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

Financial & Payroll Services for the Nonprofit Sector

Enrollment Forms for:

VDC Program Employers

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

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

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

If you have questions contact the Veterans Department at 866.970.3301

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

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

New Employer/Veteran Information

You are now an Employer!

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

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

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

Roles and Responsibilities Chart

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

Contact Information

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

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

ARIS Solutions is not open on state or federal holidays.

Financial & Payroll Services for the Nonprofit Sector

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.

CASE MANAGER / OPTIONS COUNSELOR / CARE COORDINATOR :

NAME OF VETERAN

Name _____ **GENDER** _____

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

Phone (_____)_____

Date of Birth _____

Social Security Number _____

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

ARIS Solutions 

VDC North Carolina 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:

VDC-EMPLOYER

Form 2678 Employer/Payer Appointment of Agent

(Rev. December 2023) Department of the Treasury — Internal Revenue Service

OMB No. 1545-0748

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

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

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

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

For IRS use:

Part 1: Why you're filing this form.

(Check one)

[x] You want to **appoint** an agent for tax reporting, depositing, and paying.

[ ] You want to **revoke** an existing appointment.

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

1 **Employer identification number (EIN)** [ ][ ] – [ ][ ][ ][ ][ ][ ][ ]

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

3 **Trade name** (if any)

4 **Address**

Number Street Suite or room number

City State ZIP code

Foreign country name Foreign province/county Foreign postal code

5 **Forms for which you want to appoint an agent or revoke the agent's appointment to file.** *(Check all that apply.)*

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

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

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

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

Sign your name here

Print your name here

Print your title here HCSR

Date / /

Best daytime phone

Now give this form to the agent to complete.

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	CAF No. / PTIN / Telephone No. / Fax No. / Check if new
ARIS Solutions PO Box 4409 White River Jct., VT 05001 **Check if to be sent copies of notices and communications** ☐	CAF No. 0313-84964R PTIN Telephone No. 866-970-3301 Fax No. 802-295-1912 Check if new: Address ☐ Telephone No. ☐ Fax No. ☐
Name and address **Check if to be sent copies of notices and communications** ☐	CAF No. PTIN Telephone No. Fax No. 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)

NCDOR
Web-Fill
3-20

GEN-53
Taxpayer Representative e-Business Center Access Authorization

Complete this form if you are a taxpayer representative (such as an accountant or payroll company representative) requesting view tax history and manage payment access to a taxpayer's information in the NC Department of Revenue's e-Business Center. **Note: Representatives must first create an NCID user ID and password before submitting this form.** Please review the instructions for additional information.

Step 1. Taxpayer Information *(Please type or print.)*

Legal Business or Owner's Name: _____ Daytime Telephone Number: _____

Address: _____ City, State and Zip: _____

Federal Employer Identification Number: ___-_____ or Proprietor's Social Security Number ___-__-____

Step 2. Taxpayer Representative Information

☐ *There is space provided for up to three representatives. If you need to identify more, check here and attach a list to this form to identify the additional representatives. Note that each taxpayer representative must include his or her signature and the date signed. Taxpayer must sign all attachments.*

Taxpayer Representative's Name: JANET COUTURE

Taxpayer Representative's Company Name: ARIS SOLUTIONS

Address: PO BOX 4409 City, State and Zip: WRJ VT 05001

Daytime Telephone Number: (802) 280-1911

Signature of Taxpayer Representative: _____ Date: _____

Taxpayer Representative's Name: SARAH HESSE

Taxpayer Representative's Company Name: ARIS SOLUTIONS

Address: PO BOX 4409 City, State and Zip: WRJ VT 05001

Daytime Telephone Number: (802) 280-1911

Signature of Taxpayer Representative: _____ Date: _____

Taxpayer Representative's Name: _____

Taxpayer Representative's Company Name: _____

Address: _____ City, State and Zip: _____

Daytime Telephone Number: _____

Signature of Taxpayer Representative: _____ Date: _____

Step 3. Tax Type and Period Begin Date

Select the tax type(s) and note the year or period begin date for which this authorization applies.

	Type of Tax	Year/Period Begin Date
☐	Alcoholic Beverage Tax - Beer	
☐	Alcoholic Beverage Tax - Fortified Wine	
☐	Alcoholic Beverage Tax - Unfortified Wine	
☐	Alcoholic Beverage Tax - Spirituous Liquor	
☐	Cigarette Tax - Resident	
☐	Cigarette Tax - Nonresident	
☐	Corporate Estimated Tax	
☐	Machinery and Equipment Tax	
☐	Other Tobacco Products Tax	
☐	Piped Natural Gas Excise Tax (Repealed July 1, 2014)	
☐	Utility Franchise Tax - Electric (Repealed July 1, 2014)	
☐	Utility Franchise Tax - Water and Sewer (Repealed July 1, 2014)	
☐	Combined General Rate Sales and Use Tax (Utility, Liquor, Gas and Other) formerly Utility and Liquor Sales and Use Tax	
☑	Withholding Tax (NC-5 and NC-5P)	01-01-26

Step 4. Taxpayer Signature

I hereby certify that the taxpayer representative(s) identified should be granted the authority to view tax history and manage payment information within the NC Department of Revenue's e-Business Center on my behalf. This authorization may be revoked by me at any time (see form instructions for additional information).

Signature _____ Print Name _____

Title HCSR Date _____

Fax Form Gen 53 to 919-715-1786 or mail to
North Carolina Department of Revenue, PO Box 25000, Raleigh, NC 27640-0005

Gen-53 Instr.
Web-Fill
3-20

General Instructions

PURPOSE OF THIS FORM

The NC Department of Revenue's e-Business Center is a secure web-based system within our website where you can file and pay taxes, store payment and business information for reuse, view history of online tax transactions and conduct other business with us. This form is used to grant access to a taxpayer representative (such as an accountant or payroll company representative) to view tax history and manage payment information for a taxpayer in the e-Business Center. **Note: Representatives must first create an NCID user ID and password before submitting this form.**

AUTHORITY GRANTED

The authority granted by this form is effective beginning with the period indicated in Step 3 and continues indefinitely unless revoked by the taxpayer or taxpayer representative.

REVOKING THE AUTHORIZATION

The taxpayer can revoke the taxpayer representative authorization granted on this form at any time by contacting the Department in writing.
The taxpayer can:

- Write "Revoke" at the top of a copy of this form and sign under the original signature, or
- The taxpayer can write a letter requesting revocation and submit it to the NC Department of Revenue at PO Box 25000, Raleigh, NC 27640-0005 or fax it to 919-715-1786. The statement of revocation must be signed by the taxpayer.

If the taxpayer wants to appoint a new taxpayer representative, the taxpayer can submit a new Taxpayer Representative e-Business Center Access Authorization to the same address. It is the responsibility of the taxpayer to advise the NC Department of Revenue if access authorization information has changed.

A taxpayer representative can withdraw from representation by filing a statement with the NC Department of Revenue. The statement must be signed and dated by the representative and include the name and address of the taxpayer(s) and a statement revoking the e-Business Center access authorization. Include a copy of the original Taxpayer Representative e-Business Center Access Authorization, if available.

DEFINITIONS

Taxpayer – The business which authorizes the taxpayer representative to view its tax history and manage its payment information in the e-Business Center.

Taxpayer Representative - A third party individual such as an attorney, an accountant, or a payroll company representative that is hired by a taxpayer to represent it on tax matters that might include filing tax returns and paying the tax and viewing copies of tax returns. The taxpayer representative is independent of the taxpayer.

Taxpayer Representative's Company Name – The company that employs the taxpayer representative, if applicable.

View Tax History - This access allows you to view returns and/or payments made online using the e-Business Center.

Manage Payment Information – This access allows you to save and update payment information in the e-Business Center for online payment of tax. The payment types include bank draft, and Mastercard and Visa credit/ debit card.

STEP 1: TAXPAYER INFORMATION INSTRUCTIONS

- Enter the taxpayer business' legal name, or the owner's name if the business is a sole proprietorship, telephone number and address.
- Federal Employer Identification Number or Social Security Number.
  - If the business is a corporation, provide the Federal Employer Identification Number.
  - If the business is a sole proprietorship, provide the owner's Social Security Number.

STEP 2: TAXPAYER REPRESENTATIVE INFORMATION

- Enter the taxpayer representative's name, taxpayer representative's company name, address and telephone number. Note: Only individuals may be named as representatives.
- The taxpayer representative signs and dates form here.
- There is space provided on the form for up to three representatives. If you need to identify more, check the box and attach a list to the form to identify additional representatives. Note that each taxpayer representative must include their signature and the date signed.
- All representatives must first create an NCID user ID and password before submitting this form. If you submit Form GEN-53 without first registering for an NCID, the form cannot be processed and will be returned to you. Instructions for creating an NCID are available on the Department's website at www.ncdor.gov.

STEP 3: TAX TYPE AND PERIOD BEGIN DATE

Enter the tax type(s) and the period begin date(s) associated with that tax type for which the taxpayer representative is being granted access. For example, if you are a monthly withholding taxpayer and you are granting access to a taxpayer representative beginning with the February 01, 2009 period, select the withholding tax type and enter 02-01-09 (Format: mm-dd-yy) in the period begin date field.

STEP 4: TAXPAYER SIGNATURE

The taxpayer signs here to grant view tax history and manage payment information in the Department's e-Business Center to the taxpayer representative.

- If the taxpayer is a sole proprietorship, the owner must sign.
- If the taxpayer is a corporation, an authorized officer must sign.
- If the taxpayer is a partnership or a limited liability company (LLC), an authorized partner or member must sign.
- Taxpayers must sign all attachments, if any.

NC Dept. of Commerce
Division of Employment Security
Post Office Box 26504, Raleigh, NC 27611-6504

"All fields are required unless specified optional"

POWER OF ATTORNEY AND DECLARATION OF REPRESENTATIVE

Part 1. Employer's Information. Must sign and date this form on page 2

EMPLOYER'S NAME AND ADDRESS *(Exactly as shown on the Division of Employment Security Records)*	EMPLOYER DES IDENTIFICATION NUMBER
	EMPLOYER FEDERAL IDENTIFICATION NUMBER -

Part 2. Agent

AGENT NAME	AGENT DES IDENTIFICATON NUMBER
ARIS Solutions Fiscal Agent- C/O Janet Couture	
ADDRESS PO Box 4409 White River Jct , VT 05001	AGENT FEDERAL IDENTIFICATION NUMBER
EMAIL ADDRESS tax@arissolutions.org	PHONE NUMBER 802.280.1911 FAX NUMBER (optional) 802.295.9812

The above agent is appointed to represent the above-referenced employer in any of the matters pertaining to contributions (tax) and/or benefits (claims) as listed below. The agent appointed pursuant to this Power of Attorney and Declaration is authorized to:

MAINTENANCE:

☑ Authorize maintenance of and changes to an employer's DES online account, including, but not limited to, contact details, ownership information, address (physical and mailing), FEIN, name change, reporting successorship, request change in reporting method and/or request seasonal designation, and inactivate/reactivate account.

TAX:

☑ Complete and submit documents for filing employer's tax and wage report;
☑ Complete and submit documents regarding an employer's tax rate, contributions and direct reimbursements; and/or
☑ Accept and receive correspondence sent by DES on an employer's tax contributions.

CLAIMS:

☑ Accept and receive correspondence sent by DES regarding claims for benefits, or respond to benefit claim documents, including responding to requests for information about a claimant's separation status.

The undersigned employer acknowledges that the agent appointed pursuant to this Power of Attorney and Declaration of Representative is not authorized to: (a) Represent the employer in hearings or (b) Enter appeals except as authorized by N.C. Gen. Stat. 96-17(b) and 04 N.C. Admin. Code 24A .0110(a) and (b). The undersigned employer further acknowledges that its mailing address for tax matters will remain unchanged, unless the employer submits a change of address in accordance with 04 N.C. Admin. Code 24A .0102.

Part 3. Declaration of Representative

This Power of Attorney and Declaration of Representative shall become effective on _____ and shall remain in effect until terminated by the employer, the representative, or the Division of Employment Security. Authorizing any of the above-listed roles also authorizes the agent to engage in discussion with a representative of the Division of Employment Security regarding the selected role(s). On the effective date, this Power of Attorney and Declaration of Representative revokes any earlier power of attorney on file with the Division of Employment Security on the roles selected above.

AUTHORIZED SIGNATURE	DATE SIGNED
	HCSR
TYPED OR PRINTED NAME	TITLE

The document must be signed by (a) the individual, if the employer is an individual; (b) the president, vice president, or other principal officer, if the employer is a corporation; (c) a partner, if the employer is a partnership or limited liability partnership; (d) a member, if the employer is a limited liability company or professional limited liability company; (e) a responsible and duly authorized member or officer having knowledge of its affairs, if the employer is a government entity, or other unincorporated organization; (f) the fiduciary, if the employer is a trust or an estate, or (g) a person appointed by the employer pursuant to a power of attorney under Chapter 32C of the N.C. General Statutes.

NCDOR
Web-Fill
8-19-24

GEN-58
Power of Attorney and Declaration of Representative

DOR Use Only

Part 1. Power of Attorney *(Please type or print.)*

ID Type *(Specify one)*
SSN *(Social Security Number)* or
FEIN *(Fed Employer ID Number)*

1 Taxpayer Information

Individual's First Name | **M.I.** | **Individual's Last Name** | **ID Type** | **Primary Identification Number**

Spouse's First Name | **M.I.** | **Spouse's Last Name** | **ID Type** | **Spouse Identification Number**

Entity Legal Name | **ID Type** | **Business Identification Number**

Mailing Address | **Daytime Phone Number** *(Include area code)*

City | **State** | **Zip Code**

Email Address

hereby appoint(s) the following representative(s) as attorney(s)-in-fact:

2 Representative(s) (Representative(s) must sign and date this form on page 2, Part 2.)

First Name: JANET | **Last Name**: COUTURE | **Phone Number**: (866) 970-3301
Mailing Address: PO BOX 4409
City: WHITE RIVER JCT | **State**: VT | **Zip Code**: 05001
Email Address: tax@arissolutions.org
☐ Check to receive available notice copies.

First Name: SARAH | **Last Name**: HESSE | **Phone Number**: (866-970-3301)
Mailing Address: PO BOX 4409
City: WHITE RIVER JCT | **State**: VT | **Zip Code**: 05001
Email Address: tax@arissolutions.org
☐ Check to receive available notice copies.

First Name | **Last Name** | **Phone Number**
Mailing Address
City | **State** | **Zip Code**
Email Address
☐ Check to receive available notice copies.

to represent the taxpayer(s) before the North Carolina Department of Revenue for the following matters:

3 Tax Matters You may list any tax years or periods that have already ended as of the date you sign the power of attorney. You may include future tax years or periods that end no later than three years from December 31 of the year the power of attorney is filed with the Department.

Type of Tax	Begin Tax Period	End Tax Period
WITHHOLDING	12-01-25	12-01-28

4 Acts Authorized. - The representative(s) are authorized to receive and inspect confidential tax information, which may include federal tax information, and to perform any and all acts that I (we) can perform with respect to the tax matters described on line 3, for example, the authority to sign any agreements, consents, or other documents. For purposes of this section, federal tax information is defined as federal tax returns and return information received from the Internal Revenue Service.

Check to make any specific additions or deletions from the acts authorized. ☐

If checked, you must list them below.

5 Signature of Taxpayer(s). - If you request joint representation for you and a spouse related to a joint return, both spouses must sign the form. If you request representation for just you, your spouse is not required to sign. If signed by a corporate officer, partner, guardian, tax matters partner/person, executor, representative, receiver, administrator, or trustee on behalf of the taxpayer, I certify that I have the authority to execute this form on behalf of the taxpayer.
▶ **IF NOT SIGNED AND DATED, THIS POWER OF ATTORNEY WILL BE RETURNED.**

Signature | Date | Title (if applicable)

Print Name

Signature (If applicable) | Date | Title (if applicable)

Print Name

Part 2. Declaration of Representative (To be completed by representative)

Under penalties of perjury, I declare that:

- I am authorized to represent the taxpayer(s) identified in Part 1 for the tax matter(s) specified there; and
- I am one of the following:
  - **A** Attorney - a member in good standing of the bar of the highest court of the jurisdiction shown below.
  - **B** Certified Public Accountant - duly qualified to practice as a certified public accountant in the jurisdiction shown below.
  - **C** Enrolled Agent - Enrolled as an agent under the requirements of Treasury Department Circular No. 230.
  - **D** Officer - a bona fide officer of the taxpayer's organization.
  - **E** Full-Time Employee - a full-time employee of the taxpayer.
  - **F** Family Member - a member of the taxpayer's immediate family (i.e., spouse, parent, child, brother, or sister).
  - **G** Other (explain) - FINANCIAL MANAGEMENT SERVICE PROVIDER FOR THE TAXPAYER

▶ **IF THIS DECLARATION OF REPRESENTATIVE IS NOT SIGNED AND DATED, THE POWER OF ATTORNEY WILL BE RETURNED.**

Designation - Insert above letter (A-G)	Jurisdiction (e.g. State) or Enrollment Card No.	Signature	Date
G			

Upload: Scan and upload completed Form GEN-58 at ncdor.gov/poa
Mail to: North Carolina Department of Revenue, P. O. Box 25000, Raleigh, NC 27640-0005
Fax: 919-715-1786

PROGRAM INTEGRITY and FRAUD PREVENTION

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

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

Examples of Fraud and Abuse Include

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

Results

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

REPORTING

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

Employer Confirmation of Receipt

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

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

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

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

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

Signed,

_____ _____

Signature of Employer Date

FRAUD & ABUSE STATEMENT

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

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

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

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

Examples of Medicaid/Veteran Administration Abuse include:

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

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

The difference between Fraud and Abuse

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

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

_____

Veteran's Signature Date

_____

Authorized Representative Signature Date

_____

FMS Provider Signature Date

Employer/Authorized Representative Background Check Release Form

Veteran Directed Care Program

Care Coordinator _____AAA_____

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

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

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

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

* state specific background check(s)

Signatures:

Employer/Authorized Representative: _____ Date: _____

Veteran: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES & AGREEMENT

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

DEFINITION OF MEDICAL INFORMATION

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

USES AND DISCLOSURES OF PHI

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

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

Additional disclosures-PHI may be disclosed;

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

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

HIPAA NOTICE OF PRIVACY PRACTICES & AGREEMENT
continued...

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

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

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

YOUR RIGHTS

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

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

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

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

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

PLEASE KEEP THIS FOR YOUR RECORDS

HIPAA NOTICE OF PRIVACY PRACTICES & AGREEMENT

PLEASE SIGN/DATE & RETURN TO ARIS SOLUTIONS

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

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

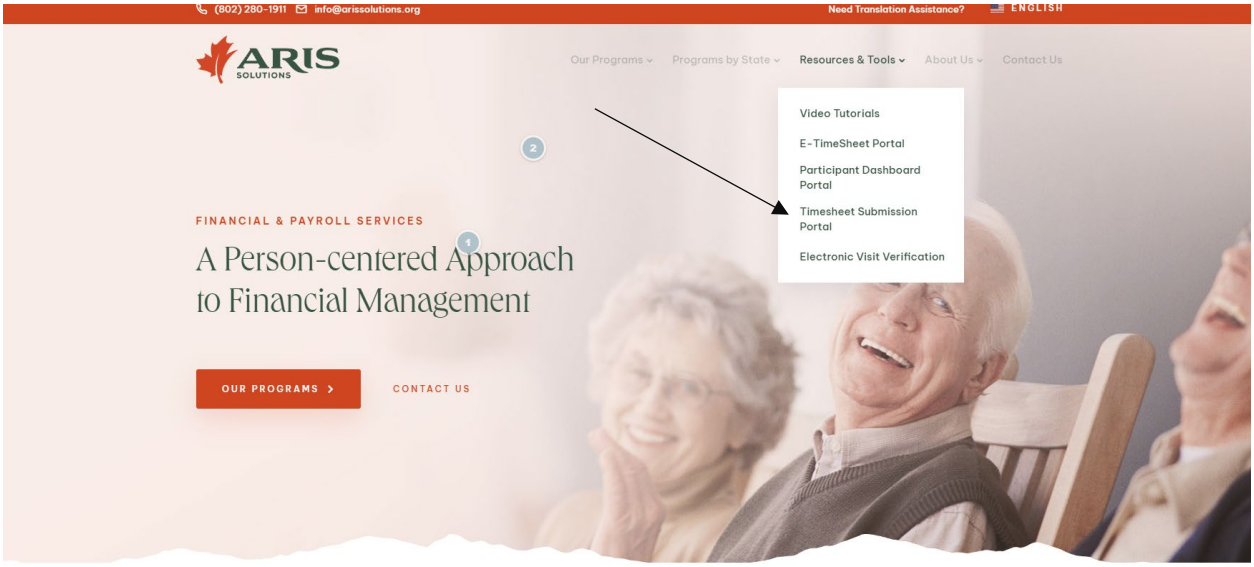
HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT AND CONSENT

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

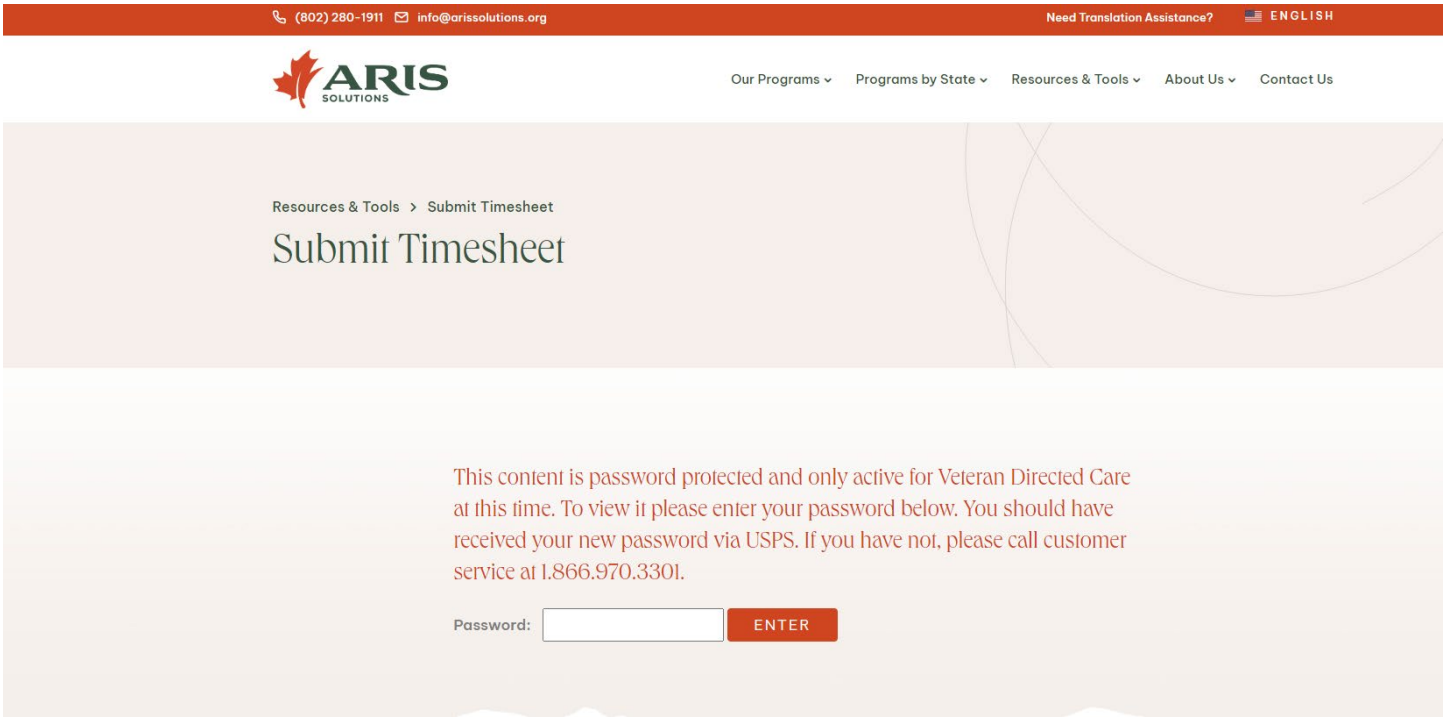
_____ _____

Signature of Employer *Date*

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



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



Your password will be:

ArisTime?4409

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

VDC_EMPLOYER

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

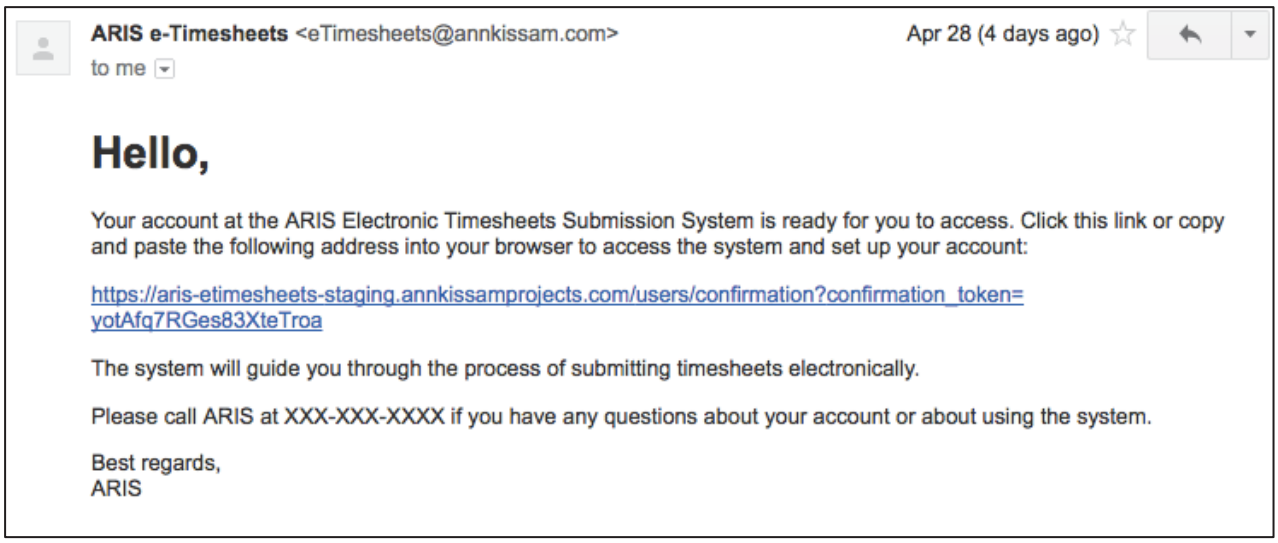
The Electronic Timesheets Module is a web-based interface through which Consumers, Employers, Representatives and Employees can respectively enter and view relevant timesheet information.

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:

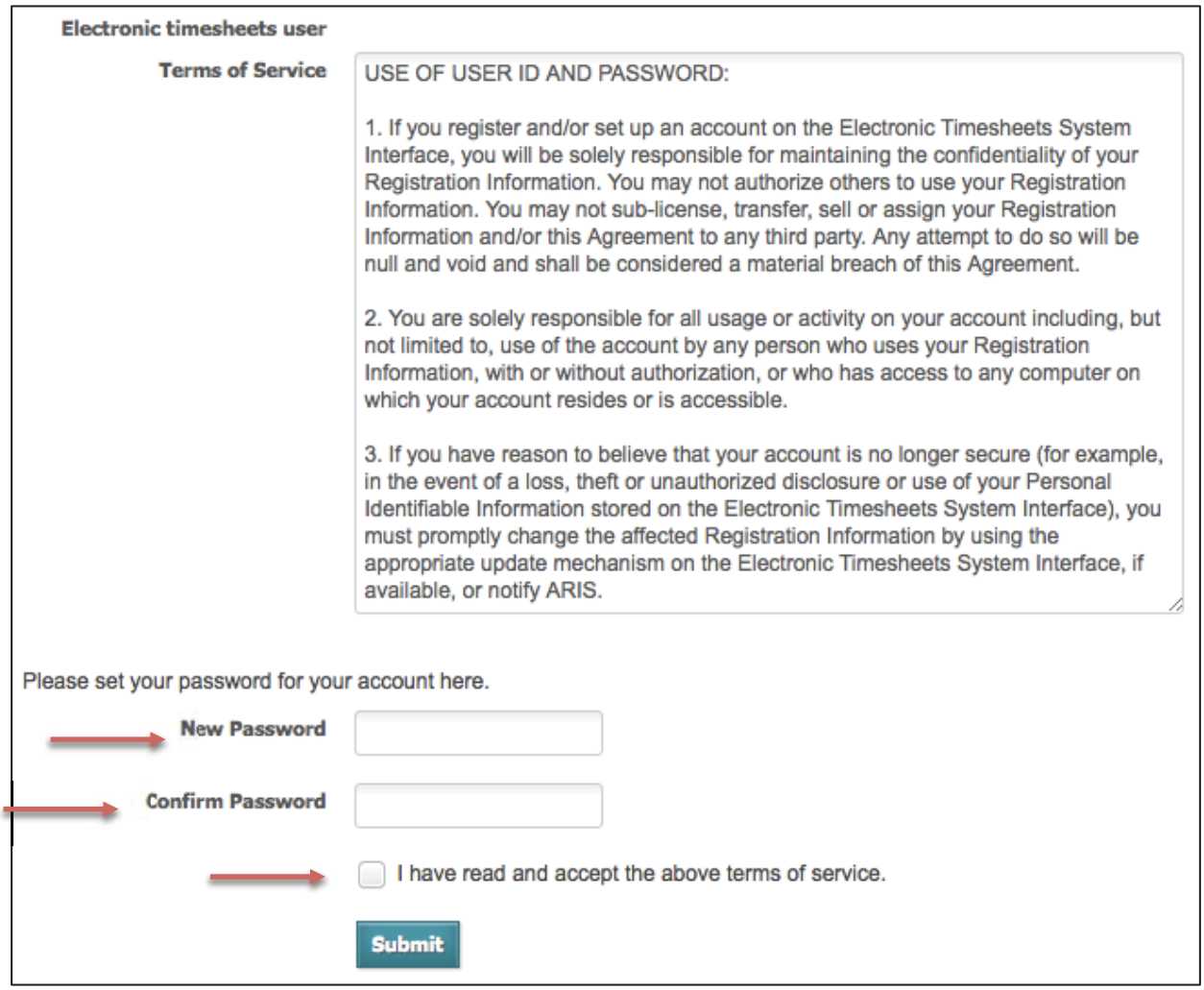
https://aris-etimesheets-staging.annkissamprojects.com/users/confirmation?confirmation_token=yotAfq7RGes83XteTroa

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.

Worker's Compensation Insurance

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

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

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
VDC-AK-CT-KS-MO-MT-NC-PA-VT

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

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

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

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

Veteran Directed Care Program Timesheet- North Carolina

VDC-EMPLOYER

***REQUIRED FIELDS**

Failure to provide the necessary information may result in delays in processing

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

***Veteran Name:** _____ **Employer Phone #**_____

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

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

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

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

***Start & End times need to be listed in quarter hour increments. Example: 12:00pm, 12:15pm, 12:45pm, etc.**

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

*Employee Signature _____ Date _____

*Employer Signature _____ Date _____

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

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

Phone: 1-866-970-3301 **Fax:** 1-802-295-9812 **Secure Portal:** https://arissolutions.org/submit-timesheet/

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