



Financial & Payroll Services for the Nonprofit Sector

Enrollment Information for CO-CPWD

Veteran Directed Program Employers (Nebraska)

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

ALL FORMS MUST BE SIGNED/DATED AND RETURNED TO ARIS SOLUTIONS

- Employer / Veteran Information Form
- Background Check Authorization form- Surrogate employer Only
- 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.
- Worker's Compensation Application
- 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
 - ❖ Application for Colorado Business Tax Registration (Form CR0100AP)- to setup a Withholding account with the Colorado Department of Revenue on your behalf.
 - Colorado Department of Revenue "Power of Attorney" (Form DR 0145) -this allows ARIS to speak with the Department of Revenue on your behalf about withholding tax.
 - ❖ Application for account with Colorado Department of Labor and Unemployment (Form UITL-100)- to apply for an unemployment insurance account number on your behalf.
 - Employer Power of Attorney Assignment (Form UITL-18) - this allows ARIS to speak with the Department of Labor and Unemployment on your behalf.
- Employer Confirmation of Receipt
- Fraud & Abuse Statement

If you have questions contact the Veteran 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



Employer/Veteran Information Form

NAME OF EMPLOYER

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.

NAME OF VETERAN

Name _____

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

Phone () _____

Date of Birth _____

Social Security Number _____



Employer Authorization to Perform Background Check(s)

I, _____, have reviewed the list of excluded convictions, substantiations, and findings. I understand that ARIS Solutions will conduct background checks for me 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.

As so, I authorize ARIS Solutions to perform the following background check(s) on behalf of the Veteran

- Criminal Background Check

Signed,

Signature of Employer

Date

Employer Social Security Number:

Alias or Maiden Name(s):



CO - CPWD

COLORADO

Bureau of Investigation

Department of Public Safety

IDENTIFICATION UNIT | 690 Kipling Street, Suite 3000 | Denver, CO 80215 | (303) 239-4208 | www.colorado.gov/cbi

Public Request for Criminal History Record Information

Please type or print clearly | \$13.00 per name (no personal checks) | Reply will be mailed in 3-5 business days

Please call (303) 239-4208 with any inquiries. Discrepancies must be reported within 30 days.

NAME TO BE CHECKED

Last Name: _____

First Name: _____

Middle Name: _____

Date of Birth (required):

/ /

MM/DD/YYYY

Gender (optional):

MALE FEMALE

Social Security Number (optional):

- -

SEND REPLY TO

Name of Business and/or Person

Street Address or P.O. Box

Apt/Unit Number

City

State

ZIP Code

Phone Number

PURPOSE FOR REQUEST

Public Request/General Inquiry

Emergency Medical Technician

Security Guard

Housing

P.O.S.T. Board

Adoption

Visa / International Travel

Immigration

Guardian/Conservator

NOTARIZING

Do you need the response notarized?

YES

NO

Notarizing may add up to three business days to your processing time.

PLEASE READ AND SIGN BELOW

The record you may receive is for lawful use only and summarizes information sent to the Colorado Bureau of Investigation from fingerprint contributors in the state of Colorado. Unless fingerprints accompanied your inquiry, the Colorado Bureau of Investigation cannot guarantee this record relates to the person in whom you have an interest. If the disposition is not shown, or further explanation of an arrest charge or disposition is desired, that information may be obtained from the agency who furnished the arrest information. Only the court of jurisdiction or the respective District Attorney's office wherein the final disposition occurred can provide an official copy to any specific disposition. State law governs access to sealed records. Because additions and deletions to a criminal history record may be made at any given time, a new inquiry should be requested when needed for subsequent use. Any report received from the Colorado Bureau of Investigation as the result of this inquiry shall not be used for the direct solicitation of business for pecuniary (monetary) gain.

X

Signature of Requesting Party (required per State law)

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

VDC-CA-CO-IA-IL-IN-ME-MN-NE-WI-WY
Time Sheet and Reimbursement Schedule 2026

Pay Period	Pay Period Start Date	Pay Period End Date	Timesheet Submission Due Date	Payment Date
1	12/28/2025	1/10/2026	1/12/2026	1/16/2026
2	1/11/2026	1/24/2026	1/26/2026	1/30/2026
3	1/25/2026	2/7/2026	2/9/2026	2/13/2026
4	2/8/2026	2/21/2026	2/23/2026	2/27/2026
5	2/22/2026	3/7/2026	3/9/2026	3/13/2026
6	3/8/2026	3/21/2026	3/23/2026	3/27/2026
7	3/22/2026	4/4/2026	4/6/2026	4/10/2026
8	4/5/2026	4/18/2026	4/20/2026	4/24/2026
9	4/19/2026	5/2/2026	5/4/2026	5/8/2026
10	5/3/2026	5/16/2026	5/18/2026	5/22/2026
11	5/17/2026	5/30/2026	6/1/2026	6/5/2026
12	5/31/2026	6/13/2026	6/15/2026	6/18/2026
13	6/14/2026	6/27/2026	6/29/2026	7/2/2026
14	6/28/2026	7/11/2026	7/13/2026	7/17/2026
15	7/12/2026	7/25/2026	7/27/2026	7/31/2026
16	7/26/2026	8/8/2026	8/10/2026	8/14/2026
17	8/9/2026	8/22/2026	8/24/2026	8/28/2026
18	8/23/2026	9/5/2026	9/7/2026	9/11/2026
19	9/6/2026	9/19/2026	9/21/2026	9/25/2026
20	9/20/2026	10/3/2026	10/5/2026	10/9/2026
21	10/4/2026	10/17/2026	10/19/2026	10/23/2026
22	10/18/2026	10/31/2026	11/2/2026	11/6/2026
23	11/1/2026	11/14/2026	11/16/2026	11/20/2026
24	11/15/2026	11/28/2026	11/30/2026	12/4/2026
25	11/29/2026	12/12/2026	12/14/2026	12/18/2026
26	12/13/2026	12/26/2026	12/28/2026	12/31/2026
27	12/27/2026	1/9/2027	1/11/2027	1/15/2027
28	1/10/2027	1/23/2027	1/25/2027	1/29/2027

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/>

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.

EIN

1	Legal name of entity (or individual) for whom the EIN is being requested																	
Type or print clearly.	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) <i>c/o ARIS SOLUTIONS PO BOX 4409</i>	5a	Street address (if different) (Don't enter a P.O. box.)														
	4b	City, state, and ZIP code (if foreign, see instructions) <i>WHITE RIVER JCT, VT 05001</i>	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)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No																	
9a	Type of entity (check only one box). Caution: If 8a is "Yes," see the instructions for the correct box to check. <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Sole proprietor (SSN) _____</td> <td><input type="checkbox"/> Estate (SSN of decedent) _____</td> </tr> <tr> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> Plan administrator (TIN) _____</td> </tr> <tr> <td><input type="checkbox"/> Corporation (enter form number to be filed) _____</td> <td><input type="checkbox"/> Trust (TIN of grantor) _____</td> </tr> <tr> <td><input type="checkbox"/> Personal service corporation</td> <td><input type="checkbox"/> Military/National Guard <input type="checkbox"/> State/local government</td> </tr> <tr> <td><input type="checkbox"/> Church or church-controlled organization</td> <td><input type="checkbox"/> Farmers' cooperative <input type="checkbox"/> Federal government</td> </tr> <tr> <td><input type="checkbox"/> Other nonprofit organization (specify) _____</td> <td><input type="checkbox"/> REMIC <input type="checkbox"/> Indian tribal governments/enterprises</td> </tr> <tr> <td><input checked="" type="checkbox"/> Other (specify) <i>HCSR</i></td> <td>Group Exemption Number (GEN) if any _____</td> </tr> </table>				<input type="checkbox"/> Sole proprietor (SSN) _____	<input type="checkbox"/> Estate (SSN of decedent) _____	<input type="checkbox"/> Partnership	<input type="checkbox"/> Plan administrator (TIN) _____	<input type="checkbox"/> Corporation (enter form number to be filed) _____	<input type="checkbox"/> Trust (TIN of grantor) _____	<input type="checkbox"/> Personal service corporation	<input type="checkbox"/> Military/National Guard <input type="checkbox"/> State/local government	<input type="checkbox"/> Church or church-controlled organization	<input type="checkbox"/> Farmers' cooperative <input type="checkbox"/> Federal government	<input type="checkbox"/> Other nonprofit organization (specify) _____	<input type="checkbox"/> REMIC <input type="checkbox"/> Indian tribal governments/enterprises	<input checked="" type="checkbox"/> Other (specify) <i>HCSR</i>	Group Exemption Number (GEN) if any _____
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<input checked="" type="checkbox"/> Other (specify) <i>HCSR</i>	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) <table style="width:100%; border:none;"> <tr> <td><input checked="" type="checkbox"/> Started new business (specify type) <i>HOME CARE SERVICE RECIPIENT</i></td> <td><input type="checkbox"/> Banking purpose (specify purpose) _____</td> </tr> <tr> <td><input type="checkbox"/> Hired employees (Check the box and see line 13.)</td> <td><input type="checkbox"/> Changed type of organization (specify new type) _____</td> </tr> <tr> <td><input type="checkbox"/> Compliance with IRS withholding regulations</td> <td><input type="checkbox"/> Purchased going business</td> </tr> <tr> <td><input type="checkbox"/> Other (specify) _____</td> <td><input type="checkbox"/> Created a trust (specify type) _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Created a pension plan (specify type) _____</td> </tr> </table>				<input checked="" type="checkbox"/> Started new business (specify type) <i>HOME CARE SERVICE RECIPIENT</i>	<input type="checkbox"/> Banking purpose (specify purpose) _____	<input type="checkbox"/> Hired employees (Check the box and see line 13.)	<input type="checkbox"/> Changed type of organization (specify new type) _____	<input type="checkbox"/> Compliance with IRS withholding regulations	<input type="checkbox"/> Purchased going business	<input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Created a trust (specify type) _____		<input type="checkbox"/> Created a pension plan (specify type) _____				
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	<input type="checkbox"/> 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.		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 <input type="checkbox"/>															
	Agricultural	Household			Other													
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. <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Construction</td> <td><input type="checkbox"/> Rental & leasing</td> <td><input type="checkbox"/> Transportation & warehousing</td> <td><input type="checkbox"/> Accommodation & food service</td> <td><input type="checkbox"/> Wholesale—agent/broker</td> </tr> <tr> <td><input type="checkbox"/> Real estate</td> <td><input type="checkbox"/> Manufacturing</td> <td><input type="checkbox"/> Finance & insurance</td> <td><input type="checkbox"/> Other (specify) _____</td> <td><input type="checkbox"/> Wholesale—other <input type="checkbox"/> Retail</td> </tr> </table>				<input type="checkbox"/> Construction	<input type="checkbox"/> Rental & leasing	<input type="checkbox"/> Transportation & warehousing	<input type="checkbox"/> Accommodation & food service	<input type="checkbox"/> Wholesale—agent/broker	<input type="checkbox"/> Real estate	<input type="checkbox"/> Manufacturing	<input type="checkbox"/> Finance & insurance	<input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Wholesale—other <input type="checkbox"/> Retail				
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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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <i>ARIS SOLUTIONS FISCAL AGENT</i>		Designee's telephone number (include area code) <i>866.970.3301</i>															
	Address and ZIP code <i>PO BOX 4409 WHITE RIVER JUNCTION VT 05001</i>		Designee's fax number (include area code) <i>802.295.9812</i>															
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														



VDC Nebraska Workers' Compensation Form

<p>Employer Legal Name:</p> <p>Employer Date of Birth:</p>
<p>Veteran name (if different than Employer name):</p>
<p>Relationship to Veteran:</p>
<p>Employer FEIN # :</p>
<p>Employer Phone:</p>
<p>Street Address (where service is provided):</p>
<p>City, State, ZIP(where service is provided):</p>
<p>Estimated Annual Payroll</p> <p>Annual Amount: _____</p>
<p>Effective Date of Coverage (start date):</p> <p>Employer Signature and Date:</p>

Form **2678** **Employer/Payer Appointment of Agent**

(Rev. December 2024) Department of the Treasury — Internal Revenue Service

OMB No. 1545-0029

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)

- 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)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Form 941, Employer's QUARTERLY Federal Tax Return (all 941 series)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Form 943, Employer's Annual Federal Tax Return for Agricultural Employees (all 943 series)	<input type="checkbox"/>	<input type="checkbox"/>
Form 944, Employer's ANNUAL Federal Tax Return (all 944 series)	<input type="checkbox"/>	<input type="checkbox"/>
Form 945, Annual Return of Withheld Federal Income Tax	<input type="checkbox"/>	<input type="checkbox"/>
Form CT-1, Employer's Annual Railroad Retirement Tax Return	<input type="checkbox"/>	<input type="checkbox"/>
Form CT-2, Employee Representative's Quarterly Railroad Tax Return	<input type="checkbox"/>	<input type="checkbox"/>

* 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.

- 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.

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 Check if to be sent copies of notices and communications <input type="checkbox"/>	CAF No. 0313-84964R PTIN _____ Telephone No. 866-970-3301 Fax No. 802-295-1912 Check if new: Address <input type="checkbox"/> Telephone No. <input type="checkbox"/> Fax No. <input type="checkbox"/>
---	---

Name and address Check if to be sent copies of notices and communications <input type="checkbox"/>	CAF No. _____ PTIN _____ Telephone No. _____ Fax No. _____ Check if new: Address <input type="checkbox"/> Telephone No. <input type="checkbox"/> Fax No. <input type="checkbox"/>
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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	940, 941x, 941 R, 940, 940x, SS4, W2, W2c	W3, 1099 2026-2028	Tax Liability
Authority to obtain FEIN	SS4, 8821	2026-2028	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)

Power of Attorney

**FORM
33**

Taxpayer's Name and Address						
Please Type or Print	Name of Taxpayer			Business Name		
	Address (Street or Other Mailing Address)			Business Address (Street or Other Mailing Address)		
	City	State	Zip Code	City	State	Zip Code
	Nebraska ID or Social Security Number			Federal ID or Social Security Number		

Attorney-in-fact's Name and Address (If more than two, see Designation of Attorney-in-fact in the instructions.)					
Name			Name		
Title or Firm Name			Title or Firm Name		
Address (Street or Other Mailing Address)			Address (Street or Other Mailing Address)		
City	State	Zip Code	City	State	Zip Code
Email Address (See Email in the instructions)		Phone Number	Email Address (See Email in the instructions)		Phone Number

The taxpayer appoints the above attorneys-in-fact for purposes of duly authorized representation in any proceedings with the Nebraska Department of Revenue (DOR) with respect to those tax categories, tax matters, and tax periods indicated below:

Tax Category	Tax Matter of Representation	Tax Period

The attorneys-in-fact designated on this form have the authority to receive confidential information on behalf of the taxpayer and the power to perform the following acts with respect to the tax matters designated above. Strike through any items for which this authority is not granted.

- Fully represent the taxpayer in any hearing, determination, or appeal.
- Enter into any compromise with DOR.
- Execute waivers, including offers of waivers, of restrictions on assessment or collection of tax deficiencies.
- Execute waivers of notice of disallowance of a claim for credit or refund.
- Execute consents extending the statutory period for issuing a notice of deficiency determination.
- Receive, but not endorse or collect, checks in payment of any refund of taxes, penalties, or interest.
- Receive all notices and other written communications with respect to the taxpayer. If more than one attorney-in-fact is named, enter name of the attorney-in-fact to receive these notices.

• Perform other acts, specifically: _____

Revocation of Prior Powers of Attorney

- A. I choose to revoke all prior powers of attorney on file with DOR with respect to the same tax matters, and tax periods listed above, except the following: _____
- B. I choose to revoke all prior powers of attorney on file with DOR.

If signed by a corporate officer, partner, member, LLC manager, or fiduciary on behalf of the taxpayer, I hereby certify that I have the authority to execute this Power of Attorney on behalf of the taxpayer.

**sign
here**

Signature	Date	
Print Name	Email Address	Title, If Applicable
Signature	Date	
Print Name	Email Address	Title, If Applicable

You may fax this form to 402-471-5927, file this form electronically using [ShareFile](#), or mail this form to: Nebraska Department of Revenue, PO Box 94818, Lincoln, NE 68509-4818.

Date Stamp

STATE OF NEBRASKA
DEPARTMENT OF LABOR
UNEMPLOYMENT INSURANCE
P O BOX 94600
LINCOLN, NEBRASKA 68509-4600
Phone: 402.471.9898
Fax: 402.471.9994
Website: dol.nebraska.gov

Employer Account Number	
Federal Identification Number	
Reviewed/Approved	DATE

POWER OF ATTORNEY

(NEB. REV. STAT. §48-607)

Business Name and Address

Business Name	Doing Business As (DBA)	Phone Number
Mailing Address	City	State
		Zip Code

Representative Name and Address

Representative Legal Name	Representative DBA Name
Representative Mailing Address	Phone Number
City	State
Zip Code	Representative E-mail Address*

The employer appoints the above entity for the purposes of representation for the following Unemployment Insurance matters as indicated below (check applicable boxes). If representative does not have prior authority, indicate correct address.

Department Functions Authorized with Power of Attorney	Representative Mailing Address (Address, City, State, Zip) and Email Address*
<input checked="" type="checkbox"/> Quarterly Tax Report Filings	PO Box 4409 White River Jct, VT 05001 tax@arissolutions.org
<input checked="" type="checkbox"/> Quarterly Tax Report Mailings	PO Box 4409 White River Jct, VT 05001 tax@arissolutions.org
<input checked="" type="checkbox"/> Combined Tax Rate Notices	PO Box 4409 White River Jct, VT 05001 tax@arissolutions.org
<input checked="" type="checkbox"/> Benefit Claims/ Benefit Charging Notices	PO Box 4409 White River Jct, VT 05001 tax@arissolutions.org
<input type="checkbox"/> Benefit Payment Control Audits	
<input type="checkbox"/> Appeal Documents	
<input type="checkbox"/> SIDES	Broker ID # _____
<input type="checkbox"/> Add	
<input type="checkbox"/> Remove	

REVOCAION OF PRIOR POWERS OF ATTORNEY

<input type="checkbox"/> I choose to revoke all prior powers of attorney on file with the Department with respect to the same Unemployment Insurance activities listed above, except the following: _____ effective _____
<input type="checkbox"/> I choose to revoke all powers of attorney on file with the Department effective _____.

* The email address provided may be used for future Department official business.

If signed by an individual, corporate officer, partner, member, LLC manager, or fiduciary on behalf of the taxpayer/representative, I hereby certify that I approve this Power of Attorney, who is authorized to execute the Power of Attorney on behalf of the taxpayer.

X
Signature of Business Owner _____ Date _____

Print Name _____ Employer E-mail Address* _____

X
Signature of Power of Attorney _____ Date _____

Print Name _____ E-mail Address* _____ Title _____

*The email address provided may be used for future Department official business.



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 Signature Page

Veteran's Signature

Date

Authorized Representative Signature

Date

FMS Provider Signature

Date

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/ VDC 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 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 fraud.

Signature _____
 Required

Print Name _____
 Required

Date _____
 Required



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 Information for Co-CPWD

Veteran Directed 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.

ALL FORMS MUST BE SIGNED/DATED AND RETURNED TO ARIS SOLUTIONS

- New Employer/Veteran Information
- ARIS Solutions Contact Sheet
- Customer Grievance Policy
- Timesheet and Reimbursement Schedule
- Employer Information Book

If you have questions contact the Veteran 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**

Financial & Payroll Services for the Nonprofit Sector

New Employer/Veteran Information

You are now an Employer!

Welcome to the Veteran Directed Home and Community Based Services 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.

CUSTOMER GRIEVANCE POLICY

At ARIS Solutions, we truly believe in providing best in class services to our customers. We aim to understand both our strengths and opportunities for improvement from our customer's point of view and work to continuously improve our services to best meet their needs.

Our Grievance Policy focuses on improving customer satisfaction by collecting feedback from all our customers and by putting action plans in place to address key issues, which are assigned to the relevant key staff for action.

We have a complaint tracking system which assigns each complaint with a number and allows us to track the aging and resolution of each complaint. The status of complaints is systematically reported to our Senior Management. Our goal is to ensure that all customer complaints are resolved within 30 days. The 30-day period will commence after all the necessary information sought from the customer is received.

The various channels through which our customers can contact us for any assistance with their grievances are listed below:

In the event your complaint is not addressed satisfactorily:

If you are not satisfied with the response received at our helpline, you can escalate your grievance to:

Name: Theresa Danforth

Email: theresa.danforth@arissolutions.org

Fax: 802.295.9812

Telephone: 866.970.3301

(Monday to Friday 8:00 am to 4:00 pm EST)

Address: PO Box 4409, White River Jct., VT 05001

For further escalation of grievances, the same can be addressed to:

Name: Elizabeth Lundberg

Email: elizabeth.lundberg@arissolutions.org

Fax: 802.295.9812

Telephone: 802.280.1911

(Monday to Friday 8:00 am to 4:00 pm EST)

Address: PO Box 4409, White River Jct., VT 05001





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 ARIS 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 ARIS FMS-Support Broker entity for goods and services that were not provided.
- Knowingly and/or purposefully having the Vendor ARIS 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 ARIS 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 ARIS FMS-Support Broker entity to remedy the situation.
- Being late in handing in Veteran/representative-employer related paperwork to the Vendor ARIS 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.

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****





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 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.