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

ARIS Solutions

Financial & Payroll Services for the Nonprofit Sector

Enrollment Forms for:

Illinois 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.

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

- ❑ Employer Confirmation of Receipt
- ❑ Fraud & Abuse Statement
- ❑ HIPAA Notice of Privacy Practices & Agreement
- ❑ Employer / Veteran Information Form
- ❑ Workers Compensation Application
- ❑ 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.
- ❑ 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
  - ❖ Department of Revenue:
    - IL Business Registration Application- Reg-1- Allows ARIS Solutions to apply for a Withholding Tax Account on behalf of the Veteran. ARIS Solutions will remit all applicable tax and filings.
    - IL-2848 Power of Attorney- Allows ARIS Solutions to correspond with IL Dept of Revenue on all tax related matters pertaining to this program ONLY.
  - ❖ Department of Labor:
    - Report to Determine Liability Under the UI Act Form REG-UI-1- Allows ARIS Solutions to apply for an Unemployment Tax Account on behalf of the Veteran to file and remit UI tax liability.
    - Power of Attorney for Representing Employer Form LE-10.- Allows ARIS Solutions to submit and speak to the State of Illinois regarding Department of Labor accounts.

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 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

The hiring process

ARIS Solutions will assist you, as needed, with all of the paperwork necessary to establish you as an employer and establish your worker as your employee.

Payroll services

ARIS Solutions will prepare and disburse payroll checks and year-end tax statements. In addition, ARIS will pay all employer taxes, withhold employee taxes, and submit tax withholding statements to the appropriate government agencies. If your employee ever needs employment verification ARIS will handle that as well, just forward the request via fax/email/ mail.

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 resources you need.

ARIS Solutions-Veteran Program staff is available for support Monday through Friday from 8:00 am to 4:00pm (EST) and can be reached at **866.970.3301** (toll free).

ARIS Solutions is not open on state or federal holidays.

Veteran Program Team

Topic	Resource	Contact Info
Veteran Program Director	Theresa Danforth	theresad@arissolutions.org
Veteran Program Specialist *Employer questions/concerns	Emilie Donka	emilied@arissolutions.org
Veteran Program Payroll Specialist (s)	Megan Whiton Janet Allen Nina Newcity	meganw@arissolutions.org janeta@arissolutions.org ninan@arissolutions.org

ARIS Solutions
Financial & Payroll Services for the Nonprofit Sector

ARIS Solutions

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 Association of Area Agency and the Veteran's Administration. Or call ARIS Solutions at 802.280.1911 and the proper people will be contacted.

ARIS Solutions

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

ARIS Solutions

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

ARIS Solutions

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.

ARIS Solutions

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

ARIS Solutions

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*

ARIS Solutions

ARIS Solutions

Employer/Veteran Information Form

NAME OF EMPLOYER

Name _____
(Last) (First) (Middle)

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

Phone (_____)_____ **Email** _____

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

FEIN (If previously issued)_____

Relationship to Veteran _____

Veteran IS EMPLOYER **YES** **NO**
If yes please skip next section.

NAME OF VETERAN

Name _____

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

Phone (_____)_____

Date of Birth _____

Social Security Number _____

VDC Illlnois Workers' Compensation Form

Employer Legal Name: Employer Date of Birth:
Veteran name (if different than Employer name):
Relationship to Veteran: ☐ Spouse ☐ Child ☐ Sibling ☐ Other (specify):
Employer FEIN # :
Employer Phone:
Street Address (where service is provided):
City, State, ZIP(where service is provided):
Estimated Number of Employees: Full Time: _____ Part Time: _____
Estimated Annual Payroll:
Effective Date of Coverage (start date): Employer Signature and Date:

INDIVIDUALS INCLUDED/EXCLUDED

PARTNERS, OFFICERS, RELATIVES TO BE INCLUDED OR EXCLUDED. (Remuneration to be included must be part of rating information section.)

#	NAME	DATE OF BIRTH	TITLE/ RELATIONSHIP	OWNER-SHIP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION
			Owner	100%		Excl	8835	0

PRIOR CARRIER INFORMATION/LOSS HISTORY

PROVIDE INFORMATION FOR THE PAST 5 YEARS AND USE THE REMARKS SECTION FOR LOSS DETAILS ☐ LOSS RUN ATTACHED

YEAR	CARRIER & POLICY NUMBER	ANNUAL PREMIUM	MOD	# CLAIMS	AMOUNT PAID	RESERVE
	CO:					
	POL #:					
	CO:					
	POL #:					
	CO:					
	POL #:					
	CO:					
	POL #:					
	CO:					
	POL #:					

NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS

GIVE COMMENTS AND DESCRIPTIONS OF BUSINESS, OPERATIONS AND PRODUCTS: MANUFACTURING-- RAW MATERIALS, PROCESSES, PRODUCT, EQUIPMENT. CONTRACTOR-- TYPE OF WORK, SUB-CONTRACTS. MERCANTILE--MERCHANDISE, CUSTOMERS, DELIVERIES. SERVICE--TYPE, LOCATION. FARM--ACREAGE, ANIMALS, MACHINERY, SUB-CONTRACTS.

Illinois Veterans Program

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	YES	NO
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT/WATERCRAFT?		✔
2. DO/HAVE PAST, PRESENT OR DISCONTINUED OPERATIONS INVOLVE(D) STORING, TREATING, DISCHARGING, APPLYING, DISPOSING, OR TRANSPORTING OF HAZARDOUS MATERIAL? (e.g. landfills, wastes, fuel tanks, etc)		✔
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?		✔
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?		✔
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?		✔
6. ARE SUB-CONTRACTORS USED? (IF YES, GIVE % OF WORK SUBCONTRACTED)		✔
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INS.?		✔
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?		✔
9. ANY GROUP TRANSPORTATION PROVIDED?		✔
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?		✔
11. ANY SEASONAL EMPLOYEES?		✔
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?		✔
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?		✔
14. DO EMPLOYEES TRAVEL OUT OF STATE?		✔
15. ARE ATHLETIC TEAMS SPONSORED?		✔

EXPLAIN ALL "YES" RESPONSES	YES	NO
16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?		✔
17. ANY OTHER INSURANCE WITH THIS INSURER?		✔
18. ANY PRIOR COVERAGE DECLINED/ CANCELLED/NON-RENEWED (Last 3 years)? NOT APPLICABLE IN MO		✔
19. ARE EMPLOYEE HEALTH PLANS PROVIDED?		✔
20. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS/SUBSIDIARY?		✔
21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?		✔
22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?		✔
23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST 5 YEARS?		✔
24. ANY UNDISPUTED AND UNPAID WORKERS COMPENSATION PREMIUM DUE FROM YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? IF YES, EXPLAIN INCLUDING ENTITIY NAME(S) AND POLICY NUMBERS(S).		✔

CONTACT INFORMATION

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

APPLICABLE IN TENNESSEE: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO ANY PARTY TO A WORKERS COMPENSATION TRANSACTION FOR THE PURPOSE OF COMMITTING FRAUD. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, HI, NE, OH, OK, OR, TN or VT; in DC, LA, ME and VA, insurance benefits may also be denied)

REMARKS

Does insured have any locations outside of this state?	No	Are cancer treatments provided?	No
Is travel radius greater than 200 miles?	No	Do they give immunizations or shots?	No
Are operations 24 hours?	No	Do they take safety precautions with pregnant employees?	No
		Do they have procedures for reporting unsafe conditions?	No
		Are all clients/patients ambulatory (ie: able to walk on their own)?	No

APPLICANT'S SIGNATURE	DATE	PRODUCER'S SIGNATURE	NATIONAL PRODUCER NUMBER

SEILAA

Form **SS-4**
(Rev. January 2010)
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.**

OMB No. 1545-0003

EIN

Type or print clearly.

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

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)
ARIS SOLUTIONS, PO BOX 4409

5a Street address (if different) (Do not enter a P.O. box.)

4b City, state, and ZIP code (if foreign, see instructions)
WHITE RIVER JUNCTION, 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) ▶ HHCSR
- ☐ Estate (SSN of decedent)
- ☐ Plan administrator (TIN)
- ☐ Trust (TIN of grantor)
- ☐ National Guard
- ☐ State/local government
- ☐ Farmers' cooperative
- ☐ Federal government/military
- ☐ REMIC
- ☐ Indian tribal governments/enterprises

Group Exemption Number (GEN) if any ▶

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

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

- ☑ Started new business (specify type) ▶ PERSONAL CARE/HOME CARE
- ☐ Hired employees (Check the box and see line 13.)
- ☐ Compliance with IRS withholding regulations
- ☐ Other (specify) ▶
- ☐ Banking purpose (specify purpose) ▶
- ☐ Changed type of organization (specify new type) ▶
- ☐ Purchased going business
- ☐ Created a trust (specify type) ▶
- ☐ Created a pension plan (specify type) ▶

11 Date business started or acquired (month, day, year). See instructions.

12 Closing month of accounting year JUNE

13 Highest number of employees expected in the next 12 months (enter -0- if none). If no employees expected, skip line 14.

Agricultural	Household	Other

14 If you expect your employment tax liability to be $1,000 or less in a full calendar year **and** want to file Form 944 annually instead of Forms 941 quarterly, check here. (Your employment tax liability generally will be $1,000 or less if you expect to pay $4,000 or less in total wages.) If you do not check this box, you must file Form 941 for every quarter. ☐

15 First date wages or annuities were paid (month, day, year). **Note.** If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year) ▶

16 Check **one** box that best describes the principal activity of your business.

☐ Construction ☐ Rental & leasing ☐ Transportation & warehousing ☐ Health care & social assistance ☐ Accommodation & food service ☐ Wholesale-agent/broker ☐ Wholesale-other ☐ Retail ☐ Real estate ☐ Manufacturing ☐ Finance & insurance ☑ Other (specify) ▶ Home & Community based personal care

17 Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided.
HOME AND COMMUNITY BASED PERSONAL CARE TO VETERAN PARTICIPANT.

18 Has the applicant entity shown on line 1 ever applied for and received an EIN? ☐ Yes ☐ No
If "Yes," write previous EIN here ▶

Third Party Designee

Complete this section **only** if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.

Designee's name: ARIS SOLUTIONS FISCAL AGENT
Designee's telephone number (include area code): 802-280-1911
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 ▶

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 16055N Form **SS-4** (Rev. 1-2010)

SEILAA

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

(Rev. August 2014) Department of the Treasury — Internal Revenue Service

OMB No. 1545-0748

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

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

  Note. This appointment is not effective until we approve your request. See the instructions for filing Form 2678 on page 3.

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

For IRS use:

Part 1: Why you are filing this form...

(Check one)

☑ You want to **appoint** an agent for tax reporting, depositing, and paying.

☐ You want to **revoke** an existing appointment.

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

1 **Employer identification number (EIN)** ☐☐ – ☐☐☐☐☐☐☐

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

3 **Trade name** (if any)

4 **Address**

Number Street Suite or room number

City State ZIP code

Foreign country name Foreign province/county Foreign postal code

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

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

*Generally you cannot appoint an agent to report, deposit, and pay tax reported on Form 940, Employer's Annual Federal Unemployment (FUTA) Tax Return, unless you are a home care service recipient.

☑ Check here if you are a home care service recipient, and you want to appoint the agent to report, deposit, and pay FUTA tax for you. See the instructions.

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

X **Sign your name here**

Print your name here

Print your title here HHCSR

Date / /

Best daytime phone

Now give this form to the agent to complete.

SEILAA

Form **8821**

(Rev. March 2015)

Department of the Treasury
Internal Revenue Service

Tax Information Authorization

▶ **Information about Form 8821 and its instructions is at *www.irs.gov/form8821*.**

▶ **Do not sign this form unless all applicable lines have been completed.**

▶ **Do not use Form 8821 to request copies of your tax returns or to authorize someone to represent you.**

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 7.

Taxpayer name and address	Taxpayer identification number(s)
	Daytime telephone number / Plan number (if applicable)

2 Appointee. If you wish to name more than one appointee, attach a list to this form. **Check here if a list of additional appointees is attached ▶** ☐

Name and address	
ARIS SOLUTIONS FISCAL AGENT PO BOX 4409 WHITE RIVER JUNCTION, VT 05001	CAF No. PTIN Telephone No. 866-970-3301 Fax No. 802-295-9812 Check if new: Address ☐ Telephone No. ☐ Fax No. ☐

3 Tax Information. Appointee 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.

(a) Type of Tax Information (Income, Employment, Payroll, Excise, Estate, Gift, Civil Penalty, Sec. 4980H Payments, etc.)	(b) Tax Form Number (1040, 941, 720, etc.)	(c) Year(s) or Period(s)	(d) Specific Tax Matters
EMPLOYMENT	941,940,941R, 941X, W2, W3	2018-2021	TAX LIABILITY
	W2C		

4 Specific use not recorded on 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 lines 5 and 6 . . . . . ▶ ☐

5 Disclosure of tax information (you **must** check a box on line 5a or 5b unless the box on line 4 is checked):

a If you want copies of tax information, notices, and other written communications sent to the appointee on an ongoing basis, check this box . . . . . ▶ ☑

Note. Appointees will no longer receive forms, publications, and other related materials with the notices.

b If you do not want any copies of notices or communications sent to your appointee, check this box . . . . . ▶ ☐

6 Retention/revocation of prior tax information authorizations. If the line 4 box is checked, skip this line. If the line 4 box is not checked, the IRS will automatically revoke all prior Tax Information Authorizations on file unless you check the line 6 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 6 instructions.

7 Signature of taxpayer. If signed by a corporate officer, partner, guardian, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute this form with respect to the tax matters and tax periods shown on line 3 above.

▶ **IF NOT COMPLETE, SIGNED, AND DATED, THIS TAX INFORMATION AUTHORIZATION WILL BE RETURNED.**

▶ **DO NOT SIGN THIS FORM IF IT IS BLANK OR INCOMPLETE.**

Signature | Date

Print Name | Title (if applicable) HHCSR

For Privacy Act and Paperwork Reduction Act Notice, see instructions. Cat. No. 11596P Form **8821** (Rev. 3-2015)

Use your 'Mouse' or the 'Tab key' to move through the fields and 'Mouse' or 'Space bar' to enable the checkboxes.

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Illinois Department of Revenue

REG-1 Illinois Business Registration Application

Register faster using **MyTax Illinois**, our online account management program, available at **mytax.illinois.gov**. If you have questions, visit our website at **tax.illinois.gov** or call us weekdays between 8:00 a.m. and 4:30 p.m. at **217 785-3707**.

Step 1: Identify your business or organization

1 Federal employer identification number (FEIN)

FEIN: _____ - _____

Proprietorships must provide the Social Security number (SSN) under which taxes will be filed.

SSN: _____ - _____ - _____

2 Legal business name:

_____

3 Doing-business-as (DBA), assumed, or trade name, if different from Line 2:

_____

4 Primary or legal business address:

_____
Street address - **No** PO Box number | Apartment or suite number

_____
City | State | ZIP

If you have other locations in Illinois from where you do business, complete and attach Schedule REG-1-L.

5 Mailing address if different from the address above:

C/O ARIS Solutions
In-care-of name

PO Box 4409
Street address or PO Box number | Apartment or suite number

White River Jct., | VT | 05001
City | State | ZIP

6 Check the organization type that applies to you:

☒ Proprietorship
☐ Check if owned by a married couple or civil union
☐ Partnership ☐ Trust or estate
☐ Corporation* ☐ S Corp (Subchapter S Corporation)*
*Is your corporation publicly traded? ☐ Yes ☐ No
If yes, provide the ticker symbol _____
☐ Governmental unit ☐ Not-for-profit organization
☐ LLC - Corporation ☐ LLC - Partnership
☐ LLC - Single member ☐ Check if disregarded

*If you are applying to be a Scholarship Granting Organization under the Invest in Kids Act of 2017, you must apply online using MyTax Illinois, available at **mytax.illinois.gov**.*

7 Illinois Secretary of State identification number:

___ - ___ ___ ___ ___ - ___ ___ ___ - ___

8 Is your business part of a unitary group? ☐ Yes ☒ No
If "Yes", provide the FEIN of your designated agent (the entity responsible for filing your Illinois income tax return):

FEIN: _____ - _____

9 Identify a contact person regarding your business.

Name: Emilie Donka Title: Tax Specialist

Phone: (866) 970-3301 Ext.: _____

FAX: (802) 295-9812

Email address: emilied@arissolutions.org

Step 2: Identify your owners and officers - If you need to identify more, **attach Schedule REG-1-O**.

10 Identification depends on the organization type you selected in Step 1, Line 6 (proprietorship - owner(s); partnership - general partners; non-publicly traded corporation - president, secretary, and treasurer; publicly traded corporation - chief operating officer and chief financial officer; trust or estate - trustee(s) or executor(s); governmental unit - one contact person; not-for-profit organization - president, secretary, or treasurer; limited liability company - managers and members). For each individual or business required, complete the following information.

Individuals: *(include Social Security number (SSN))*

a
_____ Name | _____ Title
_____ Home address - **No** PO Box number | City | State | ZIP
_____ / _____ / _____ Date of birth | (_____) _____ - _____ Phone
_____ - _____ - _____ Social Security number | Ownership percentage: _____

b
_____ Name | _____ Title
_____ Home address - **No** PO Box number | City | State | ZIP
_____ / _____ / _____ Date of birth | (_____) _____ - _____ Phone
_____ - _____ - _____ Social Security number | Ownership percentage: _____

c
_____ Name | _____ Title
_____ Home address - **No** PO Box number | City | State | ZIP
_____ / _____ / _____ Date of birth | (_____) _____ - _____ Phone
_____ - _____ - _____ Social Security number | Ownership percentage: _____

d
_____ Name | _____ Title
_____ Home address - **No** PO Box number | City | State | ZIP
_____ / _____ / _____ Date of birth | (_____) _____ - _____ Phone
_____ - _____ - _____ Social Security number | Ownership percentage: _____

Businesses: *(include federal employer identification number (FEIN))*

a
ARIS Solutions Fiscal Agent Name | 83-2065663 FEIN
72 South Main St Legal address
White River Jct. | VT | 05001 City | State | ZIP
(866) 970-3301 Phone | Ownership percentage: _____

b
_____ Name | ____-_____ FEIN
_____ Legal address
_____ City | State | ZIP
(_____) _____ - _____ Phone | Ownership percentage: _____

Step 3: Tell us about your business activities

11 Describe your business activities: Household employment for Veteran participants.

Provide your North American Industry Classification System (NAICS) number: _____

Refer to the website **www.naics.com**

12 Will you have Illinois employees? [X] Yes [ ] No

If yes, complete and attach **Schedule REG-UI-1**.

When was (is) the date of your first payroll in Illinois? ____/____/_____

13 Check all that apply to your type of business.

Sales

You must complete and attach Schedule REG-1-L to identify all **Illinois** *locations from which you make retail sales.*

- ☐ General merchandise: ____ Retail ____ Wholesale
  Note: You must check "Retail" above if you make retail sales that are filled from inventory that is maintained in Illinois prior to its delivery to your Illinois purchaser.
- ☐ Sales to Illinois customers from out of state
  - ____ Check here if you have an Illinois presence, including, but not limited to having an office or other facility in Illinois or having employees or other representatives operating in Illinois.
  - ____ Check here if you make $100,000 or more in annual sales to Illinois customers.
  - ____ Check here if you make 200 or more separate transactions annually to Illinois customers.

  Do you estimate your monthly sales and use tax liability will be over $200? ____ Yes ____ No
- ☐ Soft drinks (other than fountain soft drinks) in Chicago
- ☐ Vehicle, watercraft, aircraft, or trailers
- ☐ Sales or delivery of tires. Do you **always** pay the Tire User Fee to your supplier? ____ Yes ____ No
- ☐ Sales from vending machines. How many vending machines? ____
- ☐ Liquor at retail (bar, tavern, liquor store, *etc.*)
- ☐ Motor fuel/fuel: ____ Retail ____ Wholesale
  ____ Check here if you are required to **collect** prepaid sales tax.
- ☐ Medical cannabis - **Attach Schedule REG-1-MC**.
  ____ Cultivation Center ____ Dispensing Organization
- ☐ Aviation fuel: ____ Retail ____ Wholesale
  (if wholesale, attach Schedule REG-8-A)

When will (did) these activities begin? ____/____/_____

Services

Do you transfer items, on which tax must be collected, as part of your service? [ ] Yes [X] No

When will (did) this activity begin? ____/____/_____

Use

Does your supplier collect Illinois Sales Tax for merchandise your business uses or consumes in Illinois?

[ ] Yes [X] No

Does your supplier collect Illinois Sales Tax on sales of aviation fuel your business uses or consumes in Illinois?

[ ] Yes [X] No

When will (did) these activities begin? ____/____/_____

Cigarettes and other tobacco products

- ☐ Cigarettes - See **Schedule REG-1-C** before you check here.
- ☐ Tobacco products - See **Schedule REG-1-C** before you check here.
- ☐ Cigarette machine operator - See **Schedule REG-1-C** before you check here.

When will (did) these activities begin? ____/____/_____

Renting or leasing

- ☐ Hotel rooms for less than 30 days **- Attach Schedule REG-1-L**.
  Do you charge for telecommunication services?
  ____ Yes ____ No
- ☐ Vehicles for one year or less **- Attach Schedule REG-1-L**.
- ☐ Vehicles for more than one year

When will (did) these activities begin? ____/____/_____

Utility providers

- ☐ Electricity: ____ Retail ____ Wholesale
- ☐ Natural gas: ____ Retail ____ Wholesale
- ☐ Telecommunications - See **Schedule REG-1-T**.
  ____ Retail ____ Wholesale
- ☐ Water or sewer services
  Are you a utility cooperative? ____ Yes ____ No
  Are you a municipality? ____ Yes ____ No

When will (did) these activities begin? ____/____/_____

All other tax types

- ☐ Liquor warehousing **- Attach Schedule REG-1-A**.
- ☐ Dry cleaning: ____ Facility ____ Solvent supplier
- ☐ Own/operate coin-operated amusement devices
- ☐ You wish to purchase electricity for non-residential use and pay the tax to IDOR **- Attach Schedule REG-1-D**.
- ☐ You wish to purchase natural gas from outside of Illinois for your own use and pay the tax to IDOR **- Attach Schedule REG-1-G**.
- ☒ Not listed. Identify: Withholding Tax

When will (did) these activities begin? ____/____/_____

Step 4: Sign below

Under penalties of perjury, I state that I have examined this information and, to the best of my knowledge, it is true, correct, and complete. I further attest that I will be responsible for filing returns and paying all taxes due **unless** Schedule REG-1-R, Responsible Party Information, is attached to this application or forwarded to the department. Check here if you are attaching or forwarding Schedule REG-1-R: ☐

Signature: _____ Title: Domestic Employer/HHCSR Date: ___/___/_____

Printed name: _____ SSN: _____ - _____ - _____

Address: _____ Phone: (_____) _____ - _____

Mail your completed form, with any required attachments and payment to:

CENTRAL REGISTRATION DIVISION
ILLINOIS DEPARTMENT OF REVENUE
PO BOX 19030
SPRINGFIELD IL 62794-9030

Reset Print

Illinois Department of Revenue

IL-2848 Power of Attorney

Read this information first

Submit your completed form to **REV.POA@illinois.gov**. Do ***not*** attach to your tax return. You also may be required to provide a copy of this form to a representative of the Illinois Department of Revenue. This power of attorney automatically expires 10 years from the date it is signed. If you do not properly complete this form, you will be required to submit a new Form IL-2848. See the instructions for additional information.
Note: A separate form may need to be completed for each taxpayer. An asterisk (*) below indicates a required field.

Step 1: Complete the following taxpayer information

Name of individual or business*

Identification number (*i.e.*, FEIN or SSN)* - ***All nine digits required.***

Street address*

Illinois Account ID (if known)

City* State* ZIP*

( ) Daytime phone number*

Step 2: Identify the authorized agent or fiduciary executing this form - *Signature required in Step 6*

Complete the following if the taxpayer is a corporation, partnership, trust, or estate (*i.e.*, not an individual taxpayer) or if someone other than the taxpayer is authorizing the power of attorney and the taxpayer is an individual. If you are not the taxpayer and you already have been designated by the courts as power of attorney, do *not* complete this form. Instead complete Form IL-56, Notice of Fiduciary Relationship. See instructions for who can execute this form.

ARIS Solutions Fiscal Agent
Name*

Financial Management Services
Title*

PO Box 4409
Street address*

(866) 970-3301
Daytime phone number*

White River Jct. VT 05001
City* State* ZIP*

emilied@arissolutions.org
Email address

Step 3: Identify the representative(s) - *If more than two representatives, list the total number here: _____*

Attach a copy of page one for every two additional representatives. (See instructions.) **Note:** If any representative listed is a person who is *not* an attorney, a certified public accountant, or an enrolled agent, you must complete the notary section of Step 6.

The taxpayer named above appoints the following representative as attorney-in-fact:

Theresa Danforth
Name of individual*

Check one: (if applicable) ☐ Attorney ☐ CPA ☐ Enrolled agent

ARIS Solutions
Name of firm, if applicable

83-2065663
Identification number (Attorney License No., PTIN, FEIN, or SSN)* - *See instr.*

72 South Main St
Street address*

White River Jct VT 05001
City* State* ZIP*

(866) 970-3301
Daytime phone number*

(802) 295-9812
Fax number

theresad@arissolutions.org
Email address

☒ Check this box if you want to authorize the Department to send duplicate copies of notices to the representative listed above.

Emilie Donka
Name of individual*

Check one: (if applicable) ☐ Attorney ☐ CPA ☐ Enrolled agent

ARIS Solutions
Name of firm, if applicable

83-2065663
Identification number (Attorney License No., PTIN, FEIN, or SSN)* - *See instr.*

72 South Main St
Street address*

White River Jct VT 05001
City* State* ZIP*

(866) 970-3301
Daytime phone number*

(802) 295-9812
Fax number

emilied@arissolutions.org
Email address

☒ Check this box if you want to authorize the Department to send duplicate copies of notices to the representative listed above.

Complete the following if a box above is checked to indicate that the representative is an attorney, CPA, or enrolled agent

I declare that I am **not** currently under suspension or disbarment and that I am

- a member in good standing of the bar of the highest court of the jurisdiction indicated below; or
- duly qualified to practice as a certified public accountant in the jurisdiction indicated below; or
- enrolled as an agent pursuant to the requirements of United States Treasury Department Circular Number 230.

Signature of representative Date

Print name Jurisdiction (state(s), etc.)

Signature of representative Date

Print name Jurisdiction (state(s), etc.)

Step 4: Revocation of power of attorney appointments

This power of attorney revokes all powers of attorney on file with the Illinois Department of Revenue with respect to the same matters and years or periods covered. If you do *not* want to revoke prior powers of attorney, check this box: ☐

Step 5: Identify the tax matters and the type of appointment — *Designate the Tax Matters to which the power of attorney applies and the Type of Appointment.*

Tax Matters

Tax Type/Tax Form(s) or Notices*	Tax Year(s) or Filing Period(s)*
Employment Tax	2019-2021

Type of Appointment — *Check either* **General** *or* **Specific Appointment**. *Do not check both boxes. See instructions.*

☒ **General Appointment**

The attorneys-in-fact named above shall have, subject to revocation, full power of attorney to perform any act that the principals can and may perform, including the authority to receive and discuss confidential information for the tax matters listed above.

☐ **Specific Appointment**

The attorneys-in-fact named above shall have, subject to revocation, power of attorney to receive and discuss with the Illinois Department of Revenue confidential information for the tax matters listed above and to perform only those additional acts that the principals can and may perform designated below. *(Check the following, as applicable.)*

- ☐ **Yes** Endorse or collect checks in payment of refunds.
- ☐ **Yes** Receive checks in payment of any refund of Illinois taxes, penalties, or interest.
- ☐ **Yes** Execute waivers (including offers of waivers) of restrictions on assessment or collection of deficiencies in tax and waivers of notice of disallowance of a claim for credit or refund.
- ☐ **Yes** Execute consents extending the statutory period for assessments or collection of taxes.
- ☐ **Yes** Delegate authority or substitute another representative.
- ☐ **Yes** Execute offers in compromise or settlement of tax liability.
- ☐ **Yes** Represent the taxpayer before the Illinois Department of Revenue in administrative hearings or the Illinois Independent Tax Tribunal (requiring representation by an attorney).
- ☐ **Yes** Represent the taxpayer before the Illinois Department of Revenue in proceedings other than administrative hearings, such as proceedings before the Informal Conference Board or the Board of Appeals.
- ☐ **Yes** Obtain a private letter ruling on behalf of the taxpayer.
- ☐ **Yes** Other (Please describe.) _____

Step 6: Signature (Required) - *This form must be signed by the taxpayer listed in Step 1 or the individual listed in Step 2.*

If signing as a corporate officer, partner, fiduciary, or individual on behalf of the taxpayer, I certify that I have the authority to execute this power of attorney on behalf of the taxpayer.

Taxpayer's Signature*	Print name*	Title, if applicable	Date*
Spouse's signature (required if spouse is listed in Step 1)	Print name		Date

Complete the following if any representative listed in Step 3 is a person other than an attorney, a certified public accountant, or an enrolled agent.

If the power of attorney is granted to a person other than an attorney, a certified public accountant, or an enrolled agent, this document must be witnessed or notarized below. Please check and complete *one* of the following:

Any person signing as or for the taxpayer

☐ is known to and this document is signed in the presence of the two disinterested witnesses whose signatures appear here, ***OR***

Signature of witness	Date
Signature of witness	Date

☐ appeared this day before a notary public and acknowledged this power of attorney as his or her voluntary act and deed.

Notary seal

Signature of notary	Date

RESET PRINT

Illinois Department of Employment Security and the Illinois Department of Revenue

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REG-UI-1 Report to Determine Liability Under the Unemployment Insurance Act

Read this information first

Register faster using **MyTax Illinois**, our online account management program, at **mytax.illinois.gov**. If you have questions contact us weekdays between 8:30 a.m. and 5:00 p.m. at **(800) 247-4984.**

Important: Every newly created employing unit shall file this report within 30 days of the date upon which it commences business *(820 ILCS 405/1800; 56 Ill. Adm. Code 2760.105).* If you are registering a new business, complete and attach this form to your **REG-1, Illinois Business Registration Application**, available on the Illinois Department of Revenue website at **tax.illinois.gov**.

Step 1: Business Information

1 **Business Name:** _____ 2 **Doing Business As:** _____

3 **Primary Business Address:** _____
(If address is a non-Illinois headquarters you are required to also answer question 4)

4 **Secondary Address:** _____
(Physical location of your Illinois business or a secondary address where you conduct business in Illinois. If there is no additional address leave blank. If you want IDES correspondence sent to any other address than question 3 and 4, complete and attach IDES Form UI-1M Special Mailing Form and LE-10, Power of Attorney, if applicable)

5 **Phone Number:** _____ 6 **E-mail Address:** _____

7 **FEIN:** _____-_____ 8 **IDES previously assigned employer account no.:** _____
(If applicable)

9 **Type of organization (check one):** ☐ Association ☐ Cooperative ☐ C-Corporation ☐ Government ☐ Municipal Government ☐ Political Subdivision ☐ Instrumentality ☐ LLC-Corporation ☐ LLC-Partnership ☐ LLC-Single Member ☐ Partnership ☐ Receiver ☐ S-Corporation ☐ Sole Proprietor ☐ Trustee in Bankruptcy ☐ Trust/Estate ☒ Other: Domestic/household employment
(Describe)

10 **Is this a qualified settlement fund?** ☐ **Yes** ☐ **No**

Step 2: Entity Information

11 What is your primary business activity in Illinois?
Domestic employment for Veteran participants.

What is your principal product or service?
household care.

If you have more than one product or service, list the top two and indicate the percentages that each contributes to your total revenue:

_____ % of Sales or receipts _____

_____ % of Sales or receipts _____

Enter your NAICS Code here _____
(If you do not know your NAICS Code refer to the Bureau of Labor Statistics website for the proper code)

12 If you are a **Corporation**:

Date of Incorporation _____ State in which incorporated_____

Has any form of remuneration, including dividends, been paid to the officers of this corporation? ☐ Yes ☐ No

13 If you are a **Limited Liability Company (LLC)**:
Are there any individuals performing services for the organization other than the member manager(s)? ☐ Yes ☐ No

How is the member manager(s) treated for federal tax purposes?

☐ Sole Proprietor ☐ Partner ☐ Other (Explain) _____

If you are an **LLC-Corporation** indicate:

Date of Organization _____ State in which Organized _____

14 If you are a **Partnership**:
Are there any individuals performing services other than the partners?
☐ Yes ☐ No

15 If you are a **Sole Proprietor**:
Are there any individuals performing services, other than the sole proprietor, the sole proprietor's parent, spouse or child under the age of 18?
☐ Yes ☐ No

16 **Date you first began employing workers in Illinois:** _____

17 **Date of your first payroll in Illinois:** _____

18 Did you acquire your Illinois business or any portion of it by purchase, reorganization or a change in entity; for example, a change from sole proprietor to corporation? ☐ Yes ☒ No

*If yes, you **must** complete and attach form **UI-1 S&P, Report to Determine Succession**. Also complete the remainder of the questions on this form. Responses to the questions on this form should reflect information relative to the operation of your business **after** the date of acquisition.*

Step 3: Liability Information

19 Have you incurred liability under the Federal Unemployment Tax Act (in any state) for any of the last 4 years? ☐ Yes ☐ No

If yes, indicate the year(s) for which you incurred such liability:

_____

Step 4: Additional Liability Information

If you are not engaged in Domestic, Agricultural, Religious, Charitable, Educational, Nonprofit or Governmental services, skip to question 24.

20 **Domestic Service Entities**
In regard to domestic service workers, in a private home, local college club, or local chapter of a college fraternity or sorority, if applicable check any of the following:

a ☒ If during the current calendar year, the past four calendar years, or the future four calendar quarters, there have been or there will be any quarter in which you paid wages of $1,000 or more for domestic service.

Check the first such quarter during that period and indicate the year in which it did or will occur:

☐ Jan-Mar (Q1) _____ ☐ Apr-Jun (Q2) _____

☐ Jul-Sept (Q3) _____ ☐ Oct-Dec (Q4) _____

b ☐ If you solely employ household workers and are eligible to use Schedule H (IRS Form 1040) for filing federal unemployment taxes for the workers (whether or not you use it), then you may elect to pay contributions for each quarter and submit wage reports for each month or quarter, as the case may be, on an annual basis. Check this box (20b) if you are eligible and would like to elect to file annually.

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21 Agricultural Entities

In regard to agricultural labor, if applicable check any of the following:

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a ☐ You employ, have employed, or will employ one of more workers to perform agricultural labor.

b ☐ During the current calendar year, the past four calendar years, or the future four calendar quarters, there has been or there will be any quarter in which you paid wages of $20,000 or more for agricultural labor.

If so, check the first such quarter during that period and indicate the year in which it did or will occur:

☐ Jan-Mar (Q1) _____ ☐ Apr-Jun (Q2) _____

☐ Jul-Sept (Q3) _____ ☐ Oct-Dec (Q4) _____

c ☐ During the current calendar year, the past four calendar years, or the future four calendar quarters, there has been or there will be any calendar year during which you employed 10 or more individuals to perform agricultural labor for at least 20 weeks (whether consecutive or not).

If so, check the first such quarter during that period and indicate the year in which it did or will occur:

☐ Jan-Mar (Q1) _____ ☐ Apr-Jun (Q2) _____

☐ Jul-Sept (Q3) _____ ☐ Oct-Dec (Q4) _____

d ☐ If you checked 21a, 21b or 21c and your business includes any retail sales activity, check this box (21d).

22 Religious, Charitable, Educational or Other Nonprofit Entities

a ☐ Check if your organization is a religious, charitable, educational or other nonprofit organization as defined in **Section 501(c)(3)** of the Internal Revenue Code. If so, attach your federal IRS 501(c)(3) exemption letter to this application.

b ☐ During the current calendar year, the past four calendar years, or the future four calendar quarters, there have been or there will be any quarter in which you have had four or more workers to perform work for at least 20 weeks (whether or not consecutive).

If so, check the quarter that included the 20th week within which you have employed 4 or more individuals to perform religious, charitable education and/or nonprofit labor and indicate the year in which it did or will occur:

☐ Apr-Jun (Q2) _____ ☐ Jul-Sept (Q3) _____

☐ Oct-Dec (Q4) _____

c ☐ Check if you wish to be a reimbursable employer. Complete and attach form **UI-5NP, Reimburse Benefits in Lieu of Paying Contributions**.

23 Governmental Entities or Indian Tribes

a ☐ Check if you wish to be a reimbursable employer. Complete and attach form **UI-5LG, Reimburse Benefits in Lieu of Paying Contributions**.

b ☐ Check if your organization is an Indian Tribe (including a subdivision, subsidiary or business enterprise wholly owned by an Indian Tribe).

24 If you did not answer 20, 21, 22, 23, check any of the following boxes that apply and provide the requested information.

a ☐ Have there or will there be, any calendar quarter in either the current calendar year, the past four calendar years, or the future four calendar quarters, in which you paid wages of at least $1,500 for services in employment.

If so, check the first such quarter during that period and indicate the year in which it did or will occur:

☐ Jan-Mar (Q1) _____ ☐ Apr-Jun (Q2) _____

☐ Jul-Sept (Q3) _____ ☐ Oct-Dec (Q4) _____

b ☐ Have there or will there be, any calendar quarter in either the current calendar year, the past four calendar years, or the future four calendar quarters, in which you have had one or more individuals performing services in employment in each of at least 20 weeks (whether consecutive or not).

If so, check the first such quarter during that period and indicate the year in which it did or will occur:

☐ Apr-Jun (Q2) _____ ☐ Jul-Sept (Q3) _____

☐ Oct-Dec (Q4) _____

Step 5: Additional Business Information

25 Voluntary Coverage

If you are determined to be not liable for the payment of unemployment insurance taxes based upon the provisions of the Illinois Unemployment Insurance Act you may voluntarily elect coverage under *820 ILCS 405/302.*

☐ Check if you want voluntary coverage, complete and attach Form **UI-1B, Voluntary Election of Coverage**.

26 If you have multiple worksites in Illinois complete and attach Form **UI-ML, Multiple Worksites in Illinois**, found online at **ides.illinois.gov.**

Step 6: Certification and Signature

I hereby certify that the information contained in this report, and any sheets or forms attached hereto, is true and correct. This report must be signed by the owner, a partner, or an authorized agent within the employing enterprise. If this document is signed by any other person, complete and attach the Illinois Department of Employment Security Form LE-10, Power of Attorney, available online at **ides.illinois.gov.**

Printed Name: _____ Signature: _____

Title: Domestic Employer/HHCSR _____ Date: _____

Mail your completed form, with any required attachments to:

CENTRAL REGISTRATION DIVISION
ILLINOIS DEPARTMENT OF REVENUE
PO BOX 19030 MAIL CODE 3-222
SPRINGFIELD IL 62794-9030

This state agency is requesting information that is necessary to accomplish the statutory purpose as outlined under 820 ILCS 405/100-3200. Disclosure of this information is required. Failure to disclose this information may result in statutorily prescribed liability and sanction, including penalties and interest.

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Printed by the authority of the State of Illinois (web only)

Power of Attorney for Representing Employer under the Illinois Unemployment Insurance Act

Fax: 217-557-1948 33 South State Street, Chicago IL 60603-2802

Account No. _____

Employer _____

located at _____ ( ) _____
(Street Address, City, State, Zip Code) Telephone Number

E-mail Address _____

hereby authorizes ARIS SOLUTIONS-VETERANS DEPARTMENT

located at 72 SOUTH MAIN STREET , WHITE RIVER JCT, VT 05001 (866) 970-3301
(Street Address, City, State, Zip Code) Telephone Number

E-mail Address EMILIED@ARISSOLUTIONS.ORG

to represent the Employer before the Director in any and all matters, to act in the Employer's stead with the same consequences as the Employer, and to receive any and all information requested by said Representative pertaining to the Employer's liability for the payment of contributions, interest and penalties under the Illinois Unemployment Insurance Act (except that I understand that notices pertaining to a Determination and Assessment or Refund/Adjustment shall be sent to the employing unit at its principal place of business or its last known place of business or residence), until such time as the appointment is terminated. I understand that my Representative shall be provided information only to the extent that it is requested for one of the purposes set forth in Section 1900 of the Illinois Unemployment Insurance Act [820 ILCS 405/1900].

_____
Signature

_____
Name of Employer

By _____

Title _____

Date _____

LE-10 (Rev. 9/17)

VDC- Illinois
Time Sheet and Reimbursement Schedule 2019

Pay Period	Pay Period Start Date	Pay Period End Date	Timesheet Submission Due Date	Payment Date
1	**12/16/2018**	**12/22/2018**	**12/24/2018**	**1/2/2019**
2	12/23/2018	1/5/2019	1/7/2019	1/11/2019
3	**1/6/2019**	**1/19/2019**	**1/21/2019**	**1/25/2019**
4	1/20/2019	2/2/2019	2/4/2019	2/8/2019
5	**2/3/2019**	**2/16/2019**	**2/18/2019**	**2/22/2019**
6	2/17/2019	3/2/2019	3/4/2019	3/8/2019
7	**3/3/2019**	**3/16/2019**	**3/18/2019**	**3/22/2019**
8	3/17/2019	3/30/2019	4/1/2019	4/5/2019
9	**3/31/2019**	**4/13/2019**	**4/15/2019**	**4/19/2019**
10	4/14/2019	4/27/2019	4/29/2019	5/3/2019
11	**4/28/2019**	**5/11/2019**	**5/13/2019**	**5/17/2019**
12	5/12/2019	5/25/2019	5/27/2019	5/31/2019
13	**5/26/2019**	**6/8/2019**	**6/10/2019**	**6/14/2019**
14	6/9/2019	6/22/2019	6/24/2019	6/28/2019
15	**6/23/2019**	**7/6/2019**	**7/8/2019**	**7/12/2019**
16	7/7/2019	7/20/2019	7/22/2019	7/26/2019
17	**7/21/2019**	**8/3/2019**	**8/5/2019**	**8/9/2019**
18	8/4/2019	8/17/2019	8/19/2019	8/23/2019
19	**8/18/2019**	**8/31/2019**	**9/2/2019**	**9/6/2019**
20	9/1/2019	9/14/2019	9/16/2019	9/20/2019
21	**9/15/2019**	**9/28/2019**	**9/30/2019**	**10/4/2019**
22	9/29/2019	10/12/2019	10/14/2019	10/18/2019
23	**10/13/2019**	**10/26/2019**	**10/28/2019**	**11/1/2019**
24	10/27/2019	11/9/2019	11/11/2019	11/15/2019
25	**11/10/2019**	**11/23/2019**	**11/25/2019**	**11/29/2019**
26	11/24/2019	12/7/2019	12/9/2019	12/13/2019
27	**12/8/2019**	**12/21/2019**	**12/23/2019**	**12/27/2019**
28	12/22/2019	1/4/2020	1/6/2020	1/10/2020

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

Questions?
Veterans Department
1.866.970.3301
veteranpayroll@arissolutions.org

NATIONAL RESOURCE CENTER *for*
PARTICIPANT-DIRECTED SERVICES

VD-HCBS Resource January 2014

WHAT EMPLOYERS NEED TO KNOW

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

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How to Protect Yourself and Your Worker: A Guide for Employers

Being an employer brings not only rights but also responsibilities. This guide describes a few important issues that every employer should know about.

Maintaining a Safe Workplace

It is important to keep your home safe for your employee. Slips and falls are a common cause of injuries, so you should clean up or warn your employee of spills and wet surfaces, and keep stairs and flooring in good repair. If you have pets in your home, make sure they cannot bite or scratch your employee.

Making Hiring and Firing Decisions

Terminating Employees

Do not hesitate to terminate an employee who does not meet your needs. Most employment relationships are considered employment "at will," which means you can terminate an employee for any reason or no reason at all, so long as your reason is not discriminatory, retaliatory (see discussion below) or otherwise unlawful.

Avoiding Promises about the Length of Employment

To avoid a claim for breach of contract, do not make any promises to your employee that you will keep him employed for a certain period of time or that you would only fire him for a specific reason. Remember that a contract does not always have to be in writing to be legally binding. Spoken statements and promises can sometimes create legal obligations.

Avoiding Illegal Discrimination and Retaliation

In many states it is illegal to discriminate against employees based on certain factors, which can include race, color, religion, sex, national origin, marital status, sexual orientation. This means that you must not hire, fire, or harass employees based on such factors. While your employee is with you, be careful not to express any personal opinions that could be interpreted as discriminatory. Even if you are in your own home, the home is considered a workplace while your employee is there, and workplace discrimination and harassment are prohibited by law.

Do not allow friends or family to behave in ways that could be considered discriminatory or harassing towards your employee. As the employer, you could be held responsible for their behavior if you allow it to continue.

Sexual harassment is also illegal. It includes unwelcome sexual advances that can be physical or verbal, such as offensive comments or gestures that create a hostile environment. Remember that the harasser can be someone other than the employer, such as a guest visiting your home or someone who lives with you.

It is also illegal to fire employees in retaliation for reporting a crime or irregularity. For example, if an employee believes that an employer is misusing Medicaid funds and reports it to the authorities, it would be illegal to fire the employee in retaliation.

Providing References for Former Employees

Be careful when talking about your reasons for terminating employees, because you could risk a claim of discrimination or defamation (saying things about the employee who harms them). If you are asked for a reference about a former employee and cannot provide a positive one, it is safest not to provide a reference at all.

What Family Members and Authorized Representatives Need to Know

Your Duty as Representative

In participant-directed programs, usually the participant (the person receiving services) is the employer. It is not unusual, however, for the participant to be unable or unwilling to serve as the employer. In those cases, the participant will designate a "representative" to serve as the employer. If you are designated as an authorized representative, you have a *fiduciary* duty to the participant. "Fiduciary" means you must always act in the best interest of the participant and not in your own interest. Program funds must always be spent for the participant's benefit, not your own benefit.

Hiring and Training Employees

If the participant is likely to injure himself or others, you have a duty to warn employees of the risk and instruct them how to best handle it. Make sure to hire only employees who can deal with situations that arise. Ask them to confirm that they understand the risks and are willing and able to handle them.

If you are a parent, you must exercise reasonable care to control your minor child as best as you can, even if you are not listed as an authorized representative for the child. It is important to hire employees who are able to deal with any risks they may encounter when caring for your child. You should warn employees ahead of time of risks, and explain how to best handle situations that may to come up.

Mandatory Reporter Duty

As an authorized representative, you may have a legal duty to report to the authorities if you suspect or notice that the participant is being abused by a family member, an employee, or some other person. Many states have "mandatory reporter" laws that could require you to report abuse of a child, an elderly adult or a person with a disability. You may have a duty to report the abuse even if the abuser is a member of your own family or the participant's family.

Worker's Compensation Insurance

It is important to maintain a worker's compensation insurance policy, because such insurance will pay for claims if an employee is injured on the job.

If an employee is injured while at work, the employer is liable even if the injury is not the employer's fault. For example, if your employee drives to the grocery store on your behalf and is injured when a careless driver hits her car, the employee could ask you for compensation even though you could not have prevented the accident. This is because employers have to compensate employees for injuries sustained on the job. A worker's compensation insurance policy will pay for such claims.

Liability Insurance

Worker's compensation will pay when your employee is injured, but what happens when someone else is injured? As an employer you may be liable when your employee injures someone else, even if the injury is not your fault. For example, if your employee causes a car accident while driving you to an appointment and injures a third party, the third party could sue you because your employee caused the accident while on the job.

Employment-related claims like wrongful termination, discrimination, or defamation are another source of liability that is not covered by worker's compensation insurance.

Some homeowner's, renter's, or liability insurance policies will cover such claims. However the terms of insurance policies vary, so you should read the terms and consult with an insurance agent before you start your participant direction program. You may consider an addition to your homeowner's or renter's policy, or a separate liability insurance policy, to be covered for liability risks related to domestic employees.