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:

PCA 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
  - ❖ 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
  - ❖ Pennsylvania Enterprise Registration (Form PA-100)- To apply for account numbers for the Pennsylvania Department of Revenue & Department of Labor.
    - Rev 677 LE - Pennsylvania Department of Revenue Power of Attorney
    - UC 1208 - Pennsylvania Department of Labor Power of Attorney

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

ARIS Solutions Financial & Payroll Services for the Nonprofit Sector

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 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. (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 tha 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 "New Employer/Participant" Handbook and "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

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/ VDHCBS 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 A<u>RIS Solutions/ VDHCBS Program</u> 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/ VDHCBS Program, we respect the confidentiality of your medical information and will protect information in a responsible manner. We have a privacy program in place that meets the requirements of HIPAA, the government legislation that sets standards for the privacy of medical information.

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

HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT AND CONSENT

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

_____ _____

Signature *Date*

ARIS Solutions

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

ARIS Solutions

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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 _____

ARIS Solutions

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.*

PCA ARIS Solutions

VD-HCBS Pennsylvania Workers' Compensation Form

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

INDIVIDUALS INCLUDED/EXCLUDED

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

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

PRIOR CARRIER INFORMATION/LOSS HISTORY

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

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

NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS

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

Pennsylvania

GENERAL INFORMATION

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

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

CONTACT INFORMATION

INSPECTION	PHONE:	802-280-1191
	NAME:	Theresa Towle
ACCTNG RECORD	PHONE:	802-280-1191
	NAME:	Theresa Towle
CLAIMS INFO	PHONE:	802-280-1191
	NAME:	Theresa Towle

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

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

REMARKS

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

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

ACORD 130 (2002/09)

PCA

Form **SS-4**
(Rev. January 2010)
Department of the Treasury
Internal Revenue Service

Application for Employer Identification Number

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

▶ **See separate instructions for each line.** ▶ **Keep a copy for your records.**

OMB No. 1545-0003

EIN

Type or print clearly.

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

2 Trade name of business (if different from name on line 1)

3 Executor, administrator, trustee, "care of" name

4a Mailing address (room, apt., suite no. and street, or P.O. box)
ARIS SOLUTIONS, PO BOX 4409

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

4b City, state, and ZIP code (if foreign, see instructions)
WHITE RIVER JUNCTION, VT 05001

5b City, state, and ZIP code (if foreign, see instructions)

6 County and state where principal business is located

7a Name of responsible party

7b SSN, ITIN, or EIN

8a Is this application for a limited liability company (LLC) (or a foreign equivalent)? ☐ Yes ☑ No

8b If 8a is "Yes," enter the number of LLC members ▶

8c If 8a is "Yes," was the LLC organized in the United States? ☐ Yes ☐ No

9a **Type of entity** (check only one box). **Caution.** If 8a is "Yes," see the instructions for the correct box to check.

- ☐ Sole proprietor (SSN)
- ☐ Partnership
- ☐ Corporation (enter form number to be filed) ▶
- ☐ Personal service corporation
- ☐ Church or church-controlled organization
- ☐ Other nonprofit organization (specify) ▶
- ☑ Other (specify) ▶ HHCSR
- ☐ Estate (SSN of decedent)
- ☐ Plan administrator (TIN)
- ☐ Trust (TIN of grantor)
- ☐ National Guard
- ☐ State/local government
- ☐ Farmers' cooperative
- ☐ Federal government/military
- ☐ REMIC
- ☐ Indian tribal governments/enterprises

Group Exemption Number (GEN) if any ▶

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

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

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

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

12 Closing month of accounting year JUNE

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

Agricultural	Household	Other

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

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

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

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

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

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

Third Party Designee

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

Designee's name: ARIS SOLUTIONS FISCAL AGENT
Designee's telephone number (include area code): 802-280-1911
Address and ZIP code: PO BOX 4409 WHITE RIVER JUNCTION VT 05001
Designee's fax number (include area code): 802-295-9812

Under penalties of perjury, I declare that I have examined this application, and to the best of my knowledge and belief, it is true, correct, and complete.

Applicant's telephone number (include area code)

Name and title (type or print clearly) ▶

Applicant's fax number (include area code)

Signature ▶ Date ▶

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

PCA

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

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

OMB No. 1545-0748

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

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

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

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

For IRS use:

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

(Check one)

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

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

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

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

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

3 **Trade name** (if any)

4 **Address**

Number Street Suite or room number

City State ZIP code

Foreign country name Foreign province/county Foreign postal code

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

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

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

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

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

X **Sign your name here**

Print your name here

Print your title here HHCSR

Date / /

Best daytime phone

Now give this form to the agent to complete.

Part 3: **Agent Information: If you will be an agent for an employer or payer, or want to revoke an appointment, complete this part.**

6 Agent's employer identification number (EIN) 82 – 3749253

7 Agent's name (not trade name) ARIS SOLUTIONS PA FISCAL AGENT

8 Trade name (if any) ARIS SOLUTIONS

9 Address

PO BOX 4409
Number Street Suite or room number

WHITE RIVER JUNCTION | VT | 05001
City | State | ZIP code

Foreign country name | Foreign province/county | Foreign postal code

☑ Check here if the employer is a home care service recipient receiving home care services through a program administered by a federal, state, or local government agency.

Under penalties of perjury, I declare that I have examined this form and any attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

X Sign your name here

Print your name here: JASON RICHARDSON

Print your title here: CHIEF OPERATING OFFICER

Date / /

Best daytime phone: 802-280-1911

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. 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)

PA-100 (TR) 05-17

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF REVENUE
BUREAU OF BUSINESS TRUST FUND TAXES
PO BOX 280901
HARRISBURG, PA 17128-0901

Go Paperless . . .

REGISTER ON THE INTERNET

www.pa100.state.pa.us

PENNSYLVANIA ENTERPRISE REGISTRATION FORM AND INSTRUCTIONS

AUXILIARY AIDS AND SERVICES ARE AVAILABLE UPON REQUEST TO INDIVIDUALS WITH DISABILITIES.
EQUAL OPPORTUNITY EMPLOYER/PROGRAM.

DETACH AND MAIL COMPLETED REGISTRATION FORM TO:

COMMONWEALTH OF PA • DEPARTMENT OF REVENUE • BUREAU OF BUSINESS TRUST FUND TAXES • PO BOX 280901 • HARRISBURG, PA 17128-0901

PCA

PA-100 (03-09)

MAIL COMPLETED APPLICATION TO:
DEPARTMENT OF REVENUE
BUREAU OF BUSINESS TRUST FUND TAXES
PO BOX 280901
HARRISBURG, PA 17128-0901

COMMONWEALTH OF PENNSYLVANIA

PA ENTERPRISE REGISTRATION FORM

DEPARTMENT USE ONLY

RECEIVED DATE

TYPE OR PRINT LEGIBLY, USE BLACK INK

DEPARTMENT OF REVENUE &
DEPARTMENT OF LABOR AND INDUSTRY

SECTION 1 – REASON FOR THIS REGISTRATION

REFER TO THE INSTRUCTIONS (PAGE 18) AND CHECK THE APPLICABLE BOX(ES) TO INDICATE THE REASON(S) FOR THIS REGISTRATION.

1. ☑ NEW REGISTRATION
2. ☐ ADDING TAX(ES) & SERVICE(S)
3. ☐ REACTIVATING TAX(ES) & SERVICE(S)
4. ☐ ADDING ESTABLISHMENT(S)
5. ☐ INFORMATION UPDATE

6. DID THIS ENTERPRISE:
   - ☐ YES ☑ NO ACQUIRE ALL OR PART OF ANOTHER BUSINESS?
   - ☐ YES ☑ NO RESULT FROM A CHANGE IN LEGAL STRUCTURE (FOR EXAMPLE, FROM INDIVIDUAL PROPRIETOR TO CORPORATION, PARTNERSHIP TO CORPORATION, CORPORATION TO LIMITED LIABILITY COMPANY, ETC)?
   - ☐ YES ☑ NO UNDERGO A MERGER, CONSOLIDATION, DISSOLUTION, OR OTHER RESTRUCTURING?

SECTION 2 – ENTERPRISE INFORMATION

1. DATE OF FIRST OPERATIONS	2. DATE OF FIRST OPERATIONS IN PA	3. ENTERPRISE FISCAL YEAR END

4. ENTERPRISE LEGAL NAME	5. FEDERAL EMPLOYER IDENTIFICATION NUMBER (EIN)
6. ENTERPRISE TRADE NAME (if different than legal name)	7. ENTERPRISE TELEPHONE NUMBER ( )

8. ENTERPRISE STREET ADDRESS (**do not use PO Box**)	CITY/TOWN	COUNTY	STATE	ZIP CODE + 4

9. ENTERPRISE MAILING ADDRESS (if different than street address)	CITY/TOWN	STATE	ZIP CODE + 4

10. LOCATION OF ENTERPRISE RECORDS (street address)	CITY/TOWN	STATE	ZIP CODE + 4

11. ESTABLISHMENT NAME (doing business as)	12. NUMBER OF ESTABLISHMENTS *	13. PA SCHOOL DISTRICT	14. PA MUNICIPALITY

*** ENTERPRISES WITH ONE OR MORE ESTABLISHMENTS WITHIN PA, WHOSE PA ADDRESS WAS NOT ENTERED ABOVE, MUST COMPLETE SECTION 17. (SEE GENERAL INSTRUCTIONS AND SECTION 17 FOR MORE INFORMATION.)**

SECTION 3 – TAXES AND SERVICES

ALL REGISTRANTS MUST CHECK THE APPLICABLE BOX(ES) TO INDICATE THE TAX(ES) AND SERVICE(S) REQUESTED FOR THIS REGISTRATION AND COMPLETE THE CORRESPONDING SECTIONS INDICATED ON PAGES 2 AND 3. IF REACTIVATING ANY PREVIOUS ACCOUNT(S), LIST THE ACCOUNT NUMBER(S) IN THE SPACE PROVIDED.

	PREVIOUS ACCOUNT NUMBER		PREVIOUS ACCOUNT NUMBER
☐ CIGARETTE DEALER'S LICENSE		☐ SALES, USE, HOTEL OCCUPANCY TAX LICENSE	
☐ CORPORATION TAXES		☐ SMALL GAMES OF CHANCE LIC./CERT.	
☑ EMPLOYER WITHHOLDING TAX		☐ TRANSIENT VENDOR CERTIFICATE	
☐ FUELS TAX PERMIT		☐ UNEMPLOYMENT COMPENSATION	
☐ LIQUID FUELS TAX PERMIT		☐ USE TAX	
☐ MOTOR CARRIERS ROAD TAX/IFTA		☐ VEHICLE RENTAL TAX	
☐ PROMOTER LICENSE		☐ WHOLESALER CERTIFICATE	
☐ PUBLIC TRANSPORTATION ASSISTANCE TAX LICENSE		☐ WORKERS' COMPENSATION COVERAGE	
☐ SALES TAX EXEMPT STATUS			

SECTION 4 – AUTHORIZED SIGNATURE

I, (WE) THE UNDERSIGNED, DECLARE UNDER THE PENALTIES OF PERJURY THAT THE STATEMENTS CONTAINED HEREIN ARE TRUE, CORRECT, AND COMPLETE.

AUTHORIZED SIGNATURE (ATTACH POWER OF ATTORNEY IF APPLICABLE)	DAYTIME TELEPHONE NUMBER	TITLE
	(802) 280-1911	Program Specialist
TYPE OR PRINT NAME Emilie Donka	E-MAIL ADDRESS emilied@arissolutions.org	DATE
TYPE OR PRINT PREPARER'S NAME		TITLE
DAYTIME TELEPHONE NUMBER ( )	E-MAIL ADDRESS	DATE

ENTERPRISE NAME

DEPARTMENT USE ONLY

SECTION 5 – BUSINESS STRUCTURE

CHECK THE APPROPRIATE BOX FOR QUESTIONS 1, 2 & 3. IN ADDITION TO SECTIONS 1 THROUGH 10, COMPLETE THE SECTION(S) INDICATED.

1. ☑ SOLE PROPRIETORSHIP (INDIVIDUAL)
   ☐ CORPORATION (Sec. 11)
   ☐ GOVERNMENT (Sec. 13)
   ☐ GENERAL PARTNERSHIP
   ☐ LIMITED PARTNERSHIP
   ☐ LIMITED LIABILITY PARTNERSHIP
   ☐ JOINT VENTURE PARTNERSHIP
   ☐ ASSOCIATION
   ☐ BUSINESS TRUST
   ☐ ESTATE
   ☐ LIMITED LIABILITY COMPANY *STATE WHERE CHARTERED* _____
   ☐ RESTRICTED PROFESSIONAL COMPANY *STATE WHERE CHARTERED* _____

2. ☐ PROFIT ☑ NON-PROFIT — IS THE ENTERPRISE ORGANIZED FOR PROFIT OR NON-PROFIT?

3. ☐ YES ☑ NO — IS THE ENTERPRISE EXEMPT FROM TAXATION UNDER INTERNAL REVENUE CODE (IRC) SECTION 501(c)(3)? IF YES, PROVIDE A COPY OF THE ENTERPRISE'S EXEMPTION AUTHORIZATION LETTER FROM THE INTERNAL REVENUE SERVICE.

SECTION 6 – OWNERS, PARTNERS, SHAREHOLDERS, OFFICERS, AND RESPONSIBLE PARTY INFORMATION

PROVIDE THE FOLLOWING FOR **ALL** INDIVIDUAL AND/OR ENTERPRISE OWNERS, PARTNERS, SHAREHOLDERS, OFFICERS, AND RESPONSIBLE PARTIES. IF STOCK IS PUBLICLY TRADED, **PROVIDE THE FOLLOWING FOR ANY SHAREHOLDER WITH AN EQUITY POSITION OF 5% OR MORE.** ***ADDITIONAL SPACE IS AVAILABLE IN SECTION 6A, PAGE 11.***

1. NAME	2. SOCIAL SECURITY NUMBER	3. DATE OF BIRTH *	4. FEDERAL EIN

5.	6. TITLE	7. EFFECTIVE DATE OF TITLE	8. PERCENTAGE OF OWNERSHIP	9. EFFECTIVE DATE OF OWNERSHIP
☐ OWNER ☐ OFFICER ☐ PARTNER ☐ SHAREHOLDER ☑ RESPONSIBLE PARTY	HHCSR		100 %	

10. HOME ADDRESS (street)	CITY/TOWN	COUNTY	STATE	ZIP CODE + 4

11. THIS PERSON IS RESPONSIBLE TO REMIT/MAINTAIN: ☐ SALES TAX ☑ EMPLOYER WITHHOLDING TAX ☐ MOTOR FUEL TAXES ☑ WORKERS' COMPENSATION COVERAGE

* DATE OF BIRTH REQUIRED ONLY IF APPLYING FOR A CIGARETTE WHOLESALE DEALER'S LICENSE, A SMALL GAMES OF CHANCE DISTRIBUTOR LICENSE, OR A SMALL GAMES OF CHANCE MANUFACTURER CERTIFICATE.

SECTION 7 – ESTABLISHMENT BUSINESS ACTIVITY INFORMATION

REFER TO THE INSTRUCTIONS ON PAGES 20 & 21 TO COMPLETE THIS SECTION. COMPLETE SECTION 17 FOR MULTIPLE ESTABLISHMENTS.

1. ENTER THE PERCENTAGE THAT EACH **PA BUSINESS ACTIVITY** REPRESENTS OF THE TOTAL RECEIPTS OR REVENUES AT **THIS** ESTABLISHMENT. LIST **PRODUCTS OR SERVICES** ASSOCIATED WITH EACH BUSINESS ACTIVITY AND THE PERCENTAGE REPRESENTING THE TOTAL RECEIPTS OR REVENUES.

PA BUSINESS ACTIVITY	%	PRODUCTS OR SERVICES	%	ADDITIONAL PRODUCTS OR SERVICES	%
Accommodation & Food Services					
Agriculture, Forestry, Fishing, & Hunting					
Art, Entertainment, & Recreation Services					
Communications/Information					
Construction (must complete question 3)					
Domestics (Private Households)	100	Provide home and community based personal care to Veteran participant, so they can remain in their home.			
Educational Services					
Finance					
Health Care Services					
Insurance					
Management, Support & Remediation Services					
Manufacturing					
Mining, Quarrying, & Oil/Gas Extraction					
Other Services					
Professional, Scientific, & Technical Services					
Public Administration					
Real Estate					
Retail Trade					
Sanitary Service					
Social Assistance Services					
Transportation					
Utilities					
Warehousing					
Wholesale Trade					
TOTAL	100%				

2. ENTER THE PERCENTAGE THAT **THIS ESTABLISHMENT'S** RECEIPTS OR REVENUES REPRESENT OF THE **TOTAL PA** RECEIPTS OR REVENUES OF THE ENTERPRISE. _____ %. SINGLE ESTABLISHMENT ENTERPRISES ENTER 100%. MULTIPLE ESTABLISHMENT ENTERPRISES ENTER PERCENTAGE OF ENTERPRISE (SEE SECTION 17).

3. ESTABLISHMENTS ENGAGED IN CONSTRUCTION ***MUST*** ENTER THE PERCENTAGE OF CONSTRUCTION ACTIVITY THAT IS NEW AND/OR RENOVATIVE AND THE PERCENTAGE OF CONSTRUCTION ACTIVITY THAT IS RESIDENTIAL AND/OR COMMERCIAL.
   _____ % NEW + _____ % RENOVATIVE = 100%
   _____ % RESIDENTIAL + _____ % COMMERCIAL = 100%

4. ☐ YES ☑ NO DOES THIS ENTERPRISE WANT TO BECOME A PENNSYLVANIA LOTTERY RETAILER?

SECTION 1 – REASON FOR THIS REGISTRATION

An enterprise may select more than one reason for registration.

1. **New Registration:** An enterprise never registered with the PA Department of Revenue or the PA Department of Labor & Industry must complete Sections 1 through 10 and additional sections as appropriate.

2. **Adding Tax(es) and Service(s):** A registered enterprise adding tax(es) and service(s) must complete Sections 1 through 6 and additional sections as appropriate.

3. **Reactivating Tax(es) and Service(s):** A registered enterprise reactivating tax(es) and service(s) must complete Sections 1 through 6 and additional sections as appropriate.

4. **Adding Establishment(s):** A registered enterprise adding establishment location(s) must complete Sections 1 through 6 and Section 17, Multiple Establishment Information.

5. **Information Update:** A registered enterprise providing changes in demographic or other information must complete Sections 1 through 6 and additional sections as appropriate.

6. **Did this Enterprise:**

   An enterprise acquiring the business of another enterprise in whole or in part must complete Section 14, Predecessor/Successor Information. The business can be acquired by purchase, consolidation, merger, gift, or change in legal structure. A stock acquisition *alone* does not constitute a transfer of the business.

   Check the appropriate box to indicate the business operation of the enterprise. If yes:

   - A newly formed enterprise must complete Sections 1 through 10, Section 14 and additional sections as appropriate.
   - A previously registered enterprise must complete Sections 1 through 6, 10, 14 and additional sections as appropriate.
   - An enterprise requesting the PA Unemployment Compensation (UC) experience record and reserve account balance of a predecessor (prior owner) must also complete Section 15, Application for PA UC Experience Record and Reserve Account Balance of Predecessor.

SECTION 2 – ENTERPRISE INFORMATION

1. **Date of First Operations:** Enter the first date the enterprise conducted any activity. This includes start-up operations prior to opening for business.

2. **Date of First Operations in PA:** Enter the first date the enterprise conducted any activity in PA or employed PA residents. This includes start-up operations prior to opening for business.

3. **Enterprise Fiscal Year End:** Enter the month (January, February, etc.) used by the enterprise to designate the end of its accounting period.

4. **Enterprise Legal Name:** Enter the legal name of the enterprise.

IF THE BUSINESS STRUCTURE IS:	USE THE:
SOLE PROPRIETORSHIP	INDIVIDUAL OWNER'S NAME.
CORPORATION	NAME AS SHOWN IN THE ARTICLES OF INCORPORATION.
PARTNERSHIP	NAME AS SHOWN IN THE PARTNERSHIP AGREEMENT.
ASSOCIATION	NAME AS SHOWN IN THE ASSOCIATION AGREEMENT.
BUSINESS TRUST	NAME AS SHOWN IN THE TRUST AGREEMENT.
ESTATE	LEGAL NAME OF THE ESTATE.
TRUST	NAME AS SHOWN IN THE TRUST AGREEMENT.
LIMITED LIABILITY COMPANY	NAME AS SHOWN IN THE ARTICLES OF ORGANIZATION.
RESTRICTED PROFESSIONAL COMPANY	NAME AS SHOWN IN THE ARTICLES OF ORGANIZATION.
GOVERNMENT	OFFICIAL/LEGAL NAME OF THE ORGANIZATION.

5. **Federal EIN:** Enter the Federal Employer Identification Number (EIN) assigned to the enterprise by the Internal Revenue Service. If the enterprise does not have an EIN, enter "N/A". If the enterprise has made application for an EIN, enter "Applied For".

6. **Enterprise Trade Name:** Enter the name by which the enterprise is commonly known (doing business as, trading as, also known as), if it is a name other than the legal name. If the enterprise has a fictitious name registered with the PA Department of State, enter it here. If the trade name is the same as the legal name, enter "Same".

7. **Enterprise Telephone Number:** Enter the telephone number for the enterprise.

8. **Enterprise Street Address:** Enter the physical location of the enterprise. **A post office box is not acceptable.**

9. **Enterprise Mailing Address:** Enter the address where the enterprise prefers to receive mail, if at an address other than the enterprise street address. A post office box is acceptable. If the mailing address is the same as the enterprise street address, enter "Same".

   To indicate multiple mailing addresses and the purposes, attach a separate 8 1/2 X 11 sheet and identify the purpose of each.

   For example, an enterprise may want tax forms or licenses mailed to the enterprise address, but payroll-related forms such as Unemployment Compensation returns mailed to the address of a particular payroll service.

10. **Location of Enterprise Records:** Enter the street address where the enterprise records are kept. A post office box is not acceptable. If the records are kept at the enterprise street address, enter "Same".

11. **Establishment Name:** Enter the name by which the establishment is known to the public; for example, the name on the front of the store. If the same as the enterprise legal name, enter "Same".

12. **Number of Establishments:** Enter the number of establishments. If the enterprise has more than one establishment conducting business in PA or employing PA residents, refer to the instructions and complete Section 17, Multiple Establishment Information.

pennsylvania
DEPARTMENT OF REVENUE

POWER OF ATTORNEY AND DECLARATION OF REPRESENTATIVE

GENERAL INSTRUCTIONS:

This form provides limited authority for department representatives to speak about confidential tax matters with designated third parties. Such authority is limited to the tax period, tax type and the specific issue/purpose identified herein.

While tax practitioners are encouraged to maintain appropriate declarations of authority to handle clients' tax matters within their own records, tax practitioners should not submit unsolicited REV-677 forms to the department en masse or as a matter of routine. Such forms will be disregarded.

A REV-677 form should only be submitted to an individual within the department upon an agent's request for such authorization.

If a department representative has requested a REV-677 form to authorize discussion of confidential tax matters with a third party, please return the form to the department representative as requested.

PART I Power of Attorney

NOTE: An organization, firm or partnership may not be designated as a taxpayer's representative.

The following taxpayer

Taxpayer Name | Identifying Number

Address | City | State | ZIP

hereby appoints

Appointee Name(s): ARIS Solutions-Veteran Department | Telephone Number: 802-280-1911 | Preparer Tax Identification Number (PTIN)

Address: PO BOX 4409 | City: WHITE RIVER JCT | State: VT | ZIP: 05001

as attorney-in-fact to represent the taxpayer before any office of the PA Department of Revenue for the following tax matter(s). Specify the type(s) of tax, tax year(s) or period(s), tax return/report at issue and the specific purpose for which authorization to discuss confidential tax matters with a third-party is sought.

Type(s) of tax	Tax Year(s) or Period(s)	Tax Return/Form	Purpose for Authorization
WITHHOLDING	ALL	ALL	PAYROLL AGENT

The attorney-in-fact is authorized, subject to revocation, to receive confidential information and perform any and all acts the principal can perform with respect to the above-specified tax matters, excluding the power to receive refund checks and the power to sign the return, unless specifically granted below.

Initial here ☐ to grant the power to receive – but not to endorse or cash – refund checks for the above-referenced tax matters to the appointee named above.

Only if this form is being submitted to the department in response to an audit, provide an address below to which copies may be sent of notices and other written communications addressed to the taxpayer in proceedings involving the above-specified tax matters.

Appointee Name(s) | Telephone Number

Address | City | State | ZIP

This power of attorney revokes all earlier powers of attorney and tax information authorizations on file with the PA Department of Revenue for the same matters and years or periods covered by this power of attorney, except the following:

Granter Name | Date | ☐ Refer to attached copies of earlier powers and authorizations

Address | City | State | ZIP

Signature of or for taxpayer
If signed by a corporate officer, partner or fiduciary on behalf of the taxpayer, such party certifies he/she has the authority to execute this power of attorney on behalf of the taxpayer.

Signature	Title	Date

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
OFFICE OF UNEMPLOYMENT COMPENSATION BENEFITS

PENNSYLVANIA UNEMPLOYMENT COMPENSATION (UC) BENEFITS ADDRESS CONFIRMATION AND POWER OF ATTORNEY

Employer name _____

PA UC Account No. ☐☐ - ☐☐☐☐☐☐

FEIN ☐☐ - ☐☐☐☐☐☐☐

Part A: Benefits Address Confirmation

Employer address _____
(Street) (City) (State) (Zip Code)

_____
(Contact) (Phone) (Fax) (Email)

EXCEPT AS PROVIDED IN PART B BELOW, THE DEPARTMENT WILL SEND ALL CORRESPONDENCE FROM THE OFFICE OF UC BENEFITS POLICY AND THE OFFICE OF UC SERVICE CENTERS REGARDING UC BENEFITS TO THE ABOVE ADDRESS.

Part B: Power of Attorney

Know all men by these present that I, _____ , do hereby make,
(Employer name)

constitute and appoint ARIS SOLUTIONS- VETERANS DEPARTMENT , whose address is
(Attorney-in-fact Name)

72 SOUTH MAIN STREET WHITE RIVER JCT VERMONT 05001 ,
(Street) (City) (State) (Zip Code)

as my lawful attorney-in-fact with full power and authority to act on my behalf with the Office of UC Benefits Policy and the Office of UC Service Centers, and their successor agency or agencies within the Department of Labor & Industry, in any matter relating to UC benefits. I authorize the Office of UC Benefits Policy and the Office of UC Service Centers to send the following to the address of my attorney-in-fact:

☑ 1. Monthly Notices of Compensation Charged (UC-640),

☑ 2. Notices of Financial Determination (UC-44F(3)), Requests for Relief from Charges (UC-44FR), and determinations on requests for relief from charges (Form UC-560)

☑ 3. Employer's Notices of Application (UC-45), fact-finding questionnaires, and eligibility determinations

I hereby ratify and confirm all that said attorney-in-fact, or its agents, employees or substitutes shall or may do or cause to be done by virtue of the power herein conferred until written notice of revocation hereof is received by the department.

I hereby revoke any prior power of attorney to the extent that it designated an attorney-in-fact to act on my behalf in any matter relating to UC benefits, to receive any of the above documents regarding UC, or both.

In delegating authority to the attorney-in-fact, for the purposes specified above, it is expressly understood that the attorney-in-fact and I are equally responsible and each shall incur liability for the penalties provided for false and/or fraudulent statements or omissions, whether written or oral.

By _____ By _____
(Signature of authorized representative of Employer) (Signature of authorized representative of attorney-in-fact)

Printed name _____ Printed name EMILIE DONKA

Title HHCSR Date _____ Title PROGRAM SPECIALIST Date _____

See reverse for instructions and information on completion of this form.

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): PCA

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

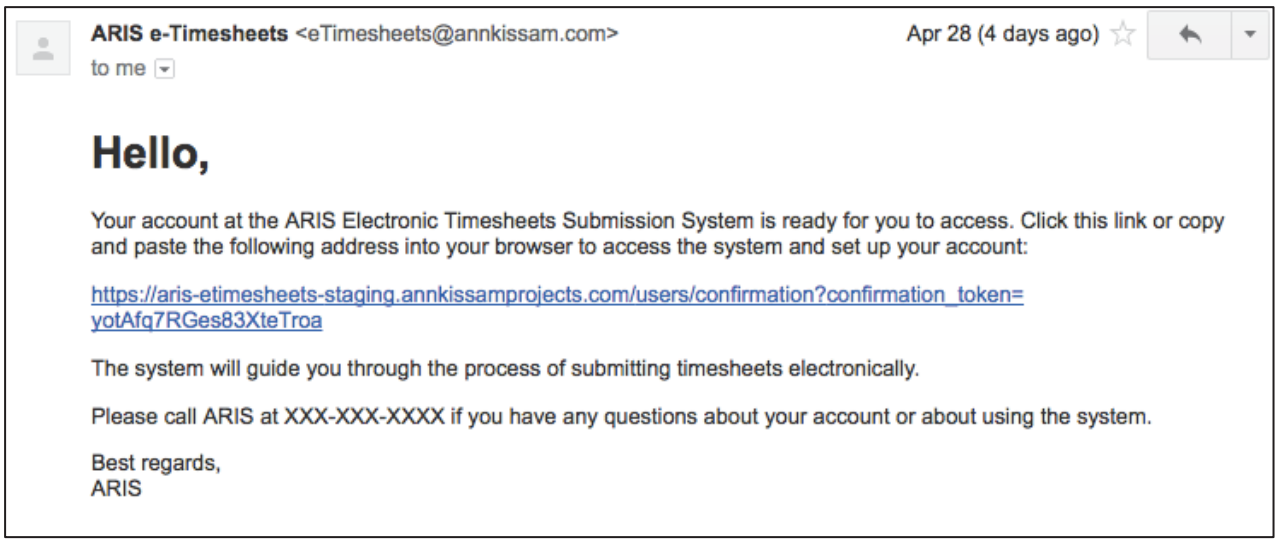
The Electronic Timesheets Module is a web-based interface through which Consumers, Employers, Representatives and Employees can respectively enter and view relevant timesheet information.

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.



ARIS e-Timesheets <eTimesheets@annkissam.com> Apr 28 (4 days ago)

to me

Hello,

Your account at the ARIS Electronic Timesheets Submission System is ready for you to access. Click this link or copy and paste the following address into your browser to access the system and set up your account:

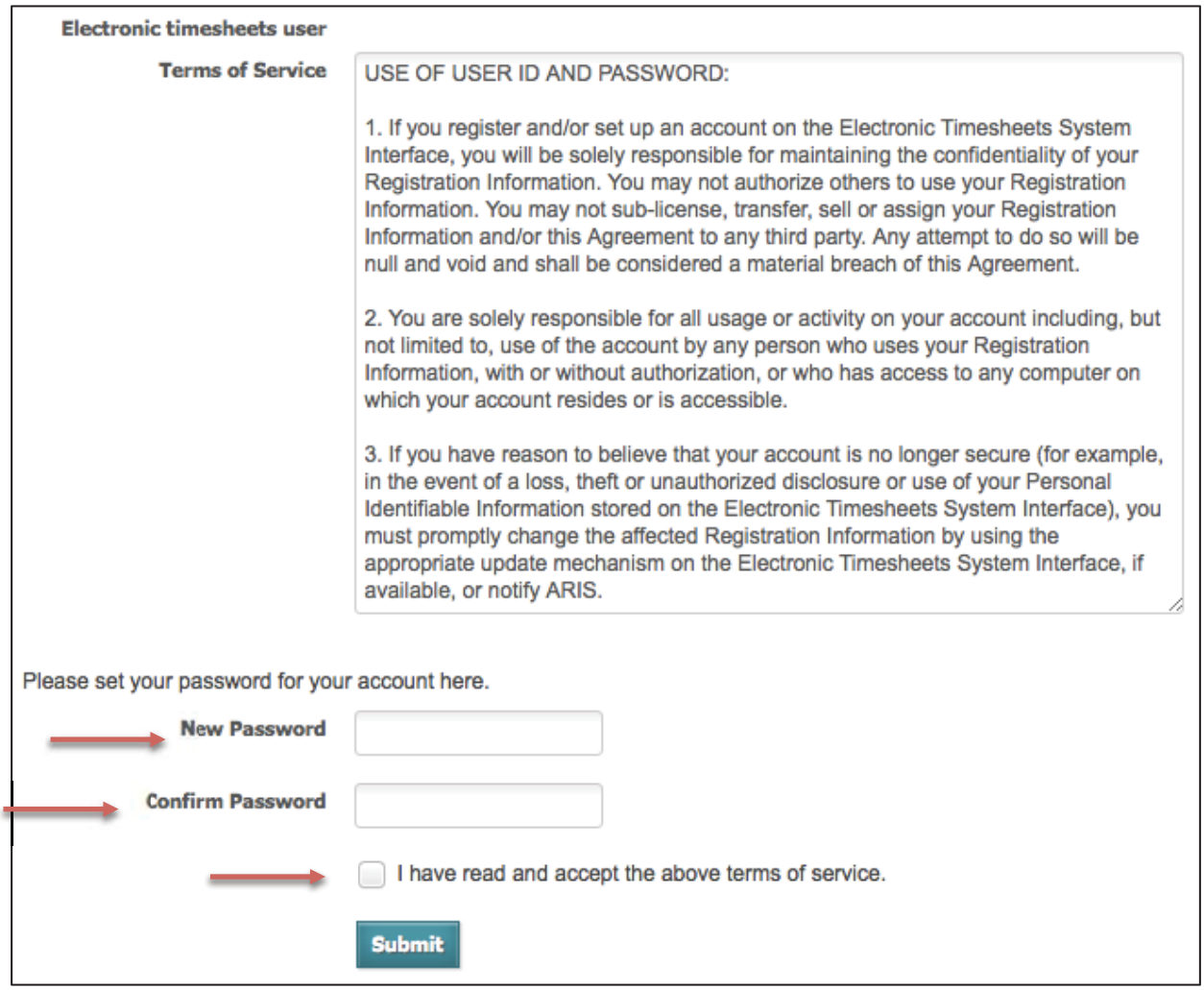
https://aris-etimesheets-staging.annkissamprojects.com/users/confirmation?confirmation_token=yotAfq7RGes83XteTroa

The system will guide you through the process of submitting timesheets electronically.

Please call ARIS at XXX-XXX-XXXX if you have any questions about your account or about using the system.

Best regards,
ARIS

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



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

NATIONAL RESOURCE CENTER *for*
PARTICIPANT-DIRECTED SERVICES

VD-HCBS Resource January 2014

WHAT EMPLOYERS NEED TO KNOW

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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.