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:

Montana 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
- ❑ 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:

- Business Registration GEN REG V-1- Allows ARIS Solutions to apply for a withholding tax account on behalf of the Veteran to remit withholding taxes to the MT Department of Revenue.
- Power of Attorney Authorization to Disclose Information-Allows ARIS Solutions to correspond with the MT Department of Revenue on all withholding tax matters pertaining to this program ONLY.

Department of Labor:

- Third Party Authorization Form - Allows ARIS Solutions to submit and speak to the State of Montana regarding Department of Labor accounts.
- Montana Unemployment Insurance Employer Registration Form UI1-Allows ARIS Solutions to apply for an unemployment tax account on behalf of the Veteran to remit State Unemployment Tax and filings.

If you have questions contact the Veteran Department at 866.970.3301

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

ARIS Solutions Financial & Payroll Services for the Nonprofit Sector

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/ VDHCBS Program and/or the Secretary of the Department of Health and Human Services. All complaints to ARIS Solutions/ VDHCBS 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/ VDC 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/VETERAN

Name _____
(Last) (First) (Middle)

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

Phone (____)_____ **Email** _____

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

FEIN (If previously issued)_____

DESIGNATED REPRESENTATIVE INFORMATION

Name _____

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

Phone (_____)_____

Relationship to Veteran _____

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
HCSR

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	Designee's telephone number (include area code)
ARIS SOLUTIONS FISCAL AGENT	802-280-1911
Address and ZIP code	**Designee's fax number (include area code)**
PO BOX 4409 WHITE RIVER JUNCTION VT 05001	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 ▶

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 HCSR

Date / /

Best daytime phone

Now give this form to the agent to complete.

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	2020-2023	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

HCSR

Print Name | Title (if applicable)

Clear Form

GEN REG
V-1 01/2018

Montana Department of Revenue
Business Registration

Legal Business Name		
Mailing Address		
City	**State**	**Zip Code**

▼ Required ▼

Federal Employer Identification Number

OR

Social Security Number

1. Reason for Registration (Check the applicable box.)

- ☒ Started new business.
- ☐ Re-registration (reopening business)
- ☐ Holding an asset (e.g., RV)
- ☐ New Tax Exempt (see instructions)
- ☐ Other - please attach explanation
- ☐ Purchased existing business. Provide the following information:

Previous business name _____

Date Acquired ☐☐ / ☐☐ / ☐☐☐☐

Previous Owners _____

2. Entity Type (Check only one box.)

- ☐ Trust
- ☐ Partnership
- ☐ C Corporation
- ☐ S Corporation
- ☒ Sole Proprietorship
- ☐ Disregarded Entity

OR

Limited Liability Company (LLC) taxed as:

- ☐ Single Member Disregarded Entity/Sole Proprietorship
- ☐ Multiple Member Partnership
- ☐ Elected to be C Corporation with IRS
- ☐ Elected to be S Corporation with IRS

3. Date of First Business Activity in Montana ☐☐ / ☐☐ / ☐☐☐☐

4. Secretary of State ID ☐☐☐☐☐☐☐☐☐

5. Federal Business Code (NAICS Code) ☐☐☐☐☐☐

6. Describe Business Activity in Montana _____

_____

7. Owner Information

If your tax type is Partnership, S corporation or Disregarded Entity, list the owners of your business below. Include a separate page if more than three owners. If the owner is an individual, estate or trust, indicate whether the owner is a resident or nonresident by using the codes R or NR. For each owner, indicate the entity type by using the following codes:

I - Individual, **E** - Estate, **T** - Trust, **C** - C corporation, **P** - Partnership, **S** - S corporation, **L** - LLC, **O** - Other

Owner's Name	R/NR	Entity Type	Owner's FEIN/SSN
1.			
2.			
3.			

8. Contact Information

Name Emilie Donka Title Veterans Department Tax Specialist

Phone 802-281-7813 Fax Number 802-295-9812

Email Address

9. Business Income Taxes

☒ Calendar Year End ☐ Fiscal Year End - Month _____

If the entity name and FEIN printed on the Montana income tax return is different than the name and FEIN entered on page 1, provide the name and FEIN of entity filing your Montana income tax return.

Name _____ FEIN ☐☐☐☐☐☐☐☐☐

10. W-2 and 1099 Withholding (*Optional–Complete this section if this tax applies to you.*)

Date Montana Source Payroll Started and/or 1099 Withholding (*e.g., 1099-R Withholding*) ☐☐ / ☐☐ / ☐☐☐☐

Check the applicable box if you are an agricultural or domestic employer. ☐ Agricultural ☒ Domestic Employee

11. Mineral Royalty Withholding (*Optional–Complete this section if this tax applies to you.*)

Date Montana Source Royalty Payments Started (*1099 misc*) ☐☐ / ☐☐ / ☐☐☐☐

Type of Mineral Production ☐ Oil ☐ Gas ☐ Coal ☐ Other Mineral (list type) _____

12. Miscellaneous Tax (*Optional–Complete only if these taxes apply to you.*)

Check the miscellaneous tax(es) for which you are registering.

☐ Lodging Facility Sales and Use Tax (short-term lodging) ☐ Rental Vehicle Tax

Start Date ☐☐ / ☐☐ / ☐☐☐☐

If you have multiple locations, copy the table below and complete for each location.

Doing Business As (DBA) Name			Is this facility within city limits?
			☐ Yes ☐ No
DBA Business Address (physical location)			Is this a seasonal business?
			☐ Yes ☐ No
City	State	Zip Code	If seasonal, what months will it be in operation?
Contact Person	Phone Number		

Attention New Montana Accommodations: The Montana Office of Tourism, a division of the Department of Commerce, provides a complete list of Montana accommodations at *visitmt.com*. This list is provided at no cost to you as a service to your business and to consumers.

Would you like the Department of Revenue to release your lodging facility tax information and account ID number to the Montana Office of Tourism so your business will be listed? ☐ Yes ☐ No

Declaration

Under penalty of false swearing, I declare that I have examined this document, and to the best of my knowledge and belief, it is true, correct and complete.

X _____ _____

Signature of Authorized Representative — Date

_____ _____Domestic Employer/HCSR_____

Print Name of Authorized Representative — Title

Send to: MT Department of Revenue, Attn: Registration Unit, PO Box 5805, Helena, MT 59604-5805
or **fax to:** (406) 444-7723, Attn: Registration Unit.

Montana Department of REVENUE

CLEAR FORM

MONTANA
POA
Rev 08 17

Power of Attorney
Authorization to Disclose Information

File online at *revenue.mt.gov on TAP.*

PART I

Caution! Taxpayers who would like to designate someone else to represent them before the Department of Revenue must complete and submit this form. Spouses filing a joint return must each complete a separate form. This form will not be honored for any purpose other than representation before the Department of Revenue. This form cannot be used for any purpose other than designating representation before the Department of Revenue.

Notice: The department will accept a completed federal form 2848 as a power of attorney for representation before the Department of Revenue if Part I, Section 3, Matters, includes the tax type, the tax form number and year(s) or period(s) that the representative is authorized to discuss with the department. If you use the federal form, you must provide a copy to the Department of Revenue.

1. Taxpayer Information. Taxpayers must sign and date this power of attorney form on page 2, section 6.

Taxpayer Name and Address	Taxpayer Identification Number(s)
	Telephone Number

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

2. Representative(s)

Name and Address ARIS Solutions Fiscal Agent C/O Emilie Donka PO Box 4409 White River Jct., VT 05001	PTIN Telephone Number (802) 281-7813 FAX Number 802.295.9812 Email Address emilied@arissolutions.org
Name and Address	PTIN Telephone Number FAX Number Email Address

to represent the taxpayer before the Montana Department of Revenue for the following matters:

3. Tax Matters and Tax Years Covered by This Form

Your representative is authorized to inspect, receive and discuss confidential information for the tax types and tax years you authorize by checking the appropriate boxes below and inserting the specific tax years. If tax matters and tax periods are not specified, you are authorizing the representative access to all tax matters and years until you revoke such authorization.

	Provide specific tax years		*Provide specific tax years*
❑ Individual Income Tax		❑ Rental Vehicle Tax	
❑ Corporation Income Tax		☒ Withholding Tax	2019-disenrolled
❑ S Corporation		❑ Lodging Facilities Tax	
❑ Partnership		❑ Combined Oil and Gas Tax	
		❑ Other, please specify below	

4. Acts Authorized by This Form

Check the box that best describes what authorization you are delegating to your representative.

☒ Representation. Department employees can provide confidential information to the representative and discuss the information.

❑ Information sharing. Department employees can provide confidential information to the representative, but cannot discuss the information.

❑ Decision-making authority. Department employees can provide confidential information to a representative, can discuss the information and the representative can act on the taxpayer's behalf for all purposes, including settlement and waiver of appeal rights.

5. Revocation of Prior Power(s) of Attorney

❑ Check this box if you want all prior POAs revoked.

If you are a representative and want to withdraw an existing POA, write WITHDRAW across the top of the existing form. See instructions on page 3.

6. Signature of taxpayer. If a tax matter concerns a year in which a joint return was filed, the spouses each file a separate power of attorney even if the same representative(s) is(are) appointed. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, fiduciary 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 not be in effect and the taxpayer will be notified.

Signature	Date	Domestic Employer/HHCSR Title (if applicable)
Print Name		Print Taxpayer Name from Line 1 (if other than individual)

PART II. Declaration of Representative

I declare that:

- I am authorized to represent the taxpayer identified in Part I for the matter(s) specified there; and
- I am one of the following:
  a. Attorney - licensed to practice law in 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 or Licensed Public Accountant, etc.
  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 (for example, spouse, parent, child, grandparent, step-parent, step-child, brother or sister).
  g. Other

Representative Signature. See instructions on page 4.

Designation - Insert Letter from Above (a-g)	Relationship to Taxpayer (see instructions for Part II)	Signature	Date

Filing this Form

► **File Online on TransAction Portal at *https://tap.dor.mt.gov*.**

► **Fax to:** (406) 444-7723**.**
Or, if you are already working with a department employee, fax your completed form to the number provided by that person.

► **Mail the completed form to:**
Montana Department of Revenue
340 N. Last Chance Gulch
PO Box 5805
Helena, MT 59604-5805

must sign. If a guardian or conservator has been appointed for a taxpayer, the guardian or conservator must sign. In all cases, the fiduciary must include the representative capacity in which the fiduciary is signing, such as “John Doe, guardian of Jane Roe.”

Part II. Declaration of Representative

The representative(s) you name may sign and date the Declaration of Representative. Enter the applicable designation (items a-g) under which the representative is authorized to handle matters before the Department of Revenue. In addition, provide a brief description of the representative’s relationship to the taxpayer:

a. Attorney – Enter the two-letter abbreviation for the state in which the attorney is admitted to practice.

b. Certified Public Accountant – Enter the two-letter abbreviation for the state in which the CPA is licensed to practice.

c. Enrolled Agent, Licensed Public Accountant, etc.

d. Officer – Enter the title of the officer (for example, President, Vice President, Secretary, etc.).

e. Full-Time Employee – Enter title or position (for example, Comptroller, Accountant, etc.)

f. Family Member – Enter the relationship to the taxpayer (for example, spouse, parent, child, brother, sister, etc.).

g. Other – Identify the type of representative and enter a brief description of the representative’s relationship to the taxpayer.

Filing this Form

File Online on TransAction Portal at *https://tap.dor.mt.gov.*

Fax the completed form to (406) 444-7723. ***Or,*** if you are already working with a department employee, fax your completed form to the number provided by that person.

Mail the completed form to:

Montana Department of Revenue
340 N. Last Chance Gulch
PO Box 5805
Helena, MT 59604-5805

Questions? Please call us at (406) 444-6900.

File online at *revenue.mt.gov on TAP.*

Mail completed form to:	MONTANA UNEMPLOYMENT INSURANCE EMPLOYER REGISTRATION	AGENCY USE ONLY	
UI Contributions Bureau PO Box 6339 Helena MT 59604-6339 **Or fax to:** (406) 444-0629		Employer Number	NAICS
		Subject Date	County Code

Fill in all spaces that apply to your business. Instructions are listed on Page 4.	**Questions?** Call (406) 444-3834 Or visit web site: UieServices.mt.gov	Remarks

1. Purpose of Registration: ☒ New Employer ☐ Change Legal Name ☐ Change Assumed Business Name (DBA) ☐ Purchased a Business ☐ Changed Business Organization ☐ Update existing Account Information

2. Corporation or Legal Name | Federal Employer ID (FEIN)

3. Business or Trade Name

4. Phone Number: 866.970.3301 | Fax Number: 802.295.9812 | Email Address of Contact Person: emilied@arissolutions.org

5. Mailing Address for Tax Forms (Number & Street or P.O. Box): C/O ARIS Solutions Fiscal Agent PO Box 4409 | City: White River Jct., | State: Vermont | ZIP Code: 05001

6. Montana Business Physical Location (Street Address) | City | State | ZIP Code

7. Phone Number | Cell Phone Number | County

8. Mailing Address for Benefit Charge Statements (if different from Tax Form address): Address | City | State | ZIP Code

9. Mailing Address for UI Claims Separation Questionnaires & Investigations (if different from Tax Form address): Address | City | State | ZIP Code

10. Type of Organization

☐ Individual ☐ Corporation ☐ Sub-chapter S Corporation ☐ Partnership (Indicate type: general, limited, LLP, etc.): _____

☐ Nonprofit Corporation ☐ Government ☐ Limited Liability Company (LLC): If LLC, how have you chosen to be taxed for income tax purposes? ☐ Sole Proprietorship (Schedule C) ☐ Partnership (Form 1065) ☐ Corporation (Form 1120) ☐ S Corporation (Form 1120 S)

☐ Indian Tribe or Wholly-Owned Entity of an Indian Tribe (Name): _____

In what state was your business originally incorporated or registered?	Date Incorporated:

Check all that apply.

☒ Domestic /Household ☐ Agriculture ☐ Non-Profit 501 (c)(3)
☐ Fiduciary/Trust ☐ PEO

11. List the owner, partners, or corporate officers. Attach separate sheet if necessary.

Name	Home Mailing Address	Title	Social Security Number	Telephone & Cell Number	% Ownership

12. Name of Person Who Prepares Records and Reports: Emilie Donka Title: Veteran's Dept Tax Specialist

Address PO Box 4409 City White River Jct State VT ZIP Code 05001

Telephone Number 866.970.3301 Cell Number _____ Fax Number 802.295.9812 Email emilied@arissolutions.org

13. Name of Accountant: Emilie Donka

Address PO Box 4409 City White River Jct State VT ZIP Code 05001

Telephone Number 866.970.3301 Cell Number _____ Fax Number 802.295.9812 Email emilied@arissolutions.org

14. **DESCRIPTION OF BUSINESS TYPE AND ACTIVITY IN MONTANA**: This section **MUST BE COMPLETED** in detail to accurately determine your business activity for proper assignment of contribution rates. **Be specific and CHECK ALL THAT APPLY**. Generalities could result in assignment of a higher contribution rate.

☐ Agriculture, Forestry, Fishing ☐ Mining ☐ Construction

☐ Wholesale Trade ☐ Retail Trade ☒ Services

☐ Transportation, Communication & Public Utilities ☐ Finance, Insurance, Real Estate ☐ Manufacturing

Primary Activity	Specific Product or Service	% of Gross Income	# MT Employees
hiring in-home caregivers for Veterans funded by the Veteran's Admin.	Domestic Employment	0%	

15. Does this establishment have employment at more than one physical location in Montana? Yes ☐ No ☒
Exclude construction and contract work site if less than six (6) months in duration.

If yes, provide the address, city and ZIP Codes of all other Montana locations.

Name of contact person and phone number: _____

16. Will you have any out-of-state employees? ☐ Yes ☒ No. If Yes, in what other states do they work? _____

17. Date wages first paid in Montana: _____ Will your total payroll for the current year equal or exceed $1,000? ☐ Yes ☐ No

The date and year payroll first equaled or exceeded $1,000: _____

18. Supply the following information concerning wages paid by the current owner **in Montana** during the current and/or preceding year(s) – if information is unavailable, leave blank:

YEARS:	To Date in 2018	2017	2016	2015	2014	2013
Wages You Paid Each Year:						

19. Are you required to pay Federal Unemployment Tax (FUTA)? ☒ Yes ☐ No

20. Complete this section only if you are a governmental entity, Indian tribe or wholly-owned entity of an Indian tribe, or a 501(c)(3) tax exempt organization.

Select one of the following payment options:

☐ Reimbursement of benefit payments attributable to employment with your organization.

☐ Experience Rated (payment of contributions) on your quarterly taxable payroll at the rate applicable for new employers.

** Default is Experience Rated: 1) If section is not completed, and 2) you have not provided an IRS exemption letter.

FORMER OWNER INFORMATION – If no prior owner or acquisition, skip to Signature and sign below.

IF YOU HAVE CHANGED YOUR BUSINESS ORGINIZATION (SUCH AS PROPRIETORSHIP TO CORPORATION), OR HAVE ACQUIRED A MONTANA BUSINESS OPERATION, YOU MUST COMPLETE THE SECTIONS BELOW.

Former Owner's Name _____ Former Owner's UI Number or FEIN, if known _____

Former Corporate Name or DBA _____ Telephone Number _____

Current Street Address (not a P.O. Box) _____ City _____ State ____ ZIP Code _____

ACQUISITION INFORMATION

1. How did you acquire this business? ☐ Organization Change ☐ Lease ☐ Other _____
   ☐ Purchased All ☐ Purchased a Portion - What did you purchase? _____

	Percent Acquired	Date Acquired
2. Did you acquire all, part or none of the former owner's assets? ☐ All ☐ Part ☐ None		

3. What assets did you purchase? _____

	Percent Acquired	Date Acquired
4. Did you acquire all, part or none of the former owner's workforce? ☐ All ☐ Part ☐ None		

5. How many employees did you acquire? _____ Please provide a list of names and social security numbers of employees acquired.

	Percent Acquired	Date Acquired
6. Did you acquire all, part or none of the former owner's Montana trade (customers/accounts)? ☐ All ☐ Part ☐ None		
7. Did you acquire all, part or none of the former owner's Montana business (products/services)? ☐ All ☐ Part ☐ None		

8. Was the Montana business operating at the time of the acquisition? ☐ Yes ☐ No
   If no, enter the date it was closed by the former owner. Date Closed (MM / DD / YYYY) _____

9. Are you continuing the Montana business you acquired? ☐ Yes ☐ No

10. Does your Montana business have substantially the same owners, officers or management as the former business? ☐ Yes ☐ No

11. Will the previous business/account continue in business in Montana? ☐ Yes ☐ No ☐ Don't Know

12. If eligible, do you wish to apply for the experience rating established by the acquired/previous business? ☐ Yes ☐ No

If you acquire your predecessor's tax rate and experience rating record, your account may be chargeable for any benefits paid to your predecessor's employees. The predecessor employer must also agree to the experience rating transfer. If you do not acquire the experience of the predecessor and this is not a mandatory transfer, you will receive the rate assigned to new employers. It will not include the predecessor's history.

PRINT NAME & TITLE (Owner, a Partner or one Corporate Officer) Domestic Employer/HCSR		**PRINT NAME & TITLE** (Additional Partner or Corporate Officer)	
Signature	**Date**	**Signature**	**Date**
PRINT NAME & TITLE (Additional Partner or Corporate Officer)		**PRINT NAME & TITLE** (Additional Partner or Corporate Officer)	
Signature	**Date**	**Signature**	**Date**

Montana Department of LABOR & INDUSTRY

Unemployment Insurance Division
Contributions Bureau
PO Box 6339, Helena, MT 59604-6339
Telephone (406) 444-3834

Third Party Authorization Form

Employer

Montana UI Employer Account Number	Federal ID Number
Owner/Officer/Partner Name	Doing Business As
Mailing Address (Street or PO Box)	City, State Zip Code
Telephone Number	Email Address emilied@arissolutions.org

Third Party Agent (TPA)

Authorized Third Party Agent ARIS SOLUTIONS FISCAL AGENT MT - EMILIE DONKA	Federal ID Number 83-2079713
Begin Authority As Of (date)	UI eServices Web Logon(s) (if known) ARISMT
Mailing Address (Street or PO Box) PO BOX 4409	City, State Zip Code WHITE RIVER JCT, VT 05001
Telephone Number (802) 281-7813	Email Address

CONSENT & AUTHORIZATIONS

Please check or initial all applicable authorizations for the above listed TPA.

_____ **Verbal Communications:** I hereby certify the Montana Department of Labor & Industry Unemployment Insurance Division is authorized to speak with the above third-party agent concerning all matters related to my unemployment insurance account.

_____ **UI eServices for Employers Access:** I hereby certify the Montana Department of Labor & Industry Unemployment Insurance Division is authorized to grant the above TPA the following level of access to my UI account via *UI eServices for Employers,* (please see page 3 for detailed descriptions of the access levels –**check only one**):

- ☐ **File Only Access**
- ☐ **Pay Only Access**
- ☐ **File & Pay Access**
- ☐ **SIDES e-Response Access**
- ☒ **Full Access**

_____ **Written Communications:** I hereby certify the Montana Department of Labor & Industry Unemployment Insurance Division is authorized to direct UI related correspondence to the above third-party agent. I authorize the following mailings to be sent directly to the above TPA (**check all that apply**):

- ☒ UI Tax Rate Notices
- ☒ Quarterly or monthly benefit charge notices
- ☒ Benefit Claim related correspondence including Separation and Potential Charge notices
- ☒ Miscellaneous forms and notices including but not limited to: UI5 Quarterly Wage Reports, monthly Statements of Account, delinquent notices, registration related forms, and credit memos. Excludes Rate Notices.

_____ State Information Data Exchange System (SIDES) e-Response Participation:
(see page 3 for more information on SIDES)

If the TPA listed on page one will NOT be responding to benefit claim information requests on your behalf via SIDES e-Response, this section should remain blank. If a separate TPA will be responding to benefit claim requests on your behalf, you will need to complete an additional authorization form for them. If you will be responding to your own benefit claim requests and would like to use SIDES, logon to eServices and complete your contact information online (no form is needed).

Complete the SIDES contact information below, only if the TPA listed on page one WILL be responding to benefit claim related requests on your behalf via SIDES.

> **NOTE:** Access to eServices is required for a TPA to respond to SIDES requests on your behalf. Please be sure to indicate either SIDES e-Response or Full Access on page one under UI eServices for Employers Access.

The SIDES contact(s) listed below will receive email notifications if/when there are requests for Benefit Claim related information (Separation Inquiries, Potential Charge Notices, etc.). You have the option to designate one contact to receive all notifications OR list a separate contact for each request type.

SIDES Contact(s)

SIDES Separation Request Contact Name	Contact Email Address	Contact Telephone Number
SIDES Charging Request Contact Name	Contact Email Address	Contact Telephone Number
SIDES Employment Verification Request Contact Name	Contact Email Address	Contact Telephone Number
SIDES Decisions & Determinations Request Contact Name	Contact Email Address	Contact Telephone Number

Signature of the Employer/Taxpayer

I relieve the Department and their representatives of any liability related to release of such information to the above-named authorized third-party agent. I understand this authorization does not absolve me, as the employer/taxpayer, of the responsibility to ensure all taxes, tax reports and/or other UI notices are filed and/or paid timely and accurately. Any authorization granted remains in effect until revoked in writing by the taxpayer or the third-party agent.

The person completing this section and signing below must have legal authority to bind the business. Persons may include the owner, corporate officer, partner, managing member, Chief Financial Officer, Chief Executive Officer, or a fiduciary of a trust or estate.

I certify I have the legal authority to execute this form and authorize disclosure of information noted above:			
PRINTED NAME & TITLE of Authorized Person		**PRINTED NAME of Witness to Authorized Person (Required)**	
SIGNATURE of Authorized Person	**DATE**	**SIGNATURE of Witness (Required)**	**DATE**

VDC- Montana
Time Sheet and Reimbursement Schedule 2020

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

Please assure that time sheets and other payment requests are submitted in a timely manner. Timesheets and invoices may be sent in as soon as the service has been provided. It is not necessary to wait until the due date.

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.

Acknowledgements: Lucia Cucu would like to acknowledge Merle Edwards-Orr and Mollie Murphy for their valuable contribution to this document. The detailed review and insightful comments they provided strengthened this resource.

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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.