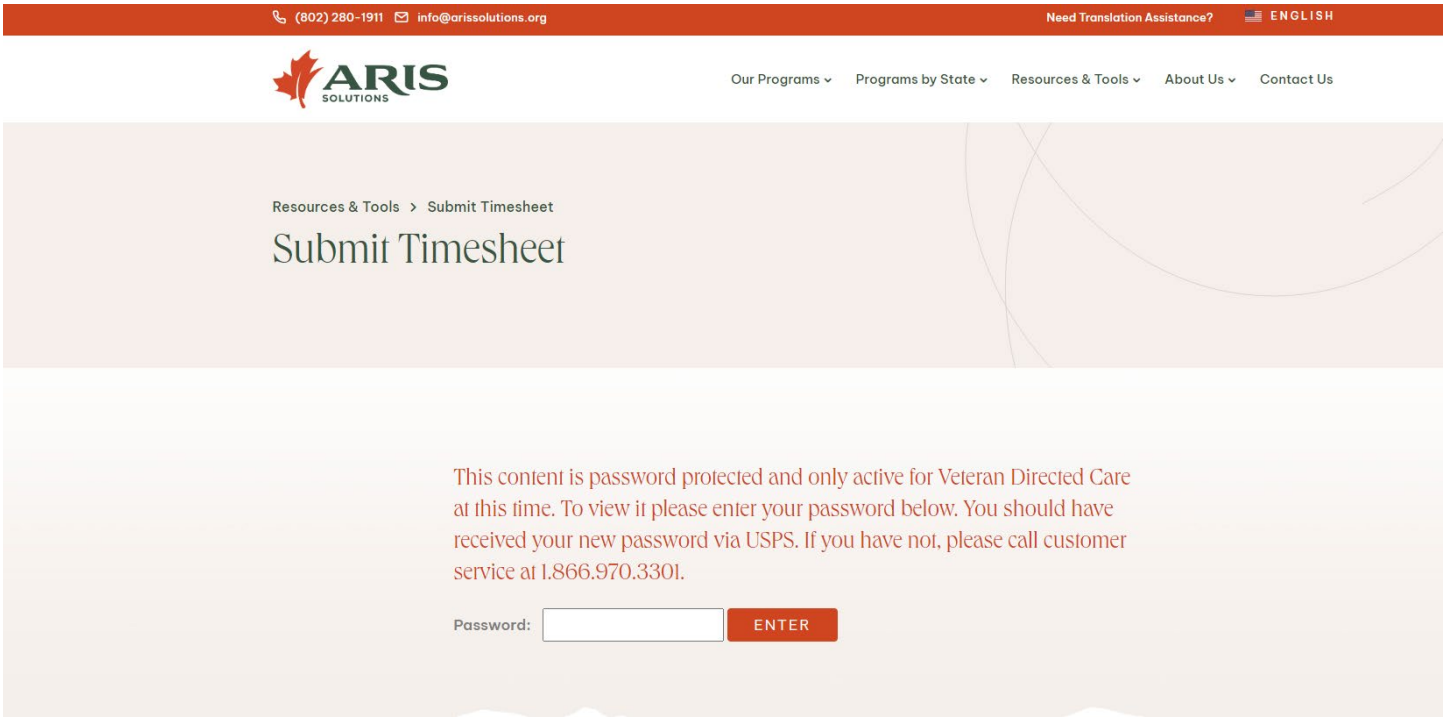
_____ _____

*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

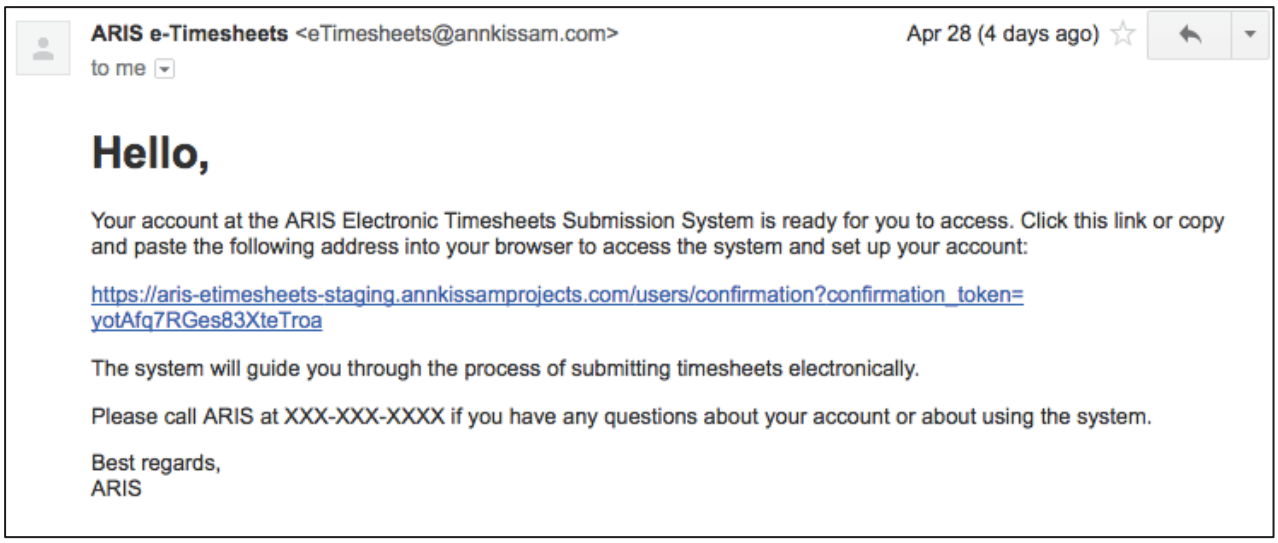
The Electronic Timesheets Module is a web-based interface through which Consumers, Employers, Representatives and Employees can respectively enter and view relevant timesheet information.

## 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:

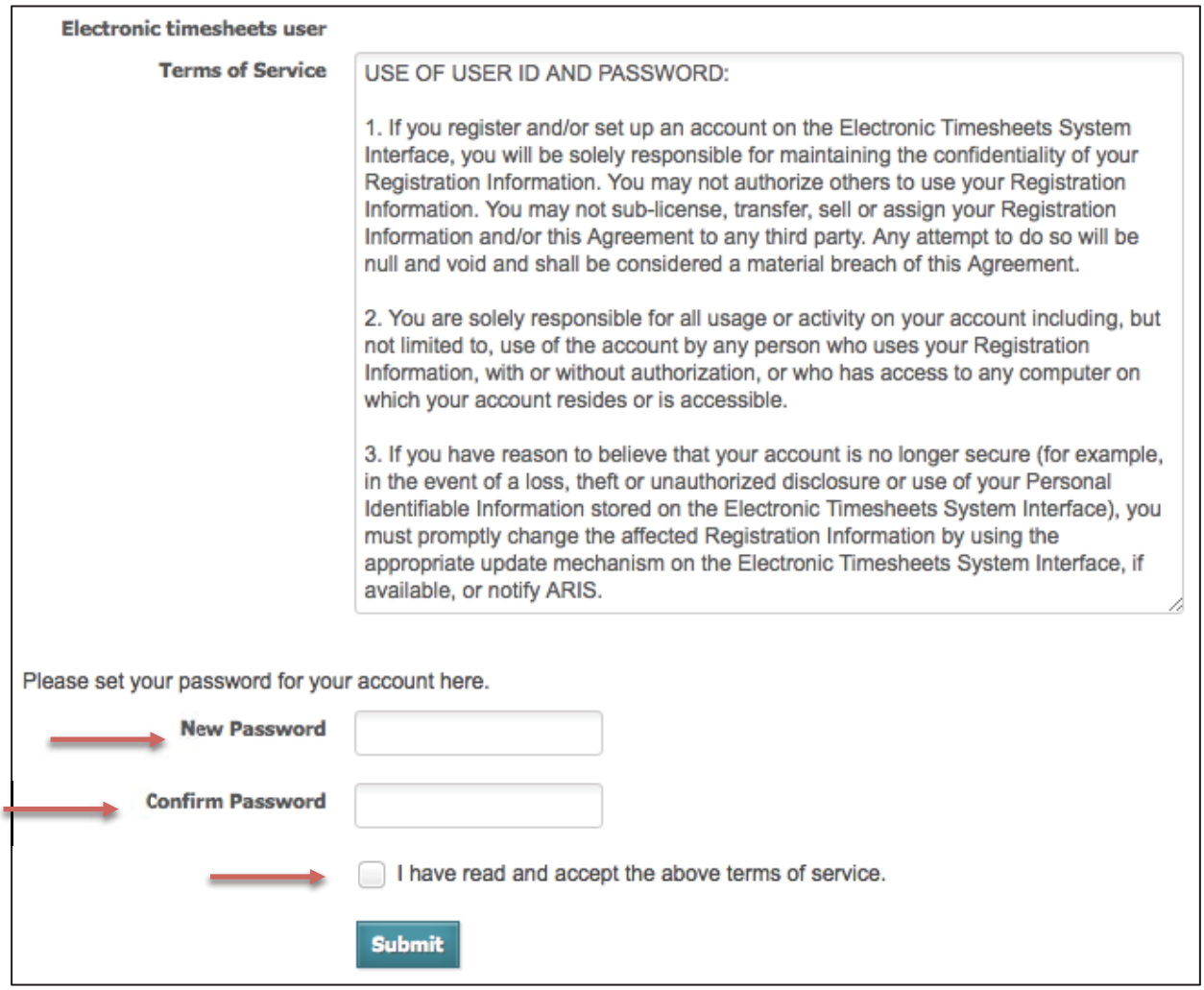
https://aris-etimesheets-staging.annkissamprojects.com/users/confirmation?confirmation_token=yotAfq7RGes83XteTroa

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/

# Veteran Directed Care Program Timesheet- Maine

**EMPLOYEE NAME:_____LAST FOUR DIGITS OF SS #_____**

**Veteran Name:_____Veteran Phone # _____**

Was the Veteran admitted to a hospital or nursing home during any of these dates? Yes_____No_____

If **YES**, indicate the dates the Veteran was **admitted to and discharged from** the hospital or nursing home_____

**NO SERVICES CAN BE PAID WHILE PARTICIPANT IS ADMITTED TO A HOSPITAL/NURSING HOME**

| Please Enter Pay Period Date Range: | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Date | Start Time | AM | PM | End Time | AM | PM | Service Code | # of Hours Worked |
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| Total Hours Worked for Current Pay Period | | | | | | | | |

*We (below) certify that the information provided on this form is true, accurate and complete.*

Employee Signature _____ Date _____

Employer Signature _____ Date _____

Timesheets received by ARIS Solutions after the due dates on the Payroll Schedule will be processed for the next scheduled pay date.

**Mail timesheets to:** ARIS Solutions- Veteran Dept. PO Box 4409 White River Jct., VT 05001

**Secure Fax:** 1.802.295.9812 **Secure Portal:** https://arissolutions.org/submit-timesheet/



***Please note it is the Veteran/Representative-Employer's responsibility to ensure the accuracy of the service codes used. Be sure to review prior to submission, especially when a Back-up worker is utilized.***

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

VD-HCBS Resource January 2014

# WHAT EMPLOYERS NEED TO KNOW

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

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# 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.