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 Confirmation of Receipt
- ❑ Fraud & Abuse Statement
- ❑ Employer/Authorized Representative Background Check Release From
- ❑ 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 Schedule employees (staying within your authorized budget) Train employees Sign timesheets Review employees job performance	Meet your requirements for hiring Complete required employment paperwork Submit a background check Submit signed timesheets to ARIS	Assist with paperwork, as needed Establish you as an employer Establish your worker as your employee Conduct criminal background checks
Dismiss employees Establish clear boundaries Let your employee know what the rules are and what their responsibilities are Prevent fraud	Respect employer's boundaries, rules and responsibilities Provide home care services to your employer as directed by your employer Prevent fraud	Provide payroll services Prepare and disburse payroll checks Pay employer taxes Prepare year-end tax reports 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

3

Employer/Veteran Information Form

NAME OF EMPLOYER *(this will be the AR or the Veteran)*

Name _____
(Last) (First) (Middle)

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

Phone (_____) _____ **Email** _____

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

FEIN (If previously issued)_____

Relationship to Veteran _____

Veteran IS EMPLOYER **YES** **NO**

If yes please skip next section.

PERSON-CENTERED COUNSELOR: _____

NAME OF VETERAN

Name _____ **GENDER** _____

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

Phone (_____) _____

Date of Birth _____

Social Security Number _____

Form **SS-4**
(Rev. December 2023)
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.)
See separate instructions for each line. Keep a copy for your records.
Go to *www.irs.gov/FormSS4* for instructions and the latest information.

OMB No. 1545-0003

EIN

Type or print clearly.

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

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)
C/O 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)
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
- ☐ Farmers' cooperative
- ☐ REMIC
- ☐ State/local government
- ☐ Federal government
- ☐ 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) Home Care Service Recipient
- ☐ 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

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 will generally be $1,000 or less if you expect to pay $5,000 or less, $6,536 or less if you're in a U.S. territory, in total wages.) If you don't check this box, you must file Form 941 for every quarter. ☐

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)

17 Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided.

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: ARIS Solutions Fiscal Agent
Designee's telephone number (include area code): 866.970.3301
Address and ZIP code: PO Box 4409 White River Jct., VT 05001
Designee's fax number (include area code): 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.

Name and title (type or print clearly)

Applicant's telephone number (include area code)

Applicant's fax number (include area code)

Signature — Date

VDC Kansas Worker's Compensation Form

Employer Legal Name: 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: Full Time: _____ Part Time: _____
Estimated Annual Payroll:
Effective Date of Coverage (start date):   Employer Signature and Date:

Note- Worker's Compensation is required in Kansas if you have non-family employees and will pay wages higher than $20,000.00. Otherwise this form is **OPTIONAL.**
Please contact ARIS Solutions if either of these conditions change.

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.

Missouri 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:	3 3 0 1
	NAME:	
ACCTNG RECORD	PHONE:	802-281-7836
	NAME:	Theresa Danforth
CLAIMS INFO	PHONE:	802-281-7836
	NAME:	Theresa Danforth

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

		Are cancer treatments provided?	No
		Do they give immunizations or shots?	No
Does insured have any locations outside of this state?	No	Do they take safety precautions with pregnant employees?	No
Is travel radius greater than 200 miles?	No	Do they have procedures for reporting unsafe conditions?	No
Are operations 24 hours?	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)

Note- Worker's Compensation is required in Kansas if you have non-family employees and will pay wages higher than $20,000.00. Otherwise this form is **OPTIONAL.** Please contact ARIS Solutions if either of these conditions change.

Form 2678 Employer/Payer Appointment of Agent

(Rev. December 2023) 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're an employer or payer who wants to request approval, complete Parts 1 and 2 and sign Part 2. Then give it to the agent. Have the agent complete Part 3 and sign it.

  Note: This appointment isn't effective until we approve your request. See the instructions for more information.

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

For IRS use:

Part 1: Why you're filing this form.

(Check one)

[x] 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, Employer's Annual Federal Unemployment (FUTA) Tax Return* (all 940 series)	[x]	[ ]
Form 941, Employer's QUARTERLY Federal Tax Return (all 941 series)	[x]	[ ]
Form 943, Employer's Annual Federal Tax Return for Agricultural Employees (all 943 series)	[ ]	[ ]
Form 944, Employer's ANNUAL Federal Tax Return (all 944 series)	[ ]	[ ]
Form 945, Annual Return of Withheld Federal Income Tax	[ ]	[ ]
Form CT-1, Employer's Annual Railroad Retirement Tax Return	[ ]	[ ]
Form CT-2, Employee Representative's Quarterly Railroad Tax Return	[ ]	[ ]

* Generally, you can't appoint an agent to report, deposit, and pay tax reported on Form 940, unless you're a home care service recipient.

[x] Check here if you're a home care service recipient, and you want to appoint the agent to report, deposit, and pay FUTA tax for you. See the instructions.

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

Sign your name here

Print your name here

Print your title here

Date / /

Best daytime phone

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 PO Box 4409 White River Jct., VT 05001	CAF No. 0313-84964R PTIN Telephone No. 866.970.3301 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. PTIN Telephone No. 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	2024-2027	Tax Liability
Authority to obtain existing FEIN	SS4, 8821	2024-2027	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

KANSAS DEPARTMENT OF REVENUE

800618

POWER OF ATTORNEY

1. TAXPAYER INFORMATION.

Include spouse's name if this is for a joint return. If a business, enter both its legal name and its trade or DBA name. Both the person granting and the person being granted the power of attorney **must** sign and date this form below in Sections 3 and 4.

Taxpayer's Name (if a business include both legal name and DBA name)					Taxpayer's EIN/SSN/PTIN
Address	City		State	Zip Code	Area Code & Phone Number
Foreign Address (if applicable)	City	Province	Country	Zip Code	Email Address
Spouse's Name					Spouse's Social Security Number
Address (if different)	City		State	Zip Code	Area Code & Phone Number
Foreign Address (if applicable)	City	Province	Country	Zip Code	Email Address

2. TAXPAYER GRANT OF POWER OF ATTORNEY.

I hereby appoint the following attorney, accountant, or other representative as my attorney-in-fact:

Representative's name and title (if member of a firm, enter both the representative's name and firm name) Emilie Donka - Associate Director Enrollment & Tax				EIN/SSN/PTIN	Phone Number 866.970.3301
Address PO BOX 4409 , WHITE RIV JCT ,VT 05001	City		State	Zip Code	Fax Number
Foreign Address (if applicable)	City	Province	Country	Zip Code	Email Address
Representative's name and title (if member of a firm, enter both the representative's name and firm name)				EIN/SSN/PTIN	Phone Number
Address	City		State	Zip Code	Fax Number
Foreign Address (if applicable)	City	Province	Country	Zip Code	Email Address

To represent me before the Kansas Department of Revenue for the following tax matters:

☐ All Tax Types (if not all list those applicable below) ☒ All Tax Years (if not all list those applicable below)

Type of Tax (Individual Income, Sales, Withholding, etc.)	Tax Year(s) or Period(s)
WITHHOLDING	

AUTHORIZED ACTS.

For the tax types and periods listed, the representative(s) are authorized to (check all applicable boxes):

☐ Receive and inspect my confidential tax information.

☒ Represent me in tax matters before the department.

☒ Sign agreements, consents or other documents on my behalf.

☒ Perform any act that I can perform with respect to the tax matter listed above.

☐ List any specific additions or deletions to the acts that are otherwise authorized in this power of attorney (see Instructions).

RETENTION/REVOCATION OF PRIOR POWERS OF ATTORNEY.

I hereby revoke all earlier powers of attorney on file with the Kansas Department of Revenue for the same tax matters and periods covered by this document.

☐ Check here if you DO NOT wish to revoke a prior power of attorney. List below representatives you want to retain power of attorney.

Representative's name and title (if member of a firm, enter both the representative's name and firm name)	EIN/SSN/PTIN
Representative's name and title (if member of a firm, enter both the representative's name and firm name)	EIN/SSN/PTIN

PLEASE SIGN PAGE 2

VDC-EMPLOYER

3. SIGNATURE OF TAXPAYER(S). If a tax matter concerns a joint return, both husband and wife must sign when joint representation is requested. When a corporate officer, partner, guardian, executor, receiver, administrator, or trustee signs this section on behalf of a taxpayer, the signatory also certifies that the signatory is authorized to execute this form on behalf of the taxpayer.

(Signature)	(Printed Name)	(Date)
(Signature)	(Printed Name)	(Date)

4. SIGNATURE OF REPRESENTATIVE(S).

(Signature)	(Printed Name)	(Date)
(Signature)	(Printed Name)	(Date)

INSTRUCTIONS FOR POWER OF ATTORNEY AUTHORIZATION

A power of attorney is a legal document authorizing someone to act as your representative. You, the taxpayer, must complete, sign, and return this form if you wish to grant a power of attorney (POA) to an attorney, accountant, agent, tax return preparer, family member, or anyone else to act on your behalf with the Kansas Department of Revenue (KDOR). You may use this form for any matter affecting any tax administered by the department, including audit and collection matters. This POA will remain in effect until the expiration date, if included under Section 2, or until you revoke it, whichever is earlier. KDOR will accept copies of this form, including fax copies.

SECTION 1. TAXPAYER INFORMATION.

Individuals. In the block provided, enter your name, SSN, address, telephone number, and email address in the spaces provided. If this POA is for a joint return and your spouse is designating the same representative or representatives, enter your spouse's name, address (if different from your own), Social Security number, and your spouse's email address.

Businesses. Enter both the legal name and the DBA or trade name, if different. For example, if the business is an individual proprietorship, enter the proprietor's name and the name under which business is transacted. *(e.g., Joe Smith dba Joe's Diner)*. Also enter the EIN (federal employer identification number), telephone number, business address, and email address.

Estates. Enter the name, title, address, and email address of the decedent's executor/personal representative in the taxpayer section. Use the spouse's section to enter the decedent's name, date of death, and SSN.

SECTION 2. TAXPAYER GRANT OF POWER OF ATTORNEY.

Representative's name. Complete all the requested information for each representative. If the representative is a member of a firm, enter the firm's name too. If you are designating more than two representatives, please complete another form and attach it to this form. Mark the second form "additional representatives."

Type of tax. If you wish the power of attorney to apply to all periods and all tax types administered by KDOR, please check the box(es) for *"All tax types"* and *"All tax periods"*. If for a specific tax type and/or tax year enter the type of tax and the tax years or reporting periods for each tax type. If the matter relates to estate, inheritance, or succession tax, please enter the date of the decedent's death.

Authorized acts. Check all boxes that apply. Use the additional lines to limit, clarify, or otherwise define the acts authorized by this POA. For example, if you wish to limit the POA to a specific time period or to establish an expiration date, enter that information and the dates (month, day, and year) on these lines.

Retention/revocation of prior powers of attorney. Unless otherwise specified, this POA replaces and revokes all previous POAs on file with the department. If there is an existing POA that you do NOT want to revoke, check the box in this section and enter the representative's name and EIN/SSN/PTIN in the space provided.

If you wish to revoke an existing POA without naming a new representative, attach a copy of the previously executed POA. On the copy of the previously executed POA, write "REVOKE" across the top of the form, and initial and date it again under your signature or signatures already in Section 3.

SECTION 3. SIGNATURE OF TAXPAYER(S).

You must sign and date the POA. If a joint return is being filed and both husband and wife intend to authorize the same person to represent them, both spouses must sign the POA unless one spouse has authorized the other in writing to sign for both. You must attach a copy of your spouse's written authorization to this POA.

SECTION 4. SIGNATURE OF REPRESENTATIVE(S).

Each representative that you name must sign and date this form.

TAXPAYER ASSISTANCE

If you have questions about this form, please visit or call our office.

Taxpayer Assistance Center
Scott State Office Building
120 SE 10th St.
PO Box 3506
Topeka, KS 66625-3506

Phone: 785-368-8222

The Department of Revenue office hours are 8 a.m. to 4:45 p.m., Monday through Friday.

Additional copies of this form are available from our website at: **ksrevenue.gov**

KANSAS DEPARTMENT OF LABOR
www.dol.ks.gov

EMPLOYER STATUS REPORT

K-CNS 010 (Rev. 10-21)

For Internal Use Only

SUBMIT ONLINE: www.KansasEmployer.gov
MAIL: Unemployment Tax Contributions
P.O. Box 400
Topeka, KS 66601-0400
FAX: (785) 291-3425

See instructions on page 5. The information requested in this report is required to be provided by K.S.A. 44-714(f) and K.A.R. 50-2-5. It will be used only by public officials in the performance of their public duties. Section 6103(d) of the Internal Revenue Code authorizes IRS to exchange information with us for audits and certifications.

1. What is your type of organization / ownership? (check one below)

☐ Individual ☐ Limited Partnership ☐ Estate
☐ General Partnership ☐ Joint Venture ☐ Receivership
☐ Limited Liability Company (LLC) ☐ Corporation (Inc.) ☐ Trust
☐ Limited Liability Partnership (LLP) ☐ Governmental/Political Sub-Division (if checked, answer questions 2a and 2b)
☑ Other: PRIVATE HOUSEHOLD

2. If you are a governmental or political sub-division, select the **branch** of government and your **finance option**:

2a. Branch of government (check one)
☐ State ☐ Local ☐ Indian Tribe

2b. Finance option (check one)
☐ Contributing ☐ Reimbursing ☐ Rated Governmental

3. Are you a 501(c)(3) exempt organization? ☐ YES ☑ NO (if YES, answer 3a and 3b)

3a. Finance option (check one) ☐ Contributing ☐ Reimbursing

3b. Have you received the 501(c)(3) exemption letter from the IRS? ☐ YES ☐ NO (if NO, explain below)
X

4. Are you a Professional Employment Organization (P.E.O.)?
☐ YES (If YES, you must submit a separate K-CNS 015 for each client.) ☑ NO

5. Describe the major service, activity or product in **Kansas** that generates the most revenue for your business:

_____

5a. Is your business considered to be in the construction industry? ☐ YES ☑ NO

6. Date you first paid wages in **Kansas**: _____

7. List your Federal Employer Identification Number (FEIN): _____

8. Legal business name *(Inc., LLC, LP, Sole Prop, etc.)*: _____

9. Business or trade name *(if different than #8)*: _____

10. Business phone: _____ Business fax: _____
Business Email: _____

11. Mailing address - Street: _____
City: WHITE RIV JCT State: VT ZIP: 05001

12. Kansas business physical address: ☐ Storefront/Physical Location ☐ Job/Construction Site ☐ Employee Residence
Street: _____
City: _____ State: _____ ZIP: _____

13. Address where accounting records are maintained/can be examined in the state of Kansas: ☐ Address same as #12
Street: PO BOX 4409
City: WHITE RIV JCT State: VT ZIP: 05001

14. Company or in-house payroll contact:

Name: ARIS SOLUTIONS FISCAL AGENT- MISSOURI Phone: (866) 970-3301

Email: TAX@ARISSOLUTIONS.ORG ☐ Address same as #12

Street: PO BOX 4409

City: WHITE RIV JCT State: VT ZIP: 05001

15. Ownership identification – Owner, Corporate Officer, Member, Member/Manager, Partner (general & limited), etc. Use full **LEGAL** names. Do NOT use nicknames. Provide residence address of each owner, officer, partner, etc. Use page 4 if additional space is needed.

Social Security number: _____ Title: DOMESTIC EMPLOYER

First name: _____ MI: _____ Last name: _____

Street: _____

City: _____ State: _____ ZIP: _____

Social Security number: _____ Title: _____

First name: _____ MI: _____ Last name: _____

Street: _____

City: _____ State: _____ ZIP: _____

16. Record all **Kansas** wages paid by calendar quarter for the current and prior calendar year.

Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
	$	$	$	$
	$	$	$	$

17. In which **WEEK** did you establish liability based on the number of weeks of employment? _____

18. Did you acquire/purchase **all** or **part** of an existing business? ☐ YES ☑ NO

18a. If YES, the date acquired (mm/dd/yyyy): _____ ☐ All ☐ Part _____ % acquired
Did you acquire substantially all of the assets? ☐ YES ☐ NO
Did you acquire substantially all of the employing enterprise, organization, trade or business? ☐ YES ☐ NO
Termination date of prior owner (mm/dd/yyyy): _____

18b. Has the previous owner continued business in **Kansas**? ☐ YES ☑ NO If YES, explain:
_____

18c. Do you want the prior owner's experience rating factors? ☐ YES ☑ NO
Transfer of rating factors is: ☐ Mandatory ☐ Elective

18d. Name of prior owner: _____
Prior owner's Kansas employer serial number: _____

18e. Prior business or trade name: _____ Current phone: _____

18f. Prior owner's current address: Street _____
City: _____ State: _____ ZIP: _____

Employer Status Report
K-CNS 010 (Rev. 10-21)

K.S.A. 44-710a(b)(2) allows a successor, defined in K.S.A. 44-703(h)(4) and K.S.A. 44-703(dd), the choice to acquire the experience rating factors of the predecessor employer. The request for transfer must be made in writing within 120 days of the acquisition. The experience rating factors are all of the unemployment taxes paid, annual payrolls and benefit charges of the predecessor employer. These factors are used to compute your unemployment tax rate for subsequent years. Alternately, successor employers may elect to be assigned their industry tax rate.

K.S.A. 44-710a(b)(1) shall be unlawful through manipulation of the employer's workforce, or business, to knowingly obtain a reduced liability for contributions related to determining a contribution rate, when the primary purpose of the business acquisition was for the purpose of obtaining a lower rate of contributions, or for a person to knowingly advise an employing unit in such a way that results in such a violation, shall be subject to penalties.

19. For the last three years, list any multiple business locations you have operated in **KANSAS.** ☑ No multiple locations
Include trade name, address, dates of operation, number of employees and business activity.

Trade Name and Address	Date Opened	Date Closed	No. Employees	Business Activity

20. Do you want to sign up for the electronic employer response system called SIDES (State Information Data Exchange System)? ☐ YES ☑ NO If YES, one valid email is required and a maximum of five can be listed.

Primary SIDES Email Address:	
Optional No. 2:	Optional No. 3:
Optional No. 4:	Optional No. 5

21. Are you subject to Federal Unemployment Tax Act (FUTA)? Current year ☑ YES ☐ NO Prior year ☐ YES ☑ NO
22. Are you continuing to pay wages in **KANSAS**? ☑ YES ☐ NO
23. Do you have individuals performing services you believe are not employees? ☐ YES ☑ NO
If YES, explain. Attach additional pages if necessary.

24. If no liability is indicated, do you wish to elect coverage?

☐ YES, beginning January 1 of the current year, or at the commencement of employment of the current year, and continuing for not less than two calendar years, on behalf of the employing unit, I voluntarily elect to: (select one or both)
☐ become an employer described in K.S.A. 44-703(h), the same as other employers, since no mandatory coverage is indicated
☐ extend coverage to all workers performing services that are excluded from coverage by the employment security law
☑ NO

25. Would you like to have a KDOL representative contact you to provide additional information on exemptions, payment options for governmental/political sub-divisions or 501(C)(3) entities, successorship or any other status report information?
☐ YES ☑ NO

26. I certify that the information I have provided on this report is complete, correct and true to the best of my knowledge and belief.

Signature of owner, partner, member/manager, corporate officer, etc. | Title | Date

KANSAS DEPARTMENT OF LABOR
www.dol.ks.gov

EMPLOYER REPRESENTATIVE AUTHORIZATION

K-CNS 032 (Rev. 12-21)

MAIL: Kansas Department of Labor
UI Tax Contributions
401 SW Topeka Blvd.
Topeka, KS 66603-3182

FAX: (785) 291-3425

Request will be denied if any item is incomplete.

Employer Serial Number: _____

Employer: _____

Physical address of business **in KANSAS**. If no physical address, store front or business location exists **in KANSAS**, you must indicate **where in KANSAS** you have workers performing a service. Do **NOT** use a Post Office Box number.

☑ Business location ☐ Job site ☐ Company representative residence

☐ Other *(explain):* _____

Address *(Do **NOT** use PO Box number)* City State ZIP

Representative retained to represent you: ARIS SOLUTIONS FISCAL AGENT

Representative's phone: (866) 970-3301 Representative's email: TAX@ARISSOLUTIONS.ORG

Indicate which Kansas unemployment insurance reports you have delegated the authority to receive. Provide the mailing address for the delegated reports.

☑ ***Employer's Quarterly Wage Report and Unemployment Tax Return*, K-CNS 100**

Name: ARIS SOLUTIONS FISCAL AGENT

Address: PO BOX 4409

City, State, ZIP: WHITE RIV JCT, VT 05001

☑ ***Annual Experience Rating Notice*, K-CNS 404, and *Annual Notice of Benefit Charges*, K-CNS 403**

Name: ARIS SOLUTIONS FISCAL AGENT

Address: PO BOX 4409

City, State, ZIP: WHITE RIV JCT , VT 05001

☑ **Last Employer, Base Period and all other Benefit and Appeal Claim Notices**

Name: ARIS SOLUTIONS FISCAL AGETN

Address: PO BOX 4409

City, State, ZIP: WHITE RIV JCT, VT 05001

_____ _____

Owner, partner, corporate officer, LLC member/manager signature Date (mm/dd/yyyy)

_____ ( )

Email Phone

More information about filing reports as an authorized employer representative is found at **www.KansasEmployer.gov**.

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 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

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 (if applicable)

Veteran Directed Care Program

Person Centered Counselor:_____ AAA: Mid-America Regional Council (MARC)

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.

* Kansas Bureau of Investigation Check *Office of Inspector General Check

Below two if not family member of Veteran:

*Kansas DCF – Adult Abuse Registry Check *Kansas Dept for Aging & Disability – Criminal Check

Signatures:

Employer/Authorized Representative:_____ Date:_____

Veteran: _____ Date: _____

STATE OF KANSAS
Department for Children & Families
Office of Background Investigations

ADULT ABUSE, NEGLECT, EXPLOITATION CENTRAL REGISTRY RELEASE OF INFORMATION

I, _____, give permission for the release of information concerning
(PRINT Full Name)

myself in the Adult Abuse, Neglect, Exploitation Central Registry to:

Contact Person(s)* _____ **Phone** _____

Agency name _____

Agency mailing address _____

Email address: **Will return via Encrypted email unless marked otherwise** _____

Maiden Name and/or Other Names Known By: _____
(PRINT ONLY)

Address: _____
Street **City** **State** **Zip Code**

DOB: _____ **SS#:** _____ ☐ Male ☐ Female
(mm/dd/yyyy) **(mark one)**

I understand that all information released will be for the exclusive and confidential use of the above named organization/person. I have read and understand this form and information provided is true and correct to the best of my knowledge.

I give permission for the release of any information concerning myself in the Adult Abuse, Neglect, Exploitation Central Registry each year while I am employed or associated with the above agency. ☐ **Yes** ☐ **No**

Signature: _____ **Date**: _____
(An Ink Signature or a Verified E-Signature is Required for Processing) **(mm/dd/yyyy)**

RETURN TO:

Email: DCF.APSRegistry@ks.gov

Mail: Office of Background Investigations
Adult Abuse Registry
P.O. Box 751043
Topeka, Kansas 66675
(Please allow 3-5 days for processing email requests and an additional 5-7 days if returning by US Postal Service)

For Official Use Only: Mark in this area if PROHIBITED	**For Official Use Only: Mark in this area if CLEARED**

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*

e-Timesheets Registration and Agreement Form

Each Employer and Employee must complete a separate form. If you are filling out this form as an Employee, you (and your Employer) must sign up for e_Timesheets with each Employer that you work for.

Please remember that each Employer and Employee must have individual email addresses (**cannot** share one with any other employer or employee).

Name: _____
Required (Please print clearly)

E-mail Address: _____
Required (Please print clearly)

Phone Number: _____ Last 4 digits of Social Security Number: _____
Required

Registering as: **Employer** ____

Employee ____ **My Employer's** name is: _____
Required if enrolling as employee

You are also agreeing that:

- You understand that ARIS Solutions reports suspected fraud to the Office of Attorney General-Medicaid Fraud and Residential Abuse Unit (MFRAU) and will automatically do that, even if the timesheet is sent through e_Timesheets,
- You will not share your User Name or Password with anyone,
- You will notify ARIS Solutions immediately if you change your email address,
- You will notify ARIS Solutions immediately if there is a change in employment status of any employee who uses e_Timesheets,
- You will notify ARIS Solutions immediately if there is a change in the employer of record for anyone who uses e_Timesheets, and
- Submitting hours or services that were not worked may be considered Medicaid fraud.

Signature _____
Required

Print Name _____
Required

Date _____
Required

About the Electronic Timesheets Module

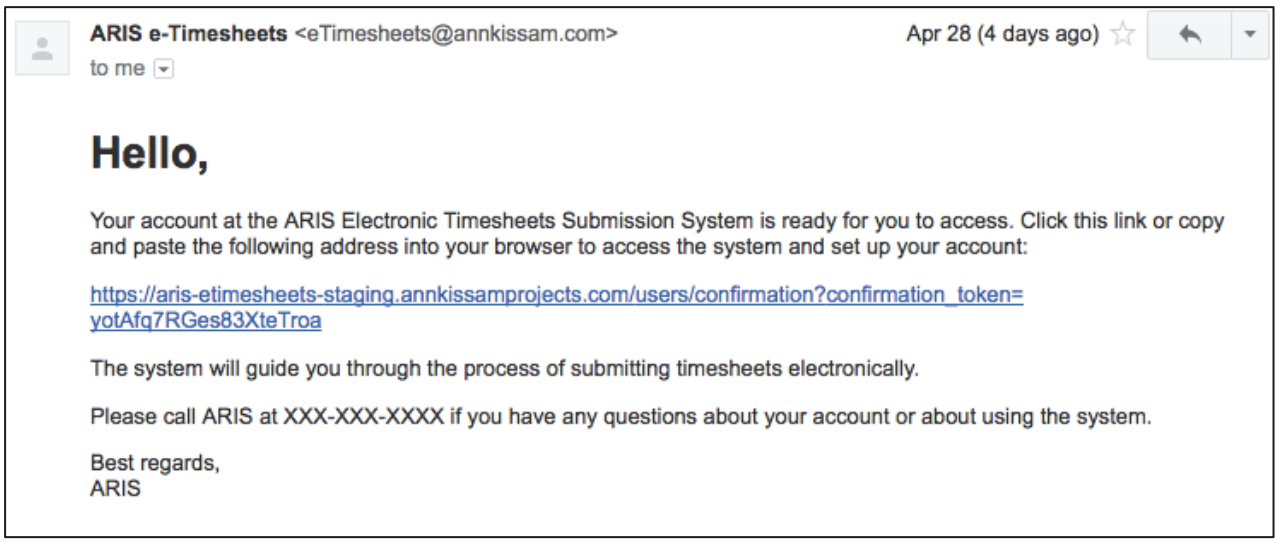
The Electronic Timesheets Module is a web-based interface through which Consumers, Employers, Representatives and Employees can respectively enter and view relevant timesheet information.

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:

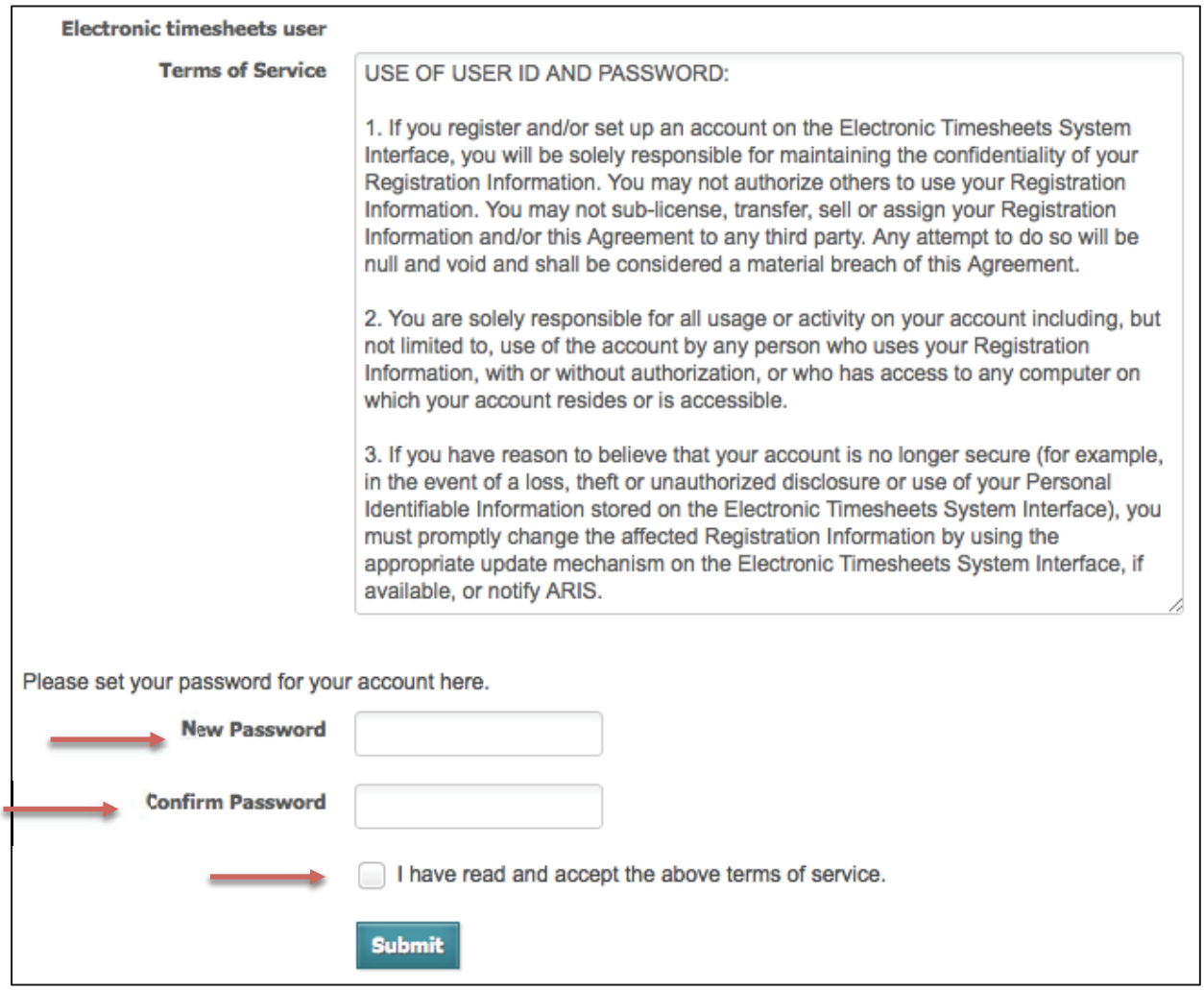
https://aris-etimesheets-staging.annkissamprojects.com/users/confirmation?confirmation_token=yotAfq7RGes83XteTroa

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.

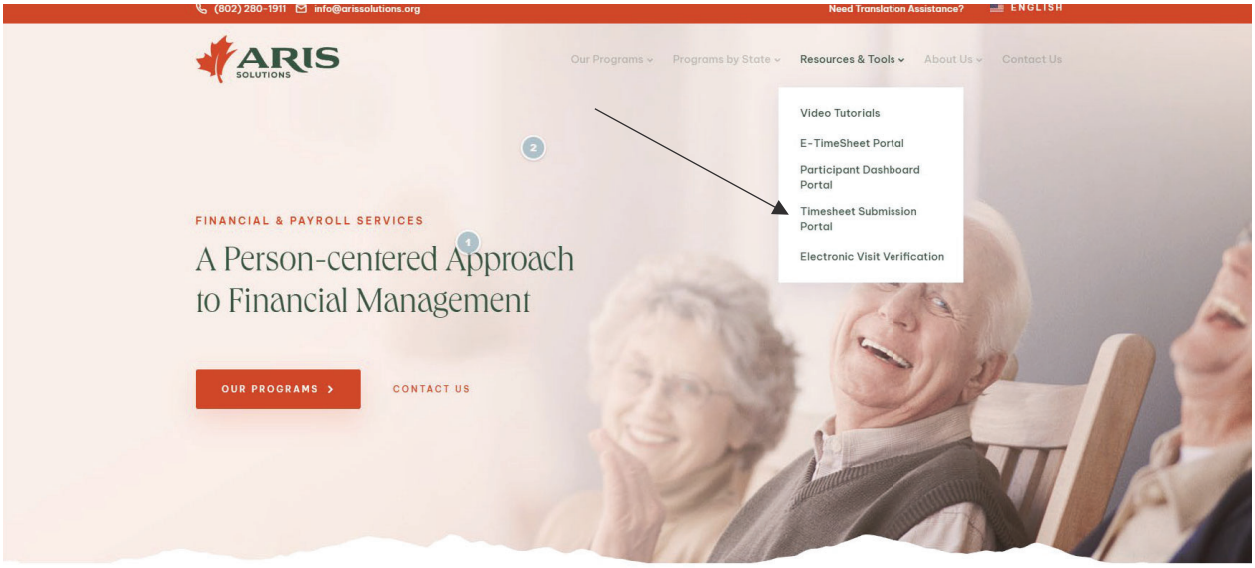
Best regards,
ARIS

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

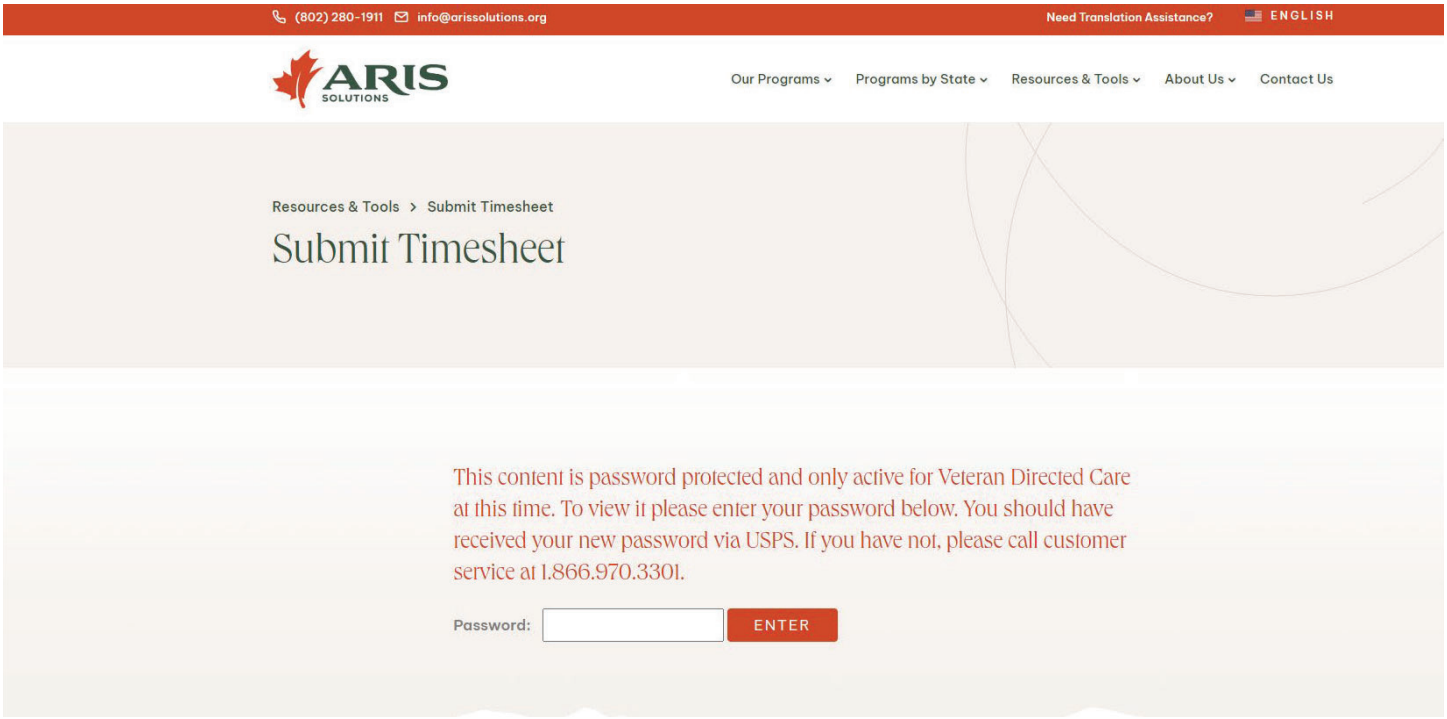


4. Once each user accepts the Terms of Service and creates a password, he or she may start using the system.

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.

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

Time Sheet and Reimbursement Schedule 2024
VDC- AK-DC-KS-MO-MT-NC-PA-VT

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

Time sheets, reimbursements, employee paperwork and check requests received by
Send to:

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

Questions?
Veterans Department
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.