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 CA-CPWD

Veteran Directed Program Employers (California)

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 ¢I·È ! ŎŎƨdzyű wŜƎƛăúŃI·úƛƨƴπ 59 ᴍ

- Employer Power of Attorney Assignment (Form UITL-18) - this allows ARIS to speak with the Department of Labor and Unemployment on your behalf.

- ☐ Paid Sick Leave Form
- ☐ Employer Confirmation of Receipt
- ☐ Fraud & Abuse Statement
- ☐ Notice to Employers- UI de1857d
  - This needs to be posted in a prominent place that employees will be able to see.
- ☐ Notice to Employees for SDI and PFL de1858
  - This pamphlet needs to be provided to employees at time of hire.
- ☐ Notice to Employees de1857a
  - This pamphlet needs to be provided to employees at time of hire.
- ☐ Copy of completed packet **must** be given to your VIP Advisor

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) (County)

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) (County)

Phone (_____)_____

Date of Birth _____

Social Security Number _____

Employer/Authorized Representative Background Check Release Form

Veteran Directed Care Program

VIP Advisor _____AAA_____

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

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

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

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

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

Signatures:

Employer:_____ Date:_____

Veteran:_____ Date:_____

Background Check Exclusions

All Employees 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 conviction for fraud, abuse and/or exploitation for an individual of any age, the worker may never work for a Veteran enrolled in VDC.

There may be additional disqualifying convictions depending on the state. These will be evaluated based on state policies which are consistent with state policy for hiring personal assistants in Medicaid HCBS waiver program for older adults and adults with disabilities.

If any of the convictions or substantiations listed below on either of the background checks, the ARISFMS will inform the Veteran (through the agency) that the prospective employee cannot be hired by the Veteran to work in this program, or if a waiver or risk mitigation plan will be needed. This is based on the policy listed in the CPWD Veterans Handbook.

Potential issues include:

- Felonies related to manufacture, distribution, prescription or dispensing of a controlled substance
- Felony conviction for abuse, neglect, assault, battery, criminal sexual conduct (1st, 2nd or 3rd degree), fraud or theft against a minor or vulnerable adult
- Felony or misdemeanor patient abuse
- Felony or misdemeanor involving cruelty or torture
- Misdemeanor health care fraud
- Misdemeanor for abuse, neglect, or exploitation of a minor or disabled adult; physical or sexual assault, violence, theft, fraud, threatening or reckless conduct
- Driving under the influence of drugs or alcohol
- Substantiated allegation of abuse, neglect or exploitation.
- Any other conduct that represents evidence of behavior that could endanger the safety or well-being of an individual.

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

- Relevance of the crime to the position sought;
- The nature of the work and/or activity to be performed;
- Time elapsed since the conviction;
- The number of offenses;
- Whether the individual has pending charges;

CPWD-CA

Form **SS-4**
(Rev. December 2025)
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 ☐ State/local government
- ☐ Farmers' cooperative ☐ Federal government
- ☐ REMIC ☐ Indian tribal governments/enterprises

Group Exemption Number (GEN) if any

9b If a corporation, name the state or foreign country (if applicable) where incorporated — State — Foreign country

10 **Reason for applying** (check only one box)

- ☑ Started new business (specify type) _____
  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 JUNCTION 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.

Applicant's telephone number (include area code)

Name and title (type or print clearly)

Applicant's fax number (include area code)

Signature

Date

VDC California Workers' Compensation Form

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

CPWD-CA

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)	☑	☐
Form 941, Employer's QUARTERLY Federal Tax Return (all 941 series)	☑	☐
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.

☑ 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.

CPWD-CA

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. 802-295-1912
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	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)

CPWD-CA

Employment Development Department
State of California

000101151

COMMERCIAL EMPLOYER ACCOUNT REGISTRATION AND UPDATE FORM

Did you know you can register online anytime? The Employment Development Department (EDD) e-Services for Business online application is secure, saves paper, postage, and time. You can access the online application at **www.edd.ca.gov/e-Services_for_Business** and follow the easy step-by-step process to complete your registration.

Review the *Instructions for Completing the Commercial Employer Account Registration and Update Form* (DE1-I) prior to completing this form. Do not submit this form until you have paid wages in excess of $100 to one or more employees in any calendar quarter. Additional information about registering with the EDD is available online at **www.edd.ca.gov/Payroll_Taxes/Am_I_Required_to_Register_as_an_Employer.htm**.

Important: This form may not be processed if the required information is missing.

A. I WANT TO (Select only one box then complete the items specified for that selection.)	☒ Register for a New Employer Account Number (Go to Item B.)	☐ Request Account for CalJOBS℠ (Go to Item B.)	
	Existing Employer Account Number: ☐☐☐-☐☐☐☐-☐ (Enter Employer Account Number when reporting an Update, Purchase, Sale, Reopen, Close, or Change in Status.)		
	Update Employer Account Information ☐ Address (O, P) ☐ DBA (J) ☐ Personal Name Change (G) ☐ Add/Change/Delete Officer/Partner/Member (H) (Provide the Employer Account Number at the top of Item A, then complete the Items identified above and Item T.) Effective Date of Update(s): ____/____/_____		
	☐ Report a Purchase of Business (Provide the Seller's Employer Account Number at the top of Item A.)	Date of Purchase ____/____/_____	Purchase Price $_____ ☐ Entire Business Purchase ☐ Partial Business Purchase
	☐ Report a Sale of Business (Provide the business' Employer Account Number at the top of Item A. Complete Item P.)	Date of Sale ____/____/_____	☐ Entire Business Sold ☐ Partial Business Sold
	☐ Reopen a Previously Closed Account (Provide the previous Employer Account Number at the top of Item A then go to Item B.)		
	☐ Close Employer Account (Provide the Employer Account Number at the top of Item A.)	Reason for Closing Account ☐ No longer have employees ☐ Out of Business	Date of Last Payroll ____/____/_____
	☐ Report a Change in Status: Business Ownership, Entity Type, or Name Reason for Change: _____ Change: From _____ To _____ (Provide the Employer Account Number at the top of Item A, and complete the rest of the form.) Effective Date of Change: ____/____/_____		
B. EMPLOYER TYPE (Select type then proceed to Item C.)	☐ COMMERCIAL	☐ PACIFIC MARITIME	☐ FISHING BOAT
C. TAXPAYER TYPE (Select only one type then complete the items specified for that selection.)	☐ Individual Owner (D, E1, F, G, J, K, L, O-T)	☐ Limited Partnership (D, F, H-T)	☐ Joint Venture (D, F, H, I, K, L, O-T)
	☐ Co-Ownership (D, E2, F, G, J, K, L, O-T)	☐ Association (D, F, H-T)	☐ Receivership (D, F, H, K, L, O-T)
	☐ General Partnership (D, E3, F, H, J, K, L, O-T)	☐ Limited Liability Company (LLC) (D, F, H-T)	☐ Estate Administration (D, F, H, I, K, L, O-T)
	☐ Corporation (D, F, H-T)	☐ Limited Liability Partnership (LLP) (D, F, H-T)	☐ Trusteeship (D, F, H, I, K, L, O-T)
	☐ Other (Specify) (Complete remaining items as applicable.)		
D. FIRST PAYROLL DATE (MM/DD/YYYY)	First payroll date wages paid exceeded $100: ____/____/_____ (Wages are all compensation for an employee's services.) Refer to *Information Sheet: Wages* (DE 231A) and *Information Sheet: Types of Payments* (DE 231TP) at **www.edd.ca.gov/Payroll_Taxes/Forms_and_Publications.htm**.		
E. EMPLOYEE INFORMATION	"Employment" does not include service performed by a child under the age of 18 years in the employ of his/her father or mother, or service performed by an individual in the employ of his/her son, daughter, or spouse, including the employee's registered domestic partner. (Section 631 of the California Unemployment Insurance Code) Refer to *Information Sheet: Family Employment* (DE 231FAM) at **www.edd.ca.gov/Payroll_Taxes/Forms_and_Publications.htm**.		
E1. INDIVIDUAL OWNER (Only)	Do you only employ your spouse, parent(s), or minor child(ren) (under 18)? If yes, you are not subject to Unemployment Insurance (UI) and State Disability Insurance (SDI) but may be subject to Personal Income Tax (PIT).	Yes ☐	No ☐
E2. CO-OWNERSHIP (Only)	Do you only employ your minor child(ren) (under 18)? If yes, you are not subject to UI and SDI but may be subject to PIT.	Yes ☐	No ☐
E3. PARTNERSHIP (Consisting of siblings only.)	Do you only employ your parent(s)? If yes, you are not subject to UI and SDI but may be subject to PIT.	Yes ☐	No ☐

CPWD-CA

COMMERCIAL EMPLOYER ACCOUNT REGISTRATION AND UPDATE FORM

000101152

F. LOCATION OF EMPLOYEE SERVICES	Do you have employees working in California?					Yes ☒	No ☐	
	Do you have employees residing in California that are working outside of California?					Yes ☐	No ☒	
G. INDIVIDUAL OWNER/ CO-OWNER INFORMATION (If applicable)	**NAME**	**TITLE**	**SSN**	**CA Driver License Number**	Add	Chg.	Del.	
					☐	☐	☐	
					☐	☐	☐	
H. CORPORATE OFFICER(S), PARTNERS, OR LLC MEMBER(S), MANAGER(S), AND/OR OFFICER INFORMATION	**NAME**	**TITLE**	**SSN**	**CA Driver License Number**	Add	Chg.	Del.	
					☐	☐	☐	
					☐	☐	☐	
					☐	☐	☐	
					☐	☐	☐	

I. LEGAL NAME OF ORGANIZATION (Corporation/LLC/LLP/LP: Enter exactly as it appears on your official registration documents.)

J. DOING BUSINESS AS (DBA) (If applicable)

K. FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN)	L. DATE OWNERSHIP BEGAN (MM/DD/YYYY) ____/____/_____
M. STATE OR PROVINCE OF INCORPORATION/ORGANIZATION	N. CALIFORNIA SECRETARY OF STATE ENTITY NUMBER

O. PHYSICAL BUSINESS LOCATION (PO Box or Private Mail Box will **not** be accepted.)	Street Number	Street Name		Unit Number (If applicable)
	City	State/Province	ZIP Code	Country
		Business Phone Number		
P. MAILING ADDRESS (PO Box or Private Mail Box **is** acceptable.) ☐ Same as above	Street Number PO BOX 4409	Street Name		Unit Number (If applicable)
	City WHITE RIV JCT	State/Province VT	ZIP Code 05001	Country
		Phone Number		
Q. E-MAIL ☐ Check to allow e-mail contact.	Valid E-mail Address			
R. INDUSTRY ACTIVITY	Describe in detail your specific product/services: HOME AND COMMUNITY BASED PERSONAL CARE FOR VETERAN AS PART OF VA FUNDED PROGRAM.			
	Select your business industry ☐ Services ☐ Retail ☐ Wholesale ☐ Manufacturing ☐ Temporary Services ☐ Leasing Employer ☐ Professional Employer Organization ☒ Other (Specify) PRIVATE HOUSEHOLD			
S. CONTACT PERSON (Complete a *Power of Attorney [POA] Declaration* [DE 48], if applicable.)	Name Britney Mann	Contact Phone Number 866.970.3301	E-mail Address TAX@ARISSOLUTIONS.ORG	
	Relation	Address		

T. DECLARATION	**I certify under penalty of perjury that the above information is true, correct, and complete, and that these actions are not being taken to receive a more favorable Unemployment Insurance rate. I further certify that I have the authority to sign on behalf of the above business.**		
	Signature		**Date**
	Name	**Title**	**Phone Number**

MAIL TO: EDD, Account Services Group, MIC 28, PO Box 826880, Sacramento, CA 94280-0001

Employment Development Department
State of California

Power of Attorney Declaration

This *Power of Attorney (POA) Declaration* (DE 48) is your written authorization for an individual or other entity to act on your behalf in tax and/or benefit reporting matters with us. A POA remains in effect until it is revoked or a new one is received.

If you would like to only authorize a POA for a set period, you must specify the date your new POA will expire.
For more information, see the *Information Sheet: Counseling Service Agent* (DE 231CSA) and *Information Sheet: Payroll Reporting Agent* (DE 231PRA).

Complete the DE 48

Online

Complete and send us your POA online with e-Services for Business (eddservices.edd.ca.gov/tap/secure/eservices).
For more information, visit e-Services for Business FAQs (edd.ca.gov/en/payroll_taxes/faq_-_e-services_for_business).

By Mail

You can also send a POA by mailing the completed DE 48 with the following required information:

Employer and taxpayer information
Enter your:

- California employer payroll tax account number (if applicable)
- Federal employer identification number
- Owner or legal name of organization
- Secretary of State identification number
- Business name or doing business (DBA)
- Mailing address
- Business phone and fax numbers
- Business location if different than the mailing address

Representative designation
Enter your representative's business, name, phone number, fax numbers and address.

- **Authorized acts**
  If you want to authorize your representative to perform all acts on your behalf, select the **General Authorization** box.
- If you want to limit this authorization, select the boxes that apply under the "Specific Declaration" header. Enter the beginning and ending dates of each interval or period you are making the declaration.

Signature authorizing power of attorney
In order for your new POA to be recognized, it must be signed and dated by an authorized signator.
An authorized signator can be the business:

- Owner
- Partners
- Members
- Managing members
- Corporate officers including the President, Vice President, Chief Executive Officer, or Chief Financial Officer

Please send an updated list of corporate officers or owners with this document.

Note: If your declaration is sent without a date, signature, or with an unauthorized signature, it will be returned.
The signature date must be within 30 days of the submission of the POA.

Mail the completed DE 48 to:

Employment Development Department
Account Services Group, MIC 28
PO Box 826880
Sacramento, CA 94280-0001
Fax 1-916-654-9211

Questions or need assistance completing this form? Call the Account Services Group Agent Line at 1-916-654-7263.

Power of Attorney Declaration

To send a Power of Attorney Declaration (POA) online, use e-Services for Business (eddservices.edd.ca.gov/tap/secure/eservices).

I. Employer and Taxpayer Information

California Employer Payroll Tax Account Number: *(if applicable)*	Federal Employer Identification Number:		
Owner (Limited Liability Company, Limited Partnership, Corporation Name)	Corporate (Limited Liability Company, Limited Partnership Identification Number)		
Business Name (Or Doing Business As):			
Business Mailing Address:	City:	State:	ZIP Code:
Business Phone Number:	Business Fax Number:		
Business Location *(if different from above)*:	City:	State:	ZIP Code:

II. Representative Designation

I hereby appoint the following person to represent the employer or taxpayer for specified matters arising under the California Unemployment Insurance Code.

Representative Business: ARIS Solutions Fiscal Agent			
Representative Name: Janet Couture	Phone Number: (802) 280-1911	Fax Number:	
Business Mailing Address: PO Box 4409	City: White River Jct.	State: VT	ZIP Code: 05001

III. Authorized Act

☑ **All Authorization:** To represent the employer or taxpayer and receive mailings for all state tax matters.

☐ **Specific Declaration:** The representative will have limited authority to your state tax matters.
Indicate the specific dates and acts you are authorizing from _____ To _____

- ☐ To represent the employer or taxpayer for any or all:
  ☐ Tax reporting ☐ Benefit reporting ☐ Both matters relating to the reporting period indicated above
- ☐ To represent the employer or taxpayer and receive mailings for any and all:
  ☐ Tax reporting ☐ Benefit reporting ☐ Both matters relating to the reporting period indicated above
- ☐ Other acts: _____

IV. Signature Authorizing Power of Attorney

Signature of the employer or taxpayer, owner, managing member, officer, receiver, administrator, or trustee for the employer or taxpayer: If you are a corporate officer, partner, guardian, tax matter person, executor, receiver, administrator, or trustee on behalf of the employer or taxpayer, you are certifying that you have the authority to execute this form on behalf of the employer or taxpayer by signing this Power of Attorney Declaration.

If this Power of Attorney Declaration is not signed and dated, it will be returned as invalid.

I certify under penalty of perjury that the above information is true, correct, and complete, and that these actions are not to be taken to receive a more favorable Unemployment Insurance rate. I further certify that I have the authority to sign on behalf of the above business.

_____ HCSR

Signature Title

_____ _____

Print Name Date

Employer Confirmation of Receipt: Paid Leave Accrual

I,_____, understand that being an employer in California grants access for my employees to **Paid Sick Leave** hours. Included below is information regarding this State mandated Paid Sick Leave Policy. As an employer, you are required to choose your preferred method provided to your employees.

- *Employers may choose to have an "accrual" policy or an "up front" policy.*
  - *Employees under an accrual plan will earn a minimum of 1 hour per 30 hours worked. You, as the employer, can decide on a more generous accrual on page 2 of this document.*
  - *Employees under an up-front plan will receive the full amount of sick leave for the year immediately upon hire. They must be provided at least 40 hours.*
- *To qualify for sick leave, an employee must:*
  - *Work for the same employer for at least 30 days within a year in California.*
  - *Satisfy a 90-day employment period before taking any sick leave*
- *Employees are paid their current hourly rate when using time.*
  - *Claiming hours is for absences during **regularly scheduled work shifts.***
  - *Please refer to the FAQ within these documents for qualifying events to use paid sick leave for.*
- *The maximum amount of paid leave an employee can accrue in one year is 80 hours.*
- *If an employee is separated from employment and rehired within 12 months with the same employer, employee shall be entitled to any previously accrued time.*
- *Upon separation of employment, the employee will not be entitled to be paid out for any remaining accrued leave time.*
- *Employers cannot deny time requested or retaliate against an employee for requesting or using paid leave. Employees have the right to file a complaint or bring civil action if either situation occurs.*
- *ARIS Solutions, as the FMS provider, will manage your paid leave policy and be available if questions arise.*

Employer Selection of Paid Sick Leave Policy

After reviewing the Paid Sick Leave Policy options available to employers in California, I understand that the policy selected below will apply to ALL of my employees. Please select ONE option:

Option 1:

☐ Accrual Method

My employees will accrue Paid Sick Leave based on hours worked.

• Employees will earn _____ hour(s) of paid sick leave for every _____ hours worked

(Example: 1 hour earned for every 30 hours worked)

• Employees may use up to _____ hours of Paid Sick Leave per year

• Employees may carry over up to _____ hours of Paid Sick Leave into the following calendar year (maximum accrual cap of 80 hours applies)

Option 2:

☐ Up-Front Method

My employees will receive Paid Sick Leave upon hire.

• Employees will receive _____ hours of Paid Sick Leave each year (minimum 40 hours required)

• Employees may carry over up to _____ hours of Paid Sick Leave into the following calendar year

---

Employer Acknowledgements

I understand and agree to the following:

• I accept my role as an employer within the Veteran Directed Program employment model.

• I am responsible for completing required employer paperwork and for managing employees and budget responsibilities within this participant-directed business model.

• I will discuss my selected Paid Sick Leave policy with my employees.

• My selected Paid Sick Leave policy begins on the employee's first day of employment. Employees must complete a 90-day employment period before using paid sick leave.

• I understand that ARIS Solutions, as the FMS provider, is not the employer.

Employer/AR Signature: _____ Date: _____

Employer/AR Name: _____

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*

Veteran Directed Care Program

ATTENTION ALL EMPLOYEES, EMPLOYERS, AND AGENCIES

ARIS Solutions' Veteran Directed Care Program utilizes a submission platform on our website as one means for timesheet submission. We felt it may be helpful to provide clarifying information to address some of the questions we have received.

- **The web address to access the new portal is:**
  arissolutions.org/submit-timesheet
- **This change is only applicable to those who had been submitting timesheets via email.** Those who send in timesheets via fax, USPS, or via e-timesheets may continue.
- **The portal is for timesheet submissions only.** Please continue to send invoices, packets, and general correspondence through the email address.
- **Submissions may be made by either the employer or the employee.**
- **All timesheet submissions must be entered under the name of the employee**. Entries may not be entered under the name of the employer or veteran.
- **Please send only one timesheet per submission.**
- **Each submission should include a timesheet for only one employee.** Submissions containing multiple employees are not permissible.
- **There will be no email confirmation.** Instead of an email, a unique code will appear on your screen once a timesheet has been successfully submitted.
- **The new timesheet portal requires a pass code, but not a log-in.** If you have been asked for log-in information, then you have likely arrived at our electronic timesheet option. If you are interested in enrolling in e-timesheets, please reach out to veteran payroll customer service for assistance.

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

About the Electronic Timesheets Module

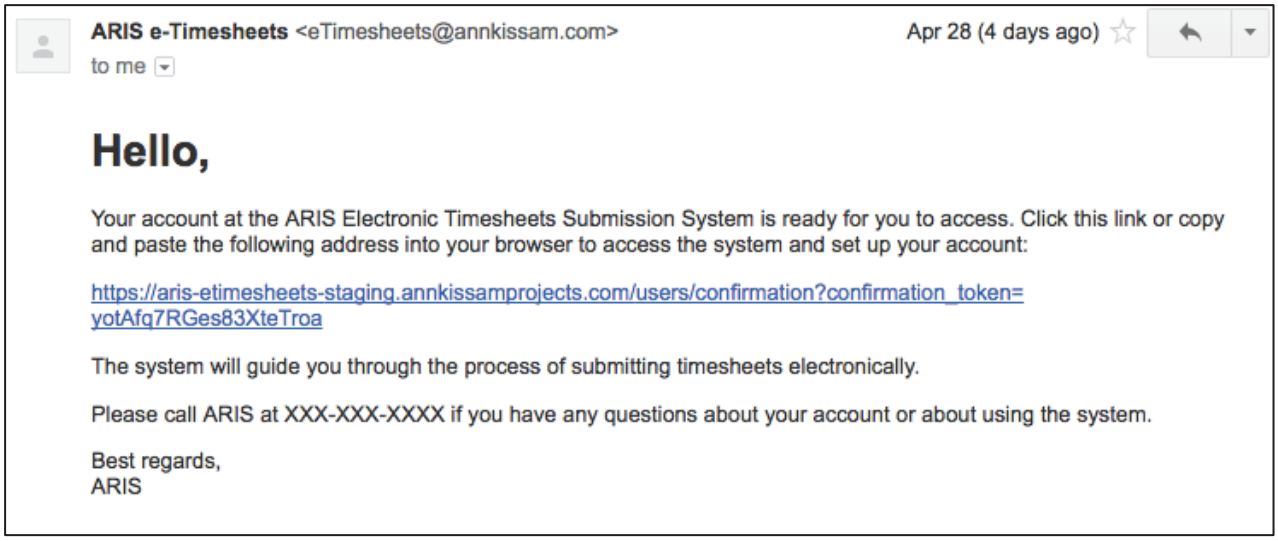
The Electronic Timesheets Module is a web-based interface through which Consumers, Employers, Representatives and Employees can respectively enter and view relevant timesheet information.

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:

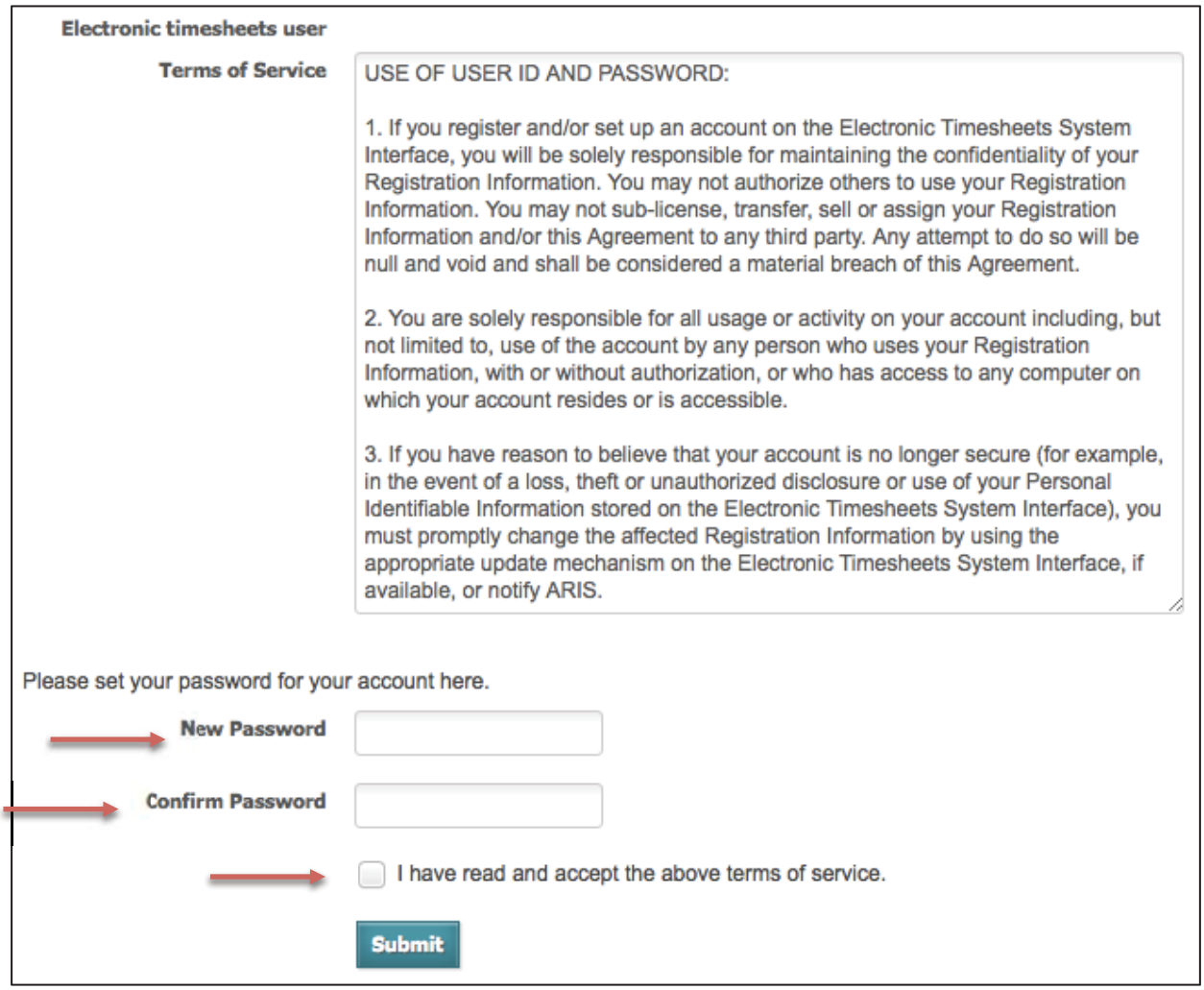
https://aris-etimesheets-staging.annkissamprojects.com/users/confirmation?confirmation_token=yotAfq7RGes83XteTroa

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.

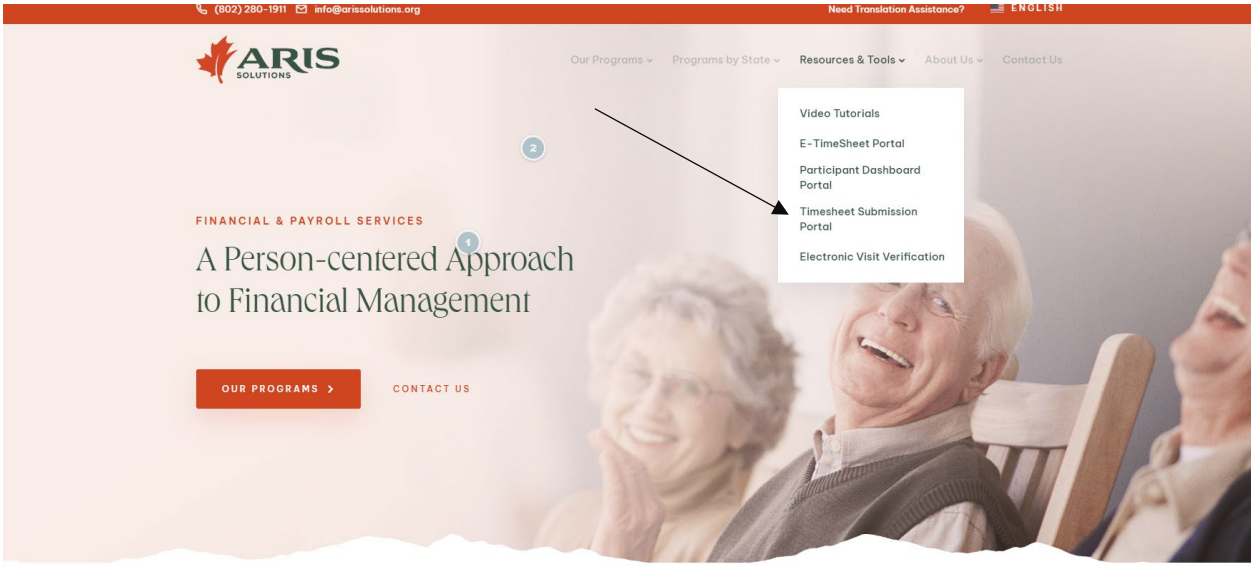
Best regards,
ARIS

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

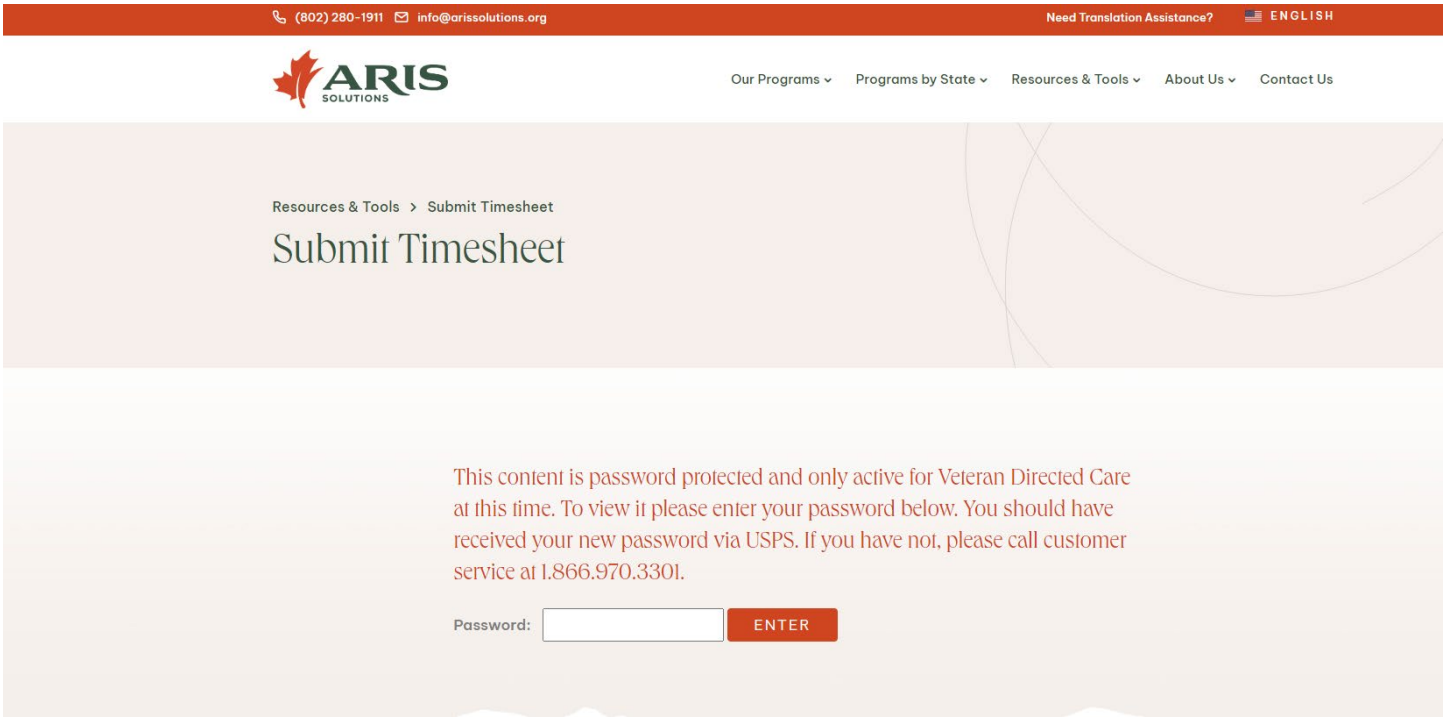


4. Once each user accepts the Terms of Service and creates a password, he or she may start using the system.

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 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/

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

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.

Financial & Payroll Services for the Nonprofit Sector

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

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.

Employment Development Department
State of California

NOTICE TO EMPLOYEES
UNEMPLOYMENT INSURANCE BENEFITS

This employer is registered under the California Unemployment Insurance Code and is reporting wage credits to the Employment Development Department (EDD) that are being accumulated for you to be used as a basis for Unemployment Insurance benefits.

You may be eligible to receive Unemployment Insurance benefits if you are:

- Unemployed or working less than full-time.

  and

- Out of work due to no fault of your own and physically able to work, ready to accept work, and looking for work.

Employees of Educational Institutions:

Unemployment Insurance benefits based on wages earned while employed by a public or nonprofit educational institution may not be paid during a school recess period if the employee has reasonable assurance of returning to work at the end of the recess period (California Unemployment Insurance Code section 1253.3). Benefits based on other covered employment may be payable during recess periods if the unemployed individual is in all other respects eligible, and the wages earned in other covered employment are sufficient to establish an Unemployment Insurance claim after excluding wages earned from a public or nonprofit educational institution(s).

Note: Some employees may be exempt from Unemployment and Disability Insurance coverage.

The fastest way to file for Unemployment Insurance (UI) is with UI Online at www.edd.ca.gov/UI_Online.

You may also file for Unemployment Insurance by calling toll-free from anywhere in the U.S. at:

English	1-800-300-5616	Mandarin	1-866-303-0706
Spanish	1-800-326-8937	Vietnamese	1-800-547-2058
Cantonese	1-800-547-3506	TTY	1-800-815-9387

Note: Waiting to file a claim could delay benefits.
EDD representatives are available Monday through Friday between 8 a.m. and 12 noon (Pacific Time).

Notice to Employees

Employment Development Department
State of California

Your employer is registered with and reporting wages to the Employment Development Department (EDD) as required by law. Wages are used for the following benefit programs, which are available to you.

Disability Insurance

You may be eligible for partial wage-replacement benefits through Disability Insurance (DI) when you are unable to work due to a non-work-related illness, injury, pregnancy, or disability.

Your employer must provide the *Disability Insurance Provisions* (DE 2515) brochure to each newly hired employee to describe benefits and eligibility requirements. You must meet all eligibility requirements to receive disability benefits.

- Request claim forms from your licensed health professional, employer, or from any California State Disability Insurance (SDI) Claims Management office. You can also order claim forms online by visiting EDD Forms and Publications (forms.edd.ca.gov/forms).
- File your *Claim for Disability Insurance (DI) Benefits* (DE 2501) within 49 days of the first day of your disability to avoid losing benefits.
- If you have disability coverage under your employer's voluntary plan, get disability claim forms from your employer or the designated third-party administrator.
- Visit Disability Insurance (edd.ca.gov/Disability/Disability_Insurance.htm) to learn how to apply for benefits.

Paid Family Leave

You may be eligible for partial wage-replacement benefits through Paid Family Leave (PFL) when you stop working or reduce your work hours to:

- Care for a family member who is seriously ill.
- Bond with a new child.
- Take part in a qualifying event resulting from a family member's military deployment to a foreign country.

Your employer must provide a copy of the *California Paid Family Leave* (DE 2511) brochure to each newly hired employee to describe benefits and eligibility requirements. You must meet all eligibility requirements to receive family leave benefits.

- Request claim forms from your licensed health professional, employer, from any California SDI Claims Management office. You can also order claim forms online by visiting EDD Forms and Publications (forms.edd.ca.gov/Forms).
- File your *Claim for Paid Family Leave (PFL) Benefits* (DE 2501F) within 41 days of the first day of your family leave to avoid losing benefits.
- If you have PFL coverage under your employer's voluntary plan, get PFL forms from your employer or designated third-party administrator.

For more information about DI and PFL, visit State Disability Insurance (edd.ca.gov/Disability).
DI: Call 1-800-480-3287. TTY (for deaf or hearing-impaired individuals only) 1-800-563-2441.
PFL: Call 1-877-238-4373. TTY (for deaf or hearing-impaired individuals only) 1-800-445-1312.
State Government employees should call 1-866-352-7675 for DI and 1-877-945-4747 for PFL.

Notice to Employees

Employment Development Department
State of California

Your employer is registered with and reporting wages to the Employment Development Department (EDD) as required by law. Wages are used for the following benefit programs, which are available to you.

Unemployment Insurance

Funded entirely by employer's taxes

Provides partial wage replacement when you are unemployed or your hours are reduced due to no fault of your own. You must meet all eligibility requirements to receive unemployment benefits.

Visit File for Unemployment (edd.ca.gov/unemployment) to learn how to apply for benefits.

Disability Insurance

Funded entirely by employees' contributions

Provides partial wage replacement when you are unable to work because of a non-work-related illness, injury, pregnancy, or disability. You must meet all eligibility requirements to receive disability benefits.

Visit Disability Insurance (edd.ca.gov/Disability/Disability_Insurance.htm) to learn how to apply for benefits.

Paid Family Leave

Funded entirely by employees' contributions

Provides partial wage replacement when you need to take time off work to:

- Care for a seriously ill family member.
- Bond with a new child.
- Participate in a qualifying event because of a family member's military deployment to a foreign country.

Visit California Paid Family Leave (edd.ca.gov/PaidFamilyLeave) to learn how to apply for benefits.

Note: Some employees may be exempt from coverage by the above insurance programs. It is illegal to make a false statement or to withhold facts to claim benefits. For additional information, visit the EDD (edd.ca.gov).

The EDD is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Requests for services, aids, and/or alternate formats need to be made by calling 1-866-490-8879 (voice). TTY users, please call the California Relay Service at 711.