



ARIS Solutions

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

Financial & Payroll Services for the Nonprofit Sector

Enrollment Forms for:

Alaska ILC VD-HCBS Program Employers

This packet contains the necessary forms and instructions that will authorize ARIS Solutions to act in your behalf as your FMS 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
- ☐ Customer Grievance Policy
- ☐ Employer / Participant Information Form
- ☐ Workers' Compensation Form
- ☐ Form SS-4 - Application for Employer Identification Number
 - ❖ 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
 - ❖ Alaska Employer Registration Form - to setup an account with the Department of Labor and Workforce Development
 - ❖ Alaska Dept. of Labor and Workforce Development "Power of Attorney" allows ARIS to speak to the Department of Labor on your behalf and file all quarterly tax forms.

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/Participant Information

You are now an Employer!

Welcome to the Veteran Directed Home and Community Based Services Program employment model. You will now manage and direct the services you receive or the services the Veteran you represent receives. In this employer model you, or a representative who you appoint, are the employer and you direct the work of your employee. (Please read the New "Employer/Participant" handbook for more details of the Employers role in the VD-HCBS Program)

The Role of ARIS Solutions as Your 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 Pass 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 Michele Swett	meganw@arissolutions.org janeta@arissolutions.org micheles@arissolutions.org



ARIS Solutions
Financial & Payroll Services for the Nonprofit Sector



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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. (Please refer to the New "Employer/Participant" Handbook for more detail on fraud within the Veteran Directed Program)

Definition

Fraud is to intentionally misrepresent, cheat or deceive in order to benefit or gain something of value. Medicaid fraud is knowingly falsifying or misrepresenting the truth to obtain unauthorized benefits. Abuse includes any practice inconsistent with acceptable practices that will unnecessarily increase costs.

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 participant 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 up to then 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 year 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

Date



FRAUD & ABUSE STATEMENT

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

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

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

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

Examples of Medicaid/Veteran Administration Abuse include:

- Making errors when filling out the employee's timesheet and not immediately reporting the error to the Vendor F/EA FMS-Support Broker entity to remedy the situation.
- Being late in handing in Veteran/representative-employer related paperwork to the Vendor F/EA FMS-Support Broker entity.

The difference between Fraud and Abuse

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

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

Veteran's Signature

Date

Authorized Representative Signature

Date

FMS Provider Signature

Date



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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/ VDH CBS 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.



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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/ VDHCB Program and/or the Secretary of the Department of Health and Human Services. All complaints to ARIS Solutions/ VDHCB Program must be made in writing. We support your right to protect your PHI.*

****PLEASE KEEP THIS FOR YOUR RECORDS****



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HIPAA NOTICE OF PRIVACY PRACTICES & AGREEMENT

PLEASE SIGN/DATE & RETURN TO ARIS SOLUTIONS

At ARIS Solutions/ VDHCB 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/ VDHCB Program and how may I obtain access to and control of this information.

Signature

Date



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CUSTOMER GRIEVANCE POLICY

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

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

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

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

In the event your complaint is not addressed satisfactorily:

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

Name: Theresa Danforth

Email: theresad@arissolutions.org

Fax: 802.295.9812

Telephone: 866.970.3301

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

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

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

Name: Jason Richardson

Email: jasonr@arissolutions.org

Fax: 802.295.9812

Telephone: 802.280.1911

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

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



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Employer/Participant 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 Participant _____

PARTICIPANT IS EMPLOYER

YES

NO

If yes please skip next section.

NAME OF PARTICIPANT

Name _____

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

Phone (_____) _____

Date of Birth _____

Social Security Number _____



Worker's Compensation Insurance

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

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



VD-HCBS AK ILC 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:

[illegible][illegible]

<p>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.</p>	
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EXPLAIN ALL "YES" RESPONSES		YES	NO	EXPLAIN ALL "YES" RESPONSES		YES	NO
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT/WATERCRAFT?				16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?			
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)				17. ANY OTHER INSURANCE WITH THIS INSURER?			
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?				18. ANY PRIOR COVERAGE DECLINED/CANCELLED/NON-RENEWED (Last 3 years)? NOT APPLICABLE IN MO			
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?				19. ARE EMPLOYEE HEALTH PLANS PROVIDED?			
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?				20. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS/SUBSIDIARY?			
6. ARE SUB-CONTRACTORS USED? (IF YES, GIVE % OF WORK SUBCONTRACTED)				21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?			
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INS.?				22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?			
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?				23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST 5 YEARS?			
9. ANY GROUP TRANSPORTATION PROVIDED?				24. ANY UNDISPUTED AND UNPAID WORKERS' COMPENSATION PREMIUM DUE FROM YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? IF YES, EXPLAIN INCLUDING ENTITY NAME(S) AND POLICY NUMBER(S).			
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?				CONTACT INFORMATION			
11. ANY SEASONAL EMPLOYEES?				IN-SPECTION	PHONE:		
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?					NAME:		
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?				ACCTNG RECORD	PHONE:		
14. DO EMPLOYEES TRAVEL OUT OF STATE?					NAME:		
15. ARE ATHLETIC TEAMS SPONSORED?				CLAIMS INFO	PHONE:		
					NAME:		
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							
APPLICANT'S SIGNATURE		DATE		PRODUCER'S SIGNATURE		NATIONAL PRODUCER NUMBER	

Application for Employer Identification Number

(For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.)

OMB No. 1545-0003

EIN

▶ See separate instructions for each line.

▶ Keep a copy for your records.

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)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			8b If 8a is "Yes," enter the number of LLC members ▶			
8c If 8a is "Yes," was the LLC organized in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No						
9a Type of entity (check only one box). Caution. If 8a is "Yes," see the instructions for the correct box to check. <input type="checkbox"/> Sole proprietor (SSN) <input type="checkbox"/> Estate (SSN of decedent) <input type="checkbox"/> Partnership <input type="checkbox"/> Plan administrator (TIN) <input type="checkbox"/> Corporation (enter form number to be filed) ▶ <input type="checkbox"/> Trust (TIN of grantor) <input type="checkbox"/> Personal service corporation <input type="checkbox"/> National Guard <input type="checkbox"/> State/local government <input type="checkbox"/> Church or church-controlled organization <input type="checkbox"/> Farmers' cooperative <input type="checkbox"/> Federal government/military <input type="checkbox"/> Other nonprofit organization (specify) ▶ <input type="checkbox"/> REMIC <input type="checkbox"/> Indian tribal governments/enterprises <input checked="" type="checkbox"/> Other (specify) ▶ HHCSR 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) <input checked="" type="checkbox"/> Started new business (specify type) ▶ PERSONAL CARE/HOME CARE <input type="checkbox"/> Hired employees (Check the box and see line 13.) <input type="checkbox"/> Compliance with IRS withholding regulations <input type="checkbox"/> Other (specify) ▶ <input type="checkbox"/> Banking purpose (specify purpose) ▶ <input type="checkbox"/> Changed type of organization (specify new type) ▶ <input type="checkbox"/> Purchased going business <input type="checkbox"/> Created a trust (specify type) ▶ <input type="checkbox"/> Created a pension plan (specify type) ▶						
11 Date business started or acquired (month, day, year). See instructions.		12 Closing month of accounting year JUNE				
13 Highest number of employees expected in the next 12 months (enter -0- if none). If no employees expected, skip line 14. <table border="1"><tr><td>Agricultural</td><td>Household</td><td>Other</td></tr></table>		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. <input type="checkbox"/>	
Agricultural	Household	Other				
15 First date wages or annuities were paid (month, day, year). Note. If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year) ▶						
16 Check one box that best describes the principal activity of your business. <input type="checkbox"/> Construction <input type="checkbox"/> Rental & leasing <input type="checkbox"/> Transportation & warehousing <input type="checkbox"/> Health care & social assistance <input type="checkbox"/> Wholesale-agent/broker <input type="checkbox"/> Real estate <input type="checkbox"/> Manufacturing <input type="checkbox"/> Finance & insurance <input type="checkbox"/> Accommodation & food service <input type="checkbox"/> Wholesale-other <input type="checkbox"/> Retail <input checked="" type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," write previous EIN here ▶						
Third Party Designee	Complete this section only if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.					
	Designee's name 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 ▶			

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**

<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------

City **State** **ZIP code**

<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------

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. ➡

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. 802-280-1911

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

HHCSR

Print Name

Title (if applicable)

Alaska Employer Registration Form

Alaska Department of Labor and Workforce Development Employment Security Tax P.O. Box 115509, Juneau, AK 99811-5509		<input checked="" type="checkbox"/> New <input type="checkbox"/> Update		Account number		Bus. type	NAICS		Predecessor		Predecessor dues?
		Field auditor	Cont. code	Rt-Hld & mailings	Rate Code		Rate year	Rate link type	Rate	Receive date	
COMPLETE BOTH SIDES OF FORM				THE ABOVE AREA IS FOR STATE USE ONLY							
1) Type of business: <input type="checkbox"/> Sole proprietor <input type="checkbox"/> Partnership: General _____ Limited _____ Date partnership formed _____ <input type="checkbox"/> Nonprofit organization <input type="checkbox"/> Federally recognized tribe <input checked="" type="checkbox"/> Other Household Employer Desired method of payment <input type="checkbox"/> Taxable <input type="checkbox"/> Reimbursable <input type="checkbox"/> Corporation: Date incorporated _____ State incorporated _____ State corporation number _____ <input type="checkbox"/> Limited Liability Company (LLC) : Number of managers (or members if no manager) _____ Date formed _____ State _____											
2) Federal Identification Number		3) Have you ever been assigned an account number with Employment Security Tax? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, list number: _____				4) Do you wish to cover employees that can be excluded? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, see Page 4					
5) What is the date your business first paid wages in Alaska, or the anticipated date you will pay wages? Month _____ Day _____ Year _____ (Your account will be opened this date)								6) Number of employees in Alaska:			
7) Legal Business Name:						8) Doing Business As (DBA) Name:					
9) Mailing address						City		State		Zip	
										10) Business phone: 802-280-1911	
11) Physical worksite address in Alaska (list additional worksites on Page 4)										12) Fax number: 802-295-9812	
13) Business Contact Name: ARIS SOLUTIONS- Veteran Department		14) Business Contact Phone Number: 802-280-1911		15) Business Contact Email: veteranpayroll@arissolutions.org		16) Business Website:					
Your rate will be determined by completion of Item 17. See Page 2 for complete instructions		17) Describe the product sold or service you provide in Alaska that generates the majority of your gross income. (Failure to complete this section may result in a higher tax rate.) Home and community based personal care services to allow the Veteran participants to remain in their home.						19) Do you anticipate using contract labor to perform the activities stated in Item 17? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes describe:			
		18) Percent of gross Alaska income derived from Item 17. <u>100%</u>									
Complete this section if you have changed your business or have acquired an Alaska business operation.											
20) Date changed or acquired: Month _____ Day _____ Year _____						21) Date wages first paid under new ownership: Month _____ Day _____ Year _____					
22) Type of change: <input type="checkbox"/> Change in Entity (Sole Proprietorship to partnership, Partnership to Corporation, etc.) <input type="checkbox"/> Change in Partner <input type="checkbox"/> Change in Corporation Stock Transfer <input type="checkbox"/> Corporate Charter Change <input type="checkbox"/> Corporate Officer Change <input type="checkbox"/> Other (Explain)											
23) Was business acquired through: <input type="checkbox"/> Purchase <input type="checkbox"/> Lease <input type="checkbox"/> Foreclosure <input type="checkbox"/> Repossession <input type="checkbox"/> Other (Describe in detail on separate paper)						24) What percentage of the Alaska Operating Assets were acquired?					
25) Prior owner(s) name(s), FEIN, and business (DBA) name:				26) Prior account number:				27) Number of employees acquired:			
Information and signature of business principals i.e. a sole proprietor, each partner, all corporate officers, directors, LLC manager(s) and LLC member(s)											
CERTIFICATION: With my signature, I certify that information provided on this form is correct and true											
Printed name and Social Security Number		Signature		Residence address and telephone number		Title and effective date		% Owned		Code	
Name: SSN:				Residence Address City _____ State _____ Zip Code Residence Telephone: _____		HHCSR Title _____ Effective Date _____		100%		6	
Name: SSN:				Residence Address City _____ State _____ Zip Code Residence Telephone: _____		Title Effective Date _____					
Name: SSN:				Residence Address City _____ State _____ Zip Code Residence Telephone: _____		Title Effective Date _____					
Name: SSN:				Residence Address City _____ State _____ Zip Code Residence Telephone: _____		Title Effective Date _____					

ALASKA DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
Division of Employment and Training Services – Unemployment Insurance (UI) Tax
1111 W. 8th St., P.O. Box 115509, Juneau, AK 99811-5509
(888) 448-3527 or (907) 465-2757, Fax: (907) 465-2374;
Alaska Relay: (800) 770-8973 or Email: esd.tax@alaska.gov

POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS:

That _____ UI account no. _____
 (business name)

Federal ID no. _____ does hereby constitute and appoint

ARIS Solutions- Veteran Department

PO Box 4409 (designated authority)

(designated authority mailing address)
 White River Junction VT 05001

City State Zip code
 802-280-1911 802-295-9812
 Phone Fax

its true and lawful attorney in fact with full power and authority to represent said company before the Alaska Department of Labor and Workforce Development, Division of Employment and Training Services effective immediately and until this authority has been revoked in writing in connection with any and all Unemployment Insurance matters as indicated below. For areas you would like this Power of Attorney to apply, check either "New" or "Add." "New" will supersede previous Powers of Attorney for lines checked. "Add" does not supersede previous Powers of Attorney for lines checked.

New Add

- ☒ ☐ 1. Filing of completed forms, including claims for refund or adjustment of account, liability or status determinations and wage record reports
- ☒ ☐ 2. Receipt of Tax Rate Notices (TR02)
- ☒ ☐ 3. Payment of contributions and any penalties and interest assessed on the account
- ☒ ☐ 4. Discuss matters affecting the experience record and contribution rate of the employer account
- ☒ ☐ 5. Discuss all matters affecting any adjustments to the employer's account
- ☒ ☐ 6. Enroll in the State Information Data Exchange System (SIDES) for electronic:
- ☒ **Notification of Separation information** ☒ **Wage Earnings Audits**
- Contact name: Emilie Donka Phone: 802-281-7813
- Email: emilied@arissolutions.org
- ☒ ☐ 7. All matters and forms affecting UI benefits, job separation information, hearing notices and decisions
- ☒ ☐ 8. Reporting agency: Discuss rates, submit Supplemental reports/payments, obtain IRS certifications

IN WITNESS WHEREOF, the said _____
 (owner, officer or member)

has caused this instrument to be duly attested by the signature of its duly qualified officer this _____ day of _____, 20____.

By (employer signature):	Printed name	Title and company: HHCSR
--------------------------	--------------	-----------------------------

STATE: _____ COUNTY OF _____, _____, 20____

Then, personally appeared the above named _____ whose title is HHCSR and acknowledged the foregoing instrument to be his/her free act and deed in his/her said capacity.

Notary public	Type or print name	My commission expires
---------------	--------------------	-----------------------

Electronic Timesheets Agreement

I. About The Electronic Timesheets Module

- a. The Electronic Timesheets Module is a web-based interface through which Consumers, Employers, Employees, and Fiscal Intermediary staff can respectively view relevant timesheet information.
- b. Consumers, Employers and Employees will be able to use the system to both submit and approve timesheets electronically for payment by the Fiscal Intermediary.
- c. A Consumer is not required to have an Employer in order to use the system. But in cases where a Consumer does have an Employer and the Consumer approves the Employer to have access to the Electronic Timesheets Submission Interface, both the Consumer and his/her Employer will have identical abilities to enter and approve timesheets for payment. If the Consumer does not feel comfortable with the electronic interface, the Employer has the ability to handle all of the Consumer's timesheet submission and approval responsibilities.

II. Terms and Conditions

By signing below, you are agreeing to the following Terms and Conditions:

- a. The Consumer and/or his/her Employer and the Employee must have valid e-mail addresses that they access frequently.
- b. The Consumer, his/her Employer (if applicable) and the Employee agree to use the Electronic Timesheets Submission Interface as a method of submitting timesheets.
 - i. Signing this Agreement does not require you to only use the Electronic Timesheets Submission Interface. Other methods of submitting time, such as faxing or mailing, are still acceptable.
- c. A timesheet may not be submitted electronically if the Consumer and the Employee have not both signed and agreed to use the Electronic Timesheets Submission Interface via this Agreement.
 - i. If the Consumer approves their Employer to use the system, then the Employer must also sign this Agreement.
- d. An individual Electronic Timesheets Agreement is required for each Consumer/Employee relationship that chooses to use the Electronic Timesheets Submission Interface.
 - i. This is true even if the Consumer or Employee is already using the Electronic Timesheets Submission Interface in another Consumer/Employee relationship.

Program (Circle one): North Carolina VDP VOICE SWIRCA Generations

Consumer Name: _____ **Consumer E-mail:** _____

Employer Name: _____ **Employer E-mail:** _____

Consumer Signature: _____ **Date:** _____

Employer Signature: _____ **Date:** _____

**** Note all fields in RED are required. Forms not completed in full will be returned.**

Please print very clearly and legibly, or processing could be delayed.

About the Electronic Timesheets Module

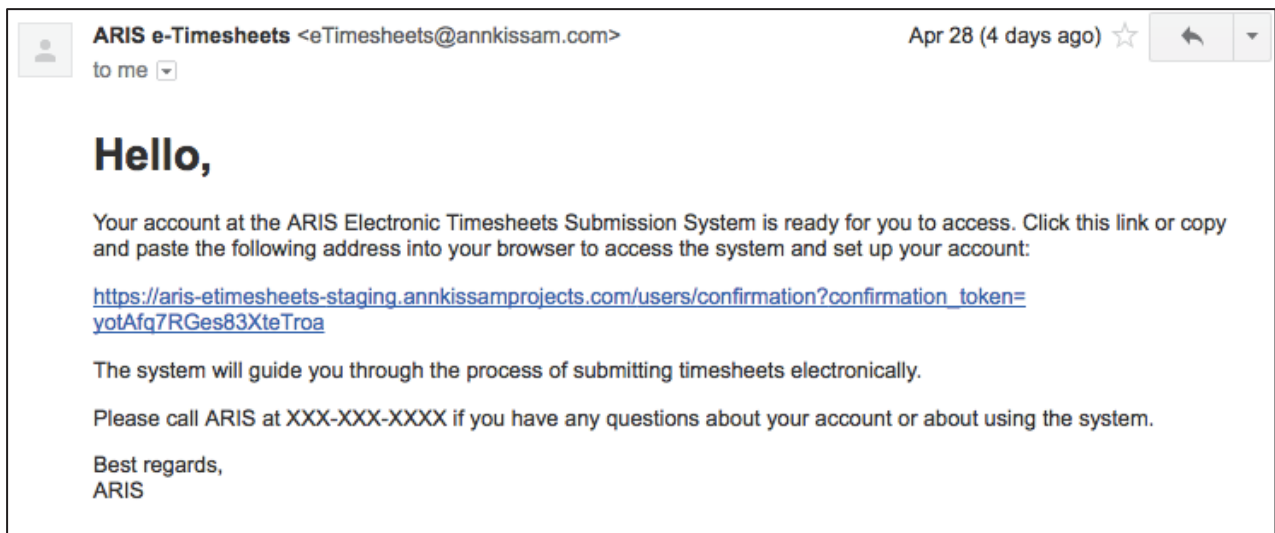
The Electronic Timesheets Module is a web-based interface through which Consumers, Employers, Representatives and Employees can respectively enter and view relevant timesheet information.

Electronic Timesheets Agreement

In order to use the Electronic Timesheets Submission interface, a Consumer, their Representative or Employer (if applicable) and their Employee must sign an Electronic Timesheets Agreement which states that they both have valid e-mail addresses, and agree to use the electronic timesheets submission interface as a method of submitting time.

Getting Started

1. An admin will create a user for the Consumer, Employer, Employee and Representative (if applicable).
2. The Consumer, Employer, Employee and Representative (if applicable) will each receive an e-mail alerting them that their account has been set up, and instructions for activating this account. Each user will click a one-time login link that expires after access to set up a password.



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

Electronic timesheets user
Terms of Service

USE OF USER ID AND PASSWORD:

1. If you register and/or set up an account on the Electronic Timesheets System Interface, you will be solely responsible for maintaining the confidentiality of your Registration Information. You may not authorize others to use your Registration Information. You may not sub-license, transfer, sell or assign your Registration Information and/or this Agreement to any third party. Any attempt to do so will be null and void and shall be considered a material breach of this Agreement.

2. You are solely responsible for all usage or activity on your account including, but not limited to, use of the account by any person who uses your Registration Information, with or without authorization, or who has access to any computer on which your account resides or is accessible.

3. If you have reason to believe that your account is no longer secure (for example, in the event of a loss, theft or unauthorized disclosure or use of your Personal Identifiable Information stored on the Electronic Timesheets System Interface), you must promptly change the affected Registration Information by using the appropriate update mechanism on the Electronic Timesheets System Interface, if available, or notify ARIS.

Please set your password for your account here.

New Password

Confirm Password

☐ I have read and accept the above terms of service.

Submit

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



WHAT EMPLOYERS NEED TO KNOW

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

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

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

Maintaining a Safe Workplace

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

Making Hiring and Firing Decisions

Terminating Employees

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

Avoiding Promises about the Length of Employment

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

Avoiding Illegal Discrimination and Retaliation

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

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

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

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

Providing References for Former Employees

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

What Family Members and Authorized Representatives Need to Know

Your Duty as Representative

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

Hiring and Training Employees

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

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

Mandatory Reporter Duty

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

Worker's Compensation Insurance

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

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

Liability Insurance

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

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

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