Pennyrile Area Development District
Veteran Directed Care (VDC) Program

Dear Employer/Participant:

You have received this letter and the enclosed forms because Pennyrile Area Development District (PeADD) will be serving as your Fiscal Employer Agent in the Veteran Directed Care Program.

The designated Case Management provider will be known as your Spoke agency and will provide the case management for each enrolled Veteran within the VDC Program.

Pennyrile Area Development District will serve as your Financial Management Service (FMS) provider by paying your personal workers and assuming responsibility for managing tax filings and payments on your behalf. You will need to complete the enclosed employer enrollment and tax forms and return those indicated with the accompanying checklist to your case manager for processing.

On the following pages, you will find the VDC Veteran Enrollment Packet and the summary of each form that needs to be completed. The Spokes and PeADD are committed to providing you as much support as possible; however, we must adhere to federal and state employment tax laws. **Therefore, all the employer and worker forms have to be signed and returned to PeADD before a worker can begin providing services.**

Please provide these completed forms to your assigned Case Manager.

Employer and PeADD Responsibilities

Veteran Directed Care allow you and your participant to use program funds to hire your own workers. The Veteran or representative is the employer and Pennyrile Area Development District (PeADD) is your Financial Management Service (FMS) provider. Below is a brief summary of what is done by whom:

As the employer, you will:

- Complete, sign, and send VDC Veteran Enrollment Packet to Case Manager, who will send to PeADD.
- Retain Employer Identification Number letter from the IRS requested by PeADD online on your behalf for your records.
- Recruit and hire workers: Download appropriate state Employee Enrollment Packet from PeADD website or contact your assigned Case Manager to ask for a packet to be sent to you; provide worker packet to potential workers; understand that employment is contingent on the worker providing all information required to successfully enroll the worker in the Vendor Fiscal/Employer Agent (VF/EA) FMS entity's payroll system and ensure compliance with tax and labor laws.
- Verify worker qualifications, including the participant-worker relationship.
- Authorize criminal background checks on your authorized representative and potential employees.
- For Respite care, the worker cannot be the participant’s guardian, conservator, parent or stepparent.
- Help select the services the participant will receive.
- Orient, train, schedule, and supervise worker.
- Schedule worker to provide services for payment only after being authorized by PeADD.
- Establish performance evaluation criteria for each worker.

- Provide a safe workplace free from excess hazards, employment discrimination, and harassment.
- Request worker to perform permitted and planned for duties, as determined in the Individual Participant Plan.
- Verify services provided by the worker by reviewing and approving (signing) timesheets, invoices, and documentation of services rendered, and ensuring submission to Case Manager in a timely manner.
- Ensure that timesheets are submitted within 3 days of the end of the pay period for the worker to be paid timely.
- Monitor your use of authorized services.
- Act in accordance with the policies and procedures outlined in your employment agreement.
- Notify workers in advance if services are not required or if participant is no longer eligible for services.
- Accept responsibility for payment of services not authorized in approved spending plan.
- Ensure that there is no misrepresentation of time, services, individuals, and/or other information.

As the Financial Management Service Provider, PeADD will:

- Process timesheets and issue paychecks to workers bi-weekly.
- Withhold appropriate state and federal taxes for each worker.
- File quarterly and/or annual forms and tax deposits with State and federal agencies (See below to learn more about what taxes are withheld).
- Issue W-2 Statements to each worker prior to IRS deadline of 1/31 of the following year.
- Answer all questions that you and your workers have.
- Help you and your workers with the enrollment process.

Fillable Information

Agency Name: _____

Agency Street Address: _____

Agency City: _____

Agency Zip: _____

Agency Phone: _____

Agency Referral Date: _____

VA Client First Name: _____

VA Client Last Name: _____

VA Client Full Name: _____

VA Client SSN: _____

VA Client Gender: _____

VA Client DOB: _____

VA Client Street Address: _____

VA Client City: _____

VA Client State: _____

VA Client Zip: _____

VA Client County: _____

VA Client Home Phone: _____

VA Client Cell Phone: _____

VA Client Email: _____

VA Client Job Title: _____

VA Client Street Address, City, State, Zip: _____

Employer of Record (vet or rep) First Name: _____

EOR Last Name: _____

EOR Full Name: _____

EOR SSN: _____

EOR Street address: _____

EORCity: _____

EOR State: _____

EOR Zip: _____

EOR Street Address, City, State, Zip: _____

EOR Phone: _____

EOR Email: _____

EOR Relationship to Veteran: _____

Agency: _____

Veteran Name: _____ # _____

VDC Veteran Enrollment Checklist

Distribution Only

- ☐ Welcome Letter/Explanation of Roles distributed
- ☐ Enrollment Form Information Packet distributed
- ☐ Grievance Policy distributed
- ☐ Notice of Privacy Practices distributed
- ☐ Blank Timesheets distributed
- ☐ Timesheet Instructions distributed
- ☐ Timesheet Due Dates distributed
- ☐ Authorized Representative Form/Employer Agreement
- ☐ Enrollment & Agreement From
- ☐ Rights & Responsibilities
- ☐ Release of Information
- ☐ Fraud & Abuse Statement
- ☐ Background/ Nurse Abuse Registry Agreement
- ☐ Veteran Set-Up form
- ☐ MEBH Assessment Tool
- ☐ IRS Form SS-4
- ☐ IRS Form 8821
- ☐ IRS Form 2678
- ☐ UI Application for Unemployment Insurance
- ☐ UI Power of Attorney
- ☐ Worker's Compensation Acknowledgment

Date _____

Return signed originals to your Case Manager
at your designated Spoke Agency.
Retain copies for your records.

Background check obtained (Date_____) if applicable

Nurse Abuse check obtained (Date _____) if applicable

PeADD Use Only

- ☐ Submit SP to VAMC _____
- ☐ SP Approved: Start date: _____
- ☐ Obtain EIN _____
- ☐ Scan/AF
- ☐ File

Veteran Directed Care Program (VDC)
Authorized Representative Form/Employer Agreement Form

The **Employer of Records** must:

- Work with the Case Manager to develop the Service & Spending Plan (budget) at startup and throughout the Veteran Directed Care Program (VDC)
- Use the VDC Budget for goods and services within the guidelines of the program
- Maintain records, complete all required paperwork, and adhere to all tax and labor laws

Authorized Representative Description – An Authorized Representative may be a family member or any other individual, **but not an employee, who willingly accepts responsibility for performing cash management tasks that the veteran is unable to perform for him or herself**. An Authorized Representative must demonstrate a commitment to the participant and must be willing to follow his or her wishes and respect the veteran's preferences while using sound judgment to act on his or her behalf. An Authorized Representative receives no monetary compensation for this service and may not serve as an employee of the veteran. All Authorized Representatives are required to report a background check and receive approval from the Spoke agency. Upon approval, the Authorized Representative will become the **"Employer of Records."**

Name of Veteran _____

Address _____

City _____, State____ Zip _____ Phone # _____

Decline of an Authorized Representative (check if applicable)

☐	I do not wish to designate an authorized representative. I, the veteran, will be the employer of records. Veteran's Signature _____ Date _____

Designation for Authorized Representative (complete if applicable)

I hereby appoint_____ to serve as my Authorized Representative in the VDC Program. This person is authorized to complete and sign all forms and to serve on my behalf as the employer of records for any personal employees under this program. This person will authorize payments from my monthly-approved spending plan, approve employee timesheets, communicate as needed with my Case Manager regarding the care I receive while participating in this program, and meet all documentation requirements as may be required. If I decide I no longer want to participate in the program, this designation expires on the date of my disenrollment from the VDC.

Veteran's Signature _____ Date _____

I hereby agree to serve as the Authorized Representative for the above name veteran and understand my responsibilities and duties under the VDC Program. I understand that I cannot pay myself for this role and that I cannot become a paid personal attendant of the above named veteran.

Authorized Representative's Signature _____
Date_____

Printed Name _____

Address
_____

City _____ , State_____ Zip _____ Phone #: _____

Relationship to veteran: _____

Case Manager Signature _____ Date _____

Veteran Directed Care (VDC) Program

Enrollment & Agreement Form

I, _____ (print name) choose to receive more information about the Veteran Directed Care (VDC) Program.

I understand that if I enroll I will develop a Service & Spending Plan with the assistance of my Case Manager that will best meet my needs and is cost effective. I understand that if I overspend my Spending Plan, I am responsible for any expenses that exceed the spending plan.

I understand that the money from the Spending Plan may be used to hire an employee(s) and pay their wages and benefits and buy approved goods or services that will help me live more independently in my home.
I understand that I can choose who provides my care and that I can hire my own employee(s) as long as the Spoke and Area Development District approve. If I choose to hire my own employee(s), I understand that I will be their "Employer of Record" and am legally required to pay employer-related taxes for the employees I hire.

I understand that the Spoke Agency Case Manager and Pennyrile Area Development District (PeADD) FMS staff will assist me with the tasks related to being an employer. I will fully cooperate with Case Manager & PeADD FMS staff to provide them with the information needed to assist me with this task.

I understand that I can ask my Case Manager any questions I have about my rights as a Veteran in VDC Program. If I decide that the VDC Program is not right for me, I understand that I may choose not to direct my own services and instead receive services from the Veterans Health Administration, the Spoke Agency, if eligible, or other home and community services programs. I will not be penalized in any way if I decide that the VDC Program is not for me and I wish to receive services in a different way. I also understand that if it is determined by the Case Manager and local VA administrator that I am no longer able to direct my own care or have an authorized representative assist me that I will not be able to participate in the VDC Program.

Confidentiality: I understand that information about me is confidential. I understand that information I provide on the forms I complete will be shared with the Pennyrile Area Agency on Aging, other Spoke Agencies, and the Veterans Health Administration. I understand that the Pennyrile Area Agency on Aging/ Spoke Agency Case Managers and FMS staff will have access to this information. I also understand that all of these groups are required to hold my name in confidence to the full extent provided by the state and federal law.

I have read and understood all of the information in this form about the Veteran Directed Care (VDC) Program.

Enroll in VDC Program →		Decline Enrollment in VDC Program→	

_____ _____

Veteran or Authorized Representative Signature Date Signed

_____ _____

Printed Name of Veteran or Authorized Representative Telephone

_____

Address, City, State, Zip

Case Manager Verification: *I have explained all the required information contained in this form and I believe that the participant/authorized representative understands the provisions contained in this form and has made an informed decision to participate in the Veteran Directed Care Program.*

_____ _____

Case Manager Signature Date Signed

Veteran Directed Care (VDC) Program
Veteran Set-Up Form

DIRECTIONS: Complete & provide to assigned Case Manager (copy of form will be submitted to PADD FMS staff).

VETERAN INFORMATION			
Last Name:		First Name:	
SSN:		Gender:	
Date of Birth:		Status:	ACTIVE
Residence Address:			
City:		County:	
State:		Zip Code:	
Email:		Job Title:	
Home Phone:		Cell Phone:	

AUTHORIZED REPRESENTATIVE INFORMATION (AS APPLICABLE)

Rep. Last Name _____ First Name _____

Address _____

City _____ State _____ Zip Code_____

Telephone _____ Email _____

SSN _____ Relationship to Vet:_____

Veteran Directed Care (VDC) Program

Rights and Responsibilities

RIGHTS

I have the right to live as I choose, in my own home, as independently as I desire.
I have the right to be treated with dignity and respect.
I have the right to privacy and confidentiality.
I have the right to create a budget and options plan that meets my needs within the guidelines of the program at any time.
I have the right to change my budget and options plan to meet my needs within the guidelines of the program at any time.
I have the right to a monthly report on how my budget is spent.
I have the right to bring whomever I wish to all meetings pertaining to the program.
I have the right to an explanation of all services and procedures for billing.
I have the right to refuse services and terminate my participation in the program at any time.
I have the right to submit a complaint about any aspect of the program.

RESPONSIBILITES

I must demonstrate the required skills and abilities needed to self-direct employees or designate an Authorized Representative to do so.
I must actively participate in developing my spending and options plan.
I must be available for home visits as policy dictates (Home visits done 1x quarterly & monthly phone calls in between) and maintain adequate communication with my Case Manager (at least 1x monthly).
I must review my monthly budget statement and monitor all expenditures to ensure that I do not exceed my monthly budget.
I must complete all necessary forms and provide information to ensure compliance with tax and labor laws.
I must manage my employees by:

- Recruiting and hiring my employees, understanding that employment is contingent on the worker providing all information required to successfully enroll the worker in the VF/EA FMS entity's payroll system.
- Setting job duties and training my employees.
- Paying my employees a fair and legal wage.
- Setting my employees' schedules in advance and reviewing time sheets to ensure they are correct.
- Supervising my employees' daily activities and reviewing the adequacy and quality of their work.
- Ensuring a safe work environment for my employees.
- Notifying Case Manager immediately if I choose no longer to employ a worker.

I must develop an emergency back-up plan if my worker is not available.
I must notify my Case Manager immediately if I am admitted to the hospital or other medical facility.
I must oversee the activities of any other service providers that provide services to me.

Important Note:

Failure to abide by these veteran responsibilities listed above but not limited to, will result in the Veteran being issued a Corrective Action Plan (CAP) first. If non-compliance continues after 30 days from the date the CAP was implemented or if this issue continues to arise, Case Manager will & has the right to seek involuntary termination from the VAMC for the veteran from the VDC Program.

By signing this form, I agree that I have read/understand my rights & responsibilities of the VDC Program and have been given the opportunity to ask questions about these rights and responsibilities:

_____ _____

Veteran or Authorized Representative Date

Veteran Directed Care (VDC) Program

Release of Information Form

I, _____ hereby give permission to the Spoke Agency and FMS Agency, which includes the Area Development Districts, to release or obtain (not limited to) the Veteran's Protected Health Information.

Name of Area Agency on Aging: _____

Agency Address:	
Agency City:	
Agency Zip:	
Agency Telephone:	

Veteran or Authorized Representative Signature: _____

Veteran or Authorized Representative Name (Printed): _____

Date: _____

Case Manager Signature: _____

Date: _____

The Veteran, Authorized Representative, or Case Manager may complete this form. The Case Manager will keep the originally signed form in the veterans file, give a copy to the veteran, and give a copy to the appropriate organization to obtain or release information.

Veteran Directed Care (VDC) Program
Fraud & Abuse Statement

Fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. Fraud includes obtaining 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 Fraud include, but are not limited to:

- Knowingly and/or purposefully filling out an employee's time sheet incorrectly for hours or services that were not provided during the times listed or on the day listed.
- Knowingly and/or purposefully allowing the Financial Management Service (FMS) to bill for services that were not provided.
- Knowingly and /or purposefully using the VDC budget for any other purpose than what has been approved in the participant's individual spending 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 FMS for goods and services that were not provided.
- Knowingly and/or purposefully having the FMS pay an individual 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 participant and his/her representative. (This is also tax fraud).
- Knowingly and/or purposely having the FMS pay for an approved individual-directed good included in the participants budget, and then return the approved individual-directed 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 the program, 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 program.

Examples of Abuse include:

- Making errors when filling out timesheets and not immediately reporting the error to the FMS to remedy the situation.
- Being late in handing in participant/representative-employer related paperwork to the FMS or the participants Case Manager.

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 VDC Program will be referred to the VAMC. Participants suspected of fraud or abuse also face termination from the VDC program.

I have read the Fraud and Abuse Statement, I understand it and agree to comply with it.

_____

Veteran or Authorized Representative's Signature Date

_____

Case Manager's Signature Date

Veteran Directed Care (VDC) Program
Background Check/Nurse Abuse Registry Agreement
(1 per Veteran / Chart)

All candidates for a veteran's Personal Assistant and/or in-home employee(s) are required to have a name-based background check prior to employment in the Veteran Directed Care (VDC) Program. The background check will be performed/requested by the Case Manager. The background check will be conducted using data from an accredited background source. In addition, all candidates must also undergo a Nurse Abuse Registry check.

☐ By marking this box, I understand & accept the terms that a **name-based background check & Nurse Abuse Registry check** has to be conducted on all personal assistant(s) and/or in-home employee(s) of my choice, prior to employment in the VDC Program as required by the Spoke and FMS agencies.

I understand I may not hire the employee until I have received and reviewed the results with my case manager, who will maintain a copy of each and provide additional copies to PeADD FMS.

I understand that I have the right to hire an employee of my choice and will assume full responsibility of hiring this person if the Spoke agency, FMS agency and VAMC approves the employee. I understand that the Spoke, FMS and VAMC staff have the right to refuse employment of an individual should the background check results show any felony charge, charge related to abuse, or listed on any type of abuse registry's. If potential employee has a criminal history, I understand that I may be required by the Case Manager to sign a background waiver form stating that the background check results have been discussed, and I still wish to hire this individual regardless of the criminal history.

If you agree to the terms mentioned above, please mark the box above & complete areas below.

Veteran or Authorized Representative Signature: _____

Veteran or Authorized Representative Name (Printed): _____

Date: _____

Case Manager Signature: _____

Case Manager Date: _____

Veteran Directed Care (VDC) Program
Worker's Compensation Acknowledgment

I, _____ (print name of Veteran or Authorized Representative) have chosen to participate in the Veteran Directed Care (VDC) Program, which is a consumer-directed publicly funded program through the federal Veterans Administration. I understand that I am directing my own services as the "Employer of Record" under this program**. I understand that I am required to obtain worker's compensation insurance for my employee(s)/ worker(s)/ PA(s) in accordance with Department of Veterans Affairs guidelines and the regulations of the state of Ohio Department of Labor.** I authorize the Pennyrile Area Development District's Financial Management staff to assist me with obtaining the worker's compensation coverage, to provide the insurance carrier with any information as may be necessary to establish the worker's compensation coverage for my worker(s), and to remit the cost of the premiums from my monthly VDC Budget allocation. I further authorize all communications from the worker's compensation insurance carrier to be mailed directly to Pennyrile Area Development District's Financial Management staff and/or Pennyrile AAAIL's VDC Coordinator (if needed) who is acting on my behalf.

I understand that if I choose to terminate my participation in the Veteran Directed Care Program, the worker's compensation coverage will be canceled effective on the date that I cease to participate in the VDC Program.

I give my authorization for a copy of this acknowledgment to be forwarded to Pennyrile Area Development District's Financial Management staff and to the worker's compensation insurance carrier.

_____ _____
Veteran Participant/Authorized Representative Signature Date

To be completed by Case Manager:

Printed Veteran's Name: _____

Address: _____ City _____ ZIP _____

Telephone #: _____

Printed Authorized Rep Name (if applicable): _____

Address: _____ City _____ ZIP _____

Telephone #: _____

Case Manager Certification:

I certify that I have reviewed this document with the participant or authorized representative and that this individual is eligible to participate in the Veteran Directed Care Program (VDC).

_____ _____
Case Manager Signature Date

Bureau of Workers' Compensation

Request to Add/Change or Terminate Permanent Authorization

To: Ohio Bureau of Workers' Compensation

☐ Employer Services Department, 22nd floor

☐ Self-Insured Department, 22nd floor

Please mark a box and return to:
30 W. Spring St.
Columbus, OH 43215-2256

Fax: 614-621-1405

Policy number
Entity
DBA
Address _____ , OH

Note: For this to be a **valid** letter, the employer services department, or the self-insured department for self-insuring employers, must stamp it.

This is to certify that effective _____
(Date)

Pennyrile Area Development District 224544-80
(Representative name and rep ID number)

Including its agents or representatives identified to you by them, has been terminated or retained to represent us before the Ohio Bureau of Workers' Compensation and the Ohio Industrial Commission in matters pertaining to our participation in the workers' compensation fund according to the type of representation checked below.

Please check only one type of representation. See description of representatives at the bottom of this form.

✓ **Type of authorized representation addition/change or termination** ☒ Add ☐ Terminate	
☐ Employer-risk claim representative (ERC)	☐ Risk-management representative (RISK)
☐ Claim-management representative (CLM)	☒ Payroll service vendor (PSV)

This authorization supersedes all permanent authorizations on file for the type of representation indicated above.

I understand and agree BWC will process any letters, requests and actions initiated by a superseded authority.

I understand this authorization, now being granted, is of a continuous nature from the effective date indicated herein. However, I possess the right to terminate this authorization at any time through written notification to the employer services or self-insured departments as appropriate.

Telephone number	Fax number	Email address	
Print name and title VDC, Employer of Record		Submitter signature	Date

BWC authorized representative service/roles

Employer-risk claim representative (ERC) – The ERC is designated as the employer's authorized representative for both risk- and claims-management-related issues. He or she is also the employer's authorized representative on each claim under the employer's policy number. The ERC receives copies of all risk and claim correspondence. The ERC has full access to the employer's risk information and information pertaining to the workers' compensation claims filed against the employer. He or she will also have the authority to access such information on bwc.ohio.gov.

BWC will consider the ERC as the authorized representative in handling risk-related issues for an employer if there is no designated group-risk claim representative (GRC). BWC also will consider the ERC as the authorized representative in handling claim-related issues for an employer if there is no designated CLM or GRC.

Risk-management representative (RISK) – The RISK is the employer's designated authorized representative for risk-related issues. He or she represents an employer on risk-related issues only. The RISK receives copies of all risk correspondence. A RISK will have access to only the employer's risk-related information and authority to access that information on bwc.ohio.gov.

BWC will consider the RISK as the authorized representative in handling risk-related issues for an employer if there is no designated GRC or ERC. The RISK will have no authority to represent the employer on any matters if either a GRC or ERC is appointed. In addition, the RISK will have access only to the employer's risk-related information and authority to access that information on bwc.ohio.gov.

Claims-management representative (CLM) – The CLM is the employer's designated authorized representative on each claim associated with the employer. He or she will receive copies of all claim correspondence. The CLM represents an employer on claim-related issues only. A CLM will have access only to information pertaining to the workers' compensation claims filed against the employer and authority to access that information on bwc.ohio.gov.

BWC will consider the CLM the authorized representative in handling claims-related issues for an employer.

Payroll service vendor (PSV) – A payroll service vendor provides payroll services, including reporting and/or withholding and remittance services for workers' compensation premium payments.

Note: Based on the designation made by the group's sponsor, only the employer services group-rating unit can update a GRC.

You cannot use the AC-2 to select a GRC authorization. This representative type only applies to private employers and public employer taxing districts. BWC will consider the GRC the authorized representative in handling risk-related issues for an employer. In addition, BWC will consider the GRC the authorized representative in handling claim-related issues for an employer if there is no designated claims-management representative (CLM).

Bureau of Workers' Compensation

Application for Ohio Workers' Compensation Coverage

Have questions? Need assistance? We are here to help!

- **Call 1-800-644-6292 and listen to the options to reach a customer service representative available Monday through Friday from 7:30 a.m. to 5:30 p.m. EST.**
- **International callers please call 1-614-367-5743.**
- **Visit our website for more information at bwc.ohio.gov.**
- **Complete all required fields (*) to avoid processing delays.**
- **Applications without a $120 non-refundable application fee will be returned, not processed, and delay the effective date of coverage.**

How to apply

- **Online:** at bwc.ohio.gov by completing all required fields and submitting payment of $120 using Visa, MasterCard, American Express, checking account, or savings account.
  - Save in progress will allow you up to 15 days to complete the application process.
  - Coverage is not in effect until the date the application with $120 is submitted successfully to BWC.
  - State-fund public employers – defined as school districts, counties, townships, or other public employer taxing districts will need to provide a copy of the resolution, meeting minutes signed by an appointing authority, and any court order creating the entity. This information will be requested when your application is being processed.
  - Live chat support is available Monday through Friday, 8 a.m. - 5 p.m.
- **Mail:** Complete all required fields on this application, along with any additional details, and mail the completed, signed application with a check/money order for $120 to:

  Ohio Bureau of Workers' Compensation
  P.O. Box 15698
  Columbus, OH 43215-0698
  Payable to: Ohio Bureau of Workers' Compensation
  - Coverage is not in effect until the completed application, with the $120 application fee is received by BWC.
- **In person:** Refer to the BWC service office locator bwc.ohio.gov under Contact Us for a local service office to drop off an application with a check/money order for the $120 nonrefundable application fee for processing.

Facts about a policy

- State-fund private employers' policies **renew every July 1** until you request cancellation in writing. (Ohio Administrative Code, (OAC) 4123-17-01(A))
- State-fund public employers' policies **renew every Jan. 1** until you request cancellation in writing. (OAC 4123-17-01(B))
- Volunteers cannot be covered under a policy unless they meet the definition of an emergency volunteer.
- An officer of a nonprofit entity who volunteers his/her services as a corporate officer to a nonprofit entity is not considered an employee for workers' compensation purposes and should not be included in payroll.

Who needs a policy?

- Any entity or employer with employees whose hiring contract was completed within the borders of Ohio.
- Any entity or employer with employees, and the employer's main supervising office is located within Ohio.
- Corporations with more than one owner/officer, the owner/officers meet the definition of statutory employee and are subject to minimum/maximum reporting of payroll unless meeting criteria for exclusion. See elective coverage for more information.
- Independent contractors and subcontractors with employees.
- Domestic household employer who pays a worker at least $160 in a calendar quarter, or any consecutive 13-week period. Job duties often include cooking, gardening, housekeeping, babysitting, etc.
- Domestic household employers hiring a contractor to perform home improvement and/or construction activities – You may want to verify they have their own active workers' compensation coverage.
- Sole proprietors or partners, and an individual incorporated as a corporation without employees if they wish to obtain coverage for themselves.

Required fields/areas are indicated by an asterisk (*) and must be completed to avoid processing delays.

General Information*

- Legal business name/homeowner
  - Legal business name includes name(s) of individual(s) for a sole proprietor, partnership, or domestic household employers (homeowner).
  - Please limit the name to 40 characters. If additional space is needed, either abbreviate or use the "doing business as" name(s) field for any overflow.

Instructions

Identification number*

- Federal identification number or Social Security number for the business.

Do you currently have any employees earning wages in Ohio? Or do you plan on hiring employees within the next 12 months?*

- If *yes,* provide the date you first hired an Ohio employee, or plan to hire an Ohio employee in the next 12 months.
  - Ohio Revised Code (ORC) 4123.01 – definition of an employee and includes corporate officers earning wages in Ohio as statutory employees, subject to minimum/maximum payroll reporting.
- If *no*, answer the No Employee Questionnaire at the end of this form.
- A no coverage penalty will be calculated from the first hire date through the effective date of the policy.
- Estimated no coverage penalty is calculated using the 12-months payroll estimate and classification for employees.
- The no coverage penalty will be adjusted if actual payroll is provided.

Business address(es)*

- Primary location
  - P.O. Box is not permitted.
  - Ohio location preferred.
  - If you are an out of state entity or there is no physical Ohio location for the business, provide the location responsible for handling and resolving your policy issues.
- Mailing address
  - All policy related correspondence, including invoices.
- Additional locations
  - To cover an additional entity under one policy, it must have the same ownership group.
  - If more than one, attach to the end of the application.
- Business communication
  - Business email
  - Business phone
  - Mailing address attention to individual may be added for mailing policy correspondence.
  - Business website
  - Business fax

Contacts*

- Up to two contacts may be added.

Business entity type*

- Association - In general, an association is a group of persons banded together for a specific purpose.
- Corporation – Conducts business, realizes net income or loss, pays taxes, and distributes profits to shareholders.
- Family farm corporation – A corporation founded for the purpose of farming agricultural land in which the majority of the voting stock is held by and the majority of the stockholders are persons or the spouse of persons related to each other within the fourth degree of kinship, according to the rules of the civil law, and at least one of the related persons is residing on or actively operating the farm, and none of whose stockholders are a corporation.
- Individual incorporated as a corporation (I-Corp) – A corporation with one sole owner/officer and no employees.
- Limited liability company acting as a corporation – An entity created by state statute and the number of members may vary.
- Limited liability company acting as a partnership – A domestic limited liability company with at least two members is classified as a partnership for federal income tax purposes unless designated on IRS Form 8832 to be treated as a corporation. Required at least 51% ownership provided to continue processing without delays.
- Limited liability company acting as a sole proprietor – If an LLC has only one member and is classified as entity disregarded from its owner, its income, deductions, gains, losses, and credits are reported on the owner's income tax return.
- Limited partnership – For professional partnerships, such as law firms or accounting firms. Required at least 51% ownership provided to continue processing without delays.
- Partnership – A relationship existing between two or more persons who join to carry on a trade or business. Each person contributes money, property, labor or skill, and expects to share in the profits and losses of the business.
- Sole proprietor – Someone who owns an unincorporated business by himself or herself.
- State/local government – The state, including state hospitals, each county, municipal corporation, township, school district, and hospital owned by a political subdivision.

Charter details

- Any limited liability company, corporation, or association must provide:
  - Charter details often filed and provided by the Secretary of State's office in the state in which the entity is registered.
  - Charter number
  - Incorporation date
  - State of incorporation

Instructions

Homeowner/Domestic employer

- Make the appropriate selection of the job description or duties for a domestic employee.
- One who pays workers $160 or more in any calendar quarter from a single household. BWC defines a calendar quarter as any consecutive 13-week period.

Special employer types

- For Professional Employer Organizations (PEO) refer to Ohio Revised Code 4125, et seq., Ohio Adm. Code 4123-17-15 for appropriate statutes and rules.
- For Alternate Employer Organizations (AEO) refer to Ohio Revised Code 4133, et seq., Ohio Adm. Code 4123-17-15 for appropriate statutes and rules.
- Respond to the special employer type questions.
- These employer types will have additional forms required for processing and to ensure the proper coverages are issued.

Out-of-state considerations

- Ohio employers with Ohio employees working outside the state and have coverage in the other state for exposure.
- Will need to file Notice of Election to Obtain Coverage from Other States for Employees Working Outside of Ohio (U-131).
- Other states coverage may be an option for these employers to seek.

Elective coverage

- Coverage on certain owners or ministers is voluntary. Listed below are the individuals who qualify for elective coverage (OAC 4123-17-07).
  - Sole proprietor
  - Partnership
  - Limited liability company acting as a sole proprietor
  - Limited liability company acting as a partnership
  - Family farm corporate officers
  - Ordained or associate minister of a religious organization
  - Individual incorporated as a corporation (I-Corp)
- Acknowledgement required for reporting requirements and how to cancel.

How much will it cost?

- Minimum/maximum reporting guidelines. (OAC 4123-17-30)
- Ordained ministers and associate ministers of a religious organization report their actual payroll, with no applicable minimum.
- Job duties and business pursuit determine the classification & rate for premium.
- Every July coverage renews and will continue to be charged until you request cancellation in writing.
- Example: Coverage added July 1, 2020, for a sole proprietor who does roofing, receiving no discounts, and makes under the minimum payroll required to report for the year.
  - $25,480 * .099625 = $2,538.45 annual premium from July 1, 2020, through July 1, 2021

What about independent contractors or sub-contractors?

- If you are an independent contractor or sub-contractor applying for a policy, and you are applying as a sole proprietor, coverage on yourself is elective.
- If adding elective coverage, premium will be calculated and assessed in addition to the $120 minimum premium.
- If you add coverage, see **How much will it cost?** for wage reporting requirements.

What if I do not add elective coverage with this application?

- Apply later to add using BWC U-3S.
- Coverage is added the date we receive your completed application, and applicable premiums charged.
- **Note:** If you choose not to add elective coverage for these individuals and he/she is injured at work, other insurance may not cover the work-related disability or medical bills.

Does the church need coverage for a minister?

- Ordained ministers are not considered employees for the purpose of workers' compensation by Ohio law and therefore, a church must add coverage for the ministers they want to cover under its policy.
- If the religious entity does not choose to cover a minister and the minister wants to have workers' compensation coverage, they would need a policy as a sole proprietor and add elective coverage for themselves. The minimum and maximum reporting for payroll would apply. See **How much will it cost?** for more information.

How do I cancel elective coverage?

- Must cancel coverage in writing. If written cancellation notice is not received, coverage will remain, and you will be invoiced applicable premiums.
- Coverage will renew each July unless we receive a written request to cancel.
- Failure to pay billed premiums will lapse your coverage; however, you will continue to be charged premiums during any lapsed period.

Owner/Officer/Minister information

- Thoroughly complete owner/officer/minister information to avoid processing delays.
- Information required for owners/officers/ministers to submit this application.
  - Name
  - Home mailing address
  - Social Security number
  - Title
  - Job duties
  - Phone number and email address

Instructions

Description of operations*

- Describe, in detail, your services and/or products, including the method of operations performed in Ohio.
- List details including any machinery, equipment, tools and raw, semi-finished materials used to perform all duties.
- Mark the best industry selection and checkbox to match your operations.
  - Refer to OAC 4123-17-04 for more information and rules around classification.
  - Refer to OAC 4123-17-08 for the rules regarding the assignment of class codes.

Estimated annual payroll by operation type*

- Provide the 12-month estimated Ohio payroll for each operation conducted by employees and the estimated number of employees in each.
- Include corporate officers in payroll totals pursuant to the OAC 4123-17-14.
- Any included coverage individual(s) estimated 12-month payroll per minimum/maximum rules, OAC 4123-17-07.
- Used to estimate and calculate any applicable no coverage penalty.

Premium payment installment plan

- Choose the payment plan best for the business, and we will do our best to accommodate your selection.
- Annual premiums totaling $250 or less will be billed as a one pay, due at the beginning of each policy year.
- If your preferred installment plan is unavailable, we will pick the closest plan when your application is being processed.
- The preferred plan on the application will be noted for consideration upon renewal of the policy.

Business formation and policy affiliations*

- Indicate the selection that best describes how the operation or business was established.
- Notice of purchase, sale, merger information involving other policies.
  - Need payroll records up to five years from the previous employer.
  - Refer to OAC 4123-17-02 for the definition of successor requiring notice to workers' compensation, even with no purchase involved in some instances.
- Operations being continued by a family member with an active policy, you may submit to update the existing policy and may not need to complete this application.
  - You may complete the Notification of Policy Update (U-117) with necessary ownership details and signatures.
  - And, Notification of Business Purchase/Merger/Sale (U-118) to make additional updates and obtain necessary signatures for changes on an existing policy.
- Provide information of affiliated policies for those owners or officers with ownership of the new entity.

Certification to submit application*

- Provide the name, title, and date of the individual completing the application when submitted.

No employee questionnaire

- For those needing a certificate of coverage without providing coverage for any employees, or being amenable by state law, to gather additional information why the policy and coverage are desired and properly underwrite the policy.

After my application is processed, what's next?

- Log in to bwc.ohio.gov for additional access after your policy is issued. Most information is found on our website at bwc.ohio.gov.
- Receive your Certificate of Coverage
- An invoice statement showing the reconciliation of the $120 application fee and any additional premiums or calculated no coverage penalty for applicable employers.

How to contact us

Toll-free: 1-800-644-6292,
Monday through Friday, 7:30 a.m. – 5:30 p.m.

- Hearing impaired:
  The Ohio Relay Service (ORS) provides full telephone accessibility to people who are deaf, deaf-blind, hard-of-hearing or speech- disabled. Specially trained Communication Assistants (CAs) process relay calls and stay on the line to relay conversations electronically, over a Text Telephone (TTY) or, in some cases, verbally to hearing parties.
  To contact ORS, call 7-1-1 and have the telephone number that you wish to call ready in advance.
- Live chat support is available during the application process Monday through Friday, 8 a.m. – 5 p.m.

Bureau of Workers' Compensation

Application for Ohio Workers' Compensation Coverage

Have questions? Need assistance? We are here to help!

- **Call 1-800-644-6292 and listen to the options to reach a customer service representative available Monday through Friday from 7:30 a.m. to 5:30 p.m. EST.**
- **International callers please call 1-614-367-5743.**
- **Visit our website for more information at bwc.ohio.gov.**
- **Complete all required fields (*) to avoid processing delays.**
- ***BWC will return applications without the $120 non-refundable application fee.***

*General information

*Legal business name/Homeowner	*Federal employer identification number/Social Security number

Doing business as

*Do you currently have any Ohio employees? Or do you plan on hiring Ohio employees within the next 12 months? ☒ Yes ☐ No *(*Note: If you do not have employees and will not be hiring any, complete the No Employee Questionnaire at the end of this form.)*	*First hire date

*Business address

*Primary physical location (Ohio preferred) address line 1 (P.O. Box not allowed)	Address line 2

*City	*State	*ZIP code

Mailing address ☐ Check if your mailing address is the same as above.

*Mailing address line 1
300 Hammond Dr

*City	*State	*ZIP code
Hopkinsville	KY	42240

Additional Ohio business name

Additional Ohio physical location address line 1 (P.O. Box not allowed)	Address line 2

City	State	ZIP code
	OH	

Note: List any additional locations at the end of this form.

*Business communication

*Business email	*Business phone	Is this a cell phone? ☐ Yes ☒ No
vdcfms@ky.gov	270-886-9484	

Mailing address attention to	Business website	Business fax
VDC FMS		

Contacts

*Primary contact name (First, Middle Initial, Last, and Suffix)
Stephanie E Starr

*Contact email	*Contact phone	Is this a cell phone? ☐ Yes ☐ No
vdcfms@ky.gov	270-886-9484	

*Title/Contact type
Senior Staff Accountant, Pennyrile Area Development District/FMS for Veterans Directed Care Program

Secondary contact name
Hayla J Swaw

Contact email	Contact phone	Is this a cell phone? ☐ Yes ☒ No
vdcfms@ky.gov	270-886-9484	

Legal business name	Quote/Policy (BWC use only)

Title/Contact type

Deputy Chief Financial Officer, Pennyrile Area Development District/FMS for Veterans Directed Care Program

*Business entity type

- [x] Sole proprietor
- [ ] Partnership
- [ ] Limited liability company acting as a sole proprietor**
- [ ] Limited liability company acting as a partnership**
- [ ] Limited partnership**
- [ ] Limited liability company acting as a corporation**
- [ ] Association**
- [ ] Individual incorporated as a corporation**
- [ ] Corporation**
- [ ] Family farm corporation**
- [ ] State/Local government

Note: For the above (**) entities, complete the required fields below (**).

**Charter number	**Incorporation date	**State of incorporation

Homeowner/Domestic employer

- [ ] **Construction – new home, room addition, remodel, roofing** (Adding a new room addition to an existing home, roofing a house, having a deck put on, installing a fence, kitchen remodel, etc.)
  - [ ] Hiring an insured contractor
  - [ ] Hiring my own employees/labor - for a homeowner and not contractors
- [x] **Domestic inside/outside help** (Cook, babysitter, gardener/lawn care, housekeeper, etc.)
- [ ] **Home improvement/maintenance** (Interior painting of room, door/window repair, drywall repair, minor carpentry work, etc.)

Special employer types

These employer types have additional forms required for processing and to ensure proper coverage. These entities must also register with BWC and follow all appropriate statutes and rules.

Are you a Temporary Service/Staffing Agency? ☐ Yes ☒ No

Are you a Professional Employer Organization (PEO)? ☐ Yes ☒ No

Are you an Alternative Employer Organization (AEO)? ☐ Yes ☒ No

Are you a nonprofit organization? ☐ Yes ☒ No

Out-of-state considerations

If you are an Ohio based employer, do you have employees from Ohio who will be working temporarily in another state and have a separate policy to cover them? ☐ Yes ☒ No

*If yes, we will send you a Notice of Election to Obtain Coverage from Other States for Employees Working Outside of Ohio (U-131), or you can download it from the employer forms section of our website.

Elective coverage

Complete ownership must be provided for any sole proprietor or partnership entity types to equal 100% total ownership. Churches who wish to cover their ministers must provide the demographic information for the minister and should read the below regarding elective coverage. If you find a need for elective coverage later, complete the Application for Elective Coverage (U-3S).

Coverage on the owner/officer(s) of certain entity types, or coverage for a minister is voluntary. Listed below are the individuals who qualify for elective coverage (OAC 4123-17-07). See the instructions for additional information and requirements for reporting of wages and premiums.

- Sole proprietor
- Partnership
- Limited partnership
- Limited liability company acting as a sole proprietor
- Limited liability company acting as a partnership
- Family farm corporate officers
- Ordained or associate minister of a religious organization
- Individual incorporated as a corporation (with no employees) (I-corp)

If individuals at the company meet the qualifications for elective coverage, you must enter their name and demographic details in the owner/officer/minister information section. If you select yes to add elective coverage, understand by doing so, you are acknowledging and agreeing to the minimum and maximum payroll reporting requirements outlined in the instructions and in accordance with OAC 4123-17-30. Remember, if you do not cover this individual, and that person is injured at work, BWC will not provide coverage, and other insurance may not cover a work-related disability or related medical bills.

Initial to acknowledge you have read and understand the elective coverage guidelines. ☐

Legal business name	Quote/Policy (BWC use only)

*Owner/Officer/Minister information

*Name (First, Middle Initial, Last, and Suffix)
☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms.

*Home mailing street address

*City	*State	*ZIP code
*Social Security number	Date of birth	*Ownership % 100%
*Email	*Phone number	Is this a cell phone? ☐ Yes ☐ No

***For individuals that qualify for elective coverage, do you wish to elect coverage? (See elective coverage section)**
☐ YES, add elective coverage for this person and agree to reporting and cancellation requirements per OAC 4123-17-30.
☒ NO, do not add coverage for this person, and understand that BWC will not pay benefits for a work-related injury for this person since coverage is declined.

*Job duties	*Title
Recipient or Recipient Representative of Veterans Directed Care services through the Department of Veterans Affairs. Services include Homemaking, Personal Care, Transportation, etc.	Household Employer Are you a volunteer for a nonprofit entity? ☐ Yes ☒ No

*Name (First, Middle Initial, Last, and Suffix)
☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms.

*Home mailing street address

*City	*State	*ZIP code
*Social Security number	Date of birth	*Ownership %
*Email	*Phone number	Is this a cell phone? ☐ Yes ☐ No

***For individuals that qualify for elective coverage, do you wish to elect coverage? (See elective coverage section)**
☐ YES, add elective coverage for this person and agree to reporting and cancellation requirements per OAC 4123-17-30.
☐ NO, do not add coverage for this person, and understand that BWC will not pay benefits for a work-related injury for this person since coverage is declined.

*Job duties	*Title
	Are you a volunteer for a nonprofit entity? ☐ Yes ☐ No

*Name (First, Middle Initial, Last, and Suffix)
☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms.

*Home mailing street address

*City	*State	*ZIP code
*Social Security number	Date of birth	*Ownership %
*Email	*Phone number	Is this a cell phone? ☐ Yes ☐ No

***For individuals that qualify for elective coverage, do you wish to elect coverage? (See elective coverage section)**
☐ YES, add elective coverage for this person and agree to reporting and cancellation requirements per OAC 4123-17-30.
☐ NO, do not add coverage for this person, and understand that BWC will not pay benefits for a work-related injury for this person since coverage is declined.

*Job duties	*Title
	Are you a volunteer for a nonprofit entity? ☐ Yes ☐ No

Legal business name	Quote/Policy (BWC use only)

*Description of operations

Describe your services and/or products, including your method of operations performed in Ohio. List any machinery, equipment, tools, raw, and semi-finished materials used to perform all duties.

As Veteran or Veteran Representative in the Veterans Directed Care Program, my repsonsibilites are as follows:

- Complete, sign, and send VDC Veteran Enrollment Packet to Case Manager, who will send to PeADD.
- Retain Employer Identification Number letter from the IRS requested by PeADD online on your behalf for your records.
- Recruit and hire workers: Download appropriate state Employee Enrollment Packet from PeADD website or contact your assigned Case Manager to ask for a packet to be sent to you; provide worker packet to potential workers; understand that employment is contingent on the worker providing all information required to successfully enroll the worker in the Vendor Fiscal/Employer Agent (VF/EA) FMS entity's payroll system and ensure compliance with tax and labor laws.
- Verify worker qualifications, including the participant-worker relationship.
- Authorize criminal background checks on your authorized representative and potential employees.
- For Respite care, the worker cannot be the participant's guardian, conservator, parent or stepparent.
- Help select the services the participant will receive.
- Orient, train, schedule, and supervise worker.
- Schedule worker to provide services for payment only after being authorized by PeADD.
- Establish performance evaluation criteria for each worker.
- Provide a safe workplace free from excess hazards, employment discrimination, and harassment.
- Request worker to perform permitted and planned for duties, as determined in the Individual Participant Plan.
- Verify services provided by the worker by reviewing and approving (signing) timesheets, invoices, and documentation of services rendered, and ensuring submission to Case Manager in a timely manner.
- Ensure that timesheets are submitted within 3 days of the end of the pay period for the worker to be paid timely.
- Monitor your use of authorized services that can include homemaking, personal care, transportation, etc. All services are unskilled services intended to keep the veteran in the home and not in a long term care facility.
- Act in accordance with the policies and procedures outlined in your employment agreement.
- Notify workers in advance if services are not required or if participant is no longer eligible for services.
- Accept responsibility for payment of services not authorized in approved spending plan.
- Ensure that there is no misrepresentation of time, services, individuals, and/or other information

Industry groups

Mark the best selection(s) to describe those business operation(s) and/or goods/services provided.

☐ **Agriculture**	☐ **Utility**
☐ **Extraction**	☐ **Commercial**
☐ **Manufacturing**	☒ **Service**
☐ **Construction**	☐ **High risk commercial/Service**
☐ **Transportation**	☐ **Office work/Miscellaneous**

Legal business name	Quote/Policy (BWC use only)

Estimated annual payroll

Include the employee operation type, estimated number of employees, and estimated 12-month payroll. Include any owner/officer(s) of a corporation, association, or a limited liability company acting as a corporation (except for individuals incorporated as a corporation without employees). These owner/officer(s) are covered as statutory employees (i.e., coverage is not voluntary) and *should* be included in the estimated annual payroll.

***Operation type** (List all types - attach additional sheets if necessary). Provide estimated information for all employees including corporate officers as noted above.	Estimated number of employees	Estimated total payroll
Clerical office personnel (no duties outside the office, in sales or service, no counter service or exposure to factory operations)		
Clerical telecommuter (clerical employees working from residence)		
Domestic workers - residences (not for construction entities)	1-4	$11,000-$63,000
Drivers (truck or delivery)		
Traveling salespeople (no handling, service, or delivery)		

Elective coverage annual payroll

*If you have elected coverage for an individual, list their names below and estimate the 12-month payroll for each. You must follow the minimum/maximum reporting requirements for these individuals as outlined, which can be found online at www.bwc.ohio.gov.

Name of individual electing coverage	Estimated total payroll
N/A	

Installment plan selection

Select the installment option you prefer for the next full policy year. For premiums totaling $250 or less BWC will set an annual payment plan. Otherwise, if a selection is not made, a bimonthly (6) payment plan will be selected.

☐ Annual (1) ☐ Semiannual (2) ☐ Quarterly (4) ☐ Bimonthly (6) ☒ Monthly (12)

For partial policy years, not starting on July 1, BWC will match as closely as possible to your selection.

*Business formation/Purchase/Sale

***Which best describes the business formation in Ohio?**

☒ Formation of a new entity operating in Ohio
☐ Asset purchase only**
☐ Involuntary transfer**
☐ Merger**
☐ Purchase**

Note: For any (**) above, you *must* complete the related purchase/sale & policy affiliations below. Any information omitted is subject to BWC findings and process.

Legal business name	Quote/Policy (BWC use only)

Purchase/Sale & Policy affiliations

*Prior business name	Prior policy number

*Date of transaction for purchase/merger/transfer

*Is there a written agreement with this transaction? ☐ Yes ☐ No (If yes, BWC may request a copy of the agreement.)

*Are you aware of any portions of the former business still having additional ongoing operations? ☐ Yes ☐ No

If yes, provide detail

*How many employees did you hire from the former employer?

*Are you operating in the same location as the former employer had? ☐ Yes ☐ No

*Do you continue to service the contracts or client lists of the former employer? ☐ Yes ☐ No

*During the transfer, have operations continued without interruption? ☐ Yes ☐ No

*Are you conducting business in a similar manner as the former employer? ☐ Yes ☐ No

If no, provide detail

*Name of the individual to contact regarding this transaction

*Email	*Phone number	Is this a cell phone? ☐ Yes ☐ No

*Have any of the owners/officers associated with this business been affiliated with another Ohio workers' compensation policy before now? ☐ Yes ☐ No
If yes, please list the names of those owners/officers or businesses and policy number(s), if known.

Prior business name	Prior policy number

Certification

I, _____ (print certifier name) certify I have the authority to execute this application, and that the facts set forth on this application are true and correct to the best of my knowledge and belief. I am aware that any person who does not secure or maintain workers' compensation coverage and pay all appropriate premiums in accordance with Ohio laws, or misrepresents, conceals facts, or makes false statements to obtain coverage may be subject to civil, criminal, and/or administrative penalties.

Certifier signature _____ **Title** VDC Employer of Record **Date** _____

WARNING: The policy is not in effect until BWC receives the completed application with the $120 non-refundable application fee. In addition, coverage is contingent on the timely receipt of the first installment payment. BWC cannot process incomplete applications or applications submitted without payment. Signature and date are required.

BWC USE ONLY

Policy number	Quote number	Effective date	Payment type ☐ Money order ☐ Check	Payment amount	Date received	Initials

Veteran Directed Care (VDC) Program
Mental/Emotional/Behavioral Health Assessment (MEBH)

Referral Date _____ Diagnosis Code: _____

Date Assessed _____ Date Reassessed _____

Respondent (specify relationship) _____

Case Manager _____

Last Name _____ **First Name** _____ **MI** _____

Address 1 _____

Address 2 _____

City _____ Zip Code _____ County _____

Home Phone _____ Other _____ DOB _____

Sex: ☐ Male ☐ Female Primary Language _____

Marital Status: ☐ Married ☐ Never Married ☐ Separated ☐ Divorced ☐ Widowed

Social Security # _____

Medicaid # _____

Medicare Number _____ ☐ A ☐ B ☐ C ☐ D

Private/Supplemental _____ Policy # _____

VA Identification #s _____

Main Support:

Name _____

Relationship _____

Phone _____

Alt. Phone _____

Back Up Support:

Name _____

Relationship _____

Phone _____

Alt. Phone _____

Emergency Contact: Check here if same as main support

Name _____

Relationship _____

Address _____

City, State, Zip _____

Phone _____ Alt. Phone _____

Emergency Plan:
Specify who would provide backup support in the event of an emergency, inability of employee to provide care, and/or lack of hired employee(s).

Name _____

Relationship _____

Address _____

City, State, Zip _____

Phone _____ Alt. Phone _____

Comments:

Court Appointed Conservator/Guardian (if applicable):

Name _____

Relationship _____

Address _____

City, State, Zip _____

PHYSICAL HEALTH

Date of last hospitalization _____

Reason for last hospitalization _____

Diagnosis (provide details)

- ☐ CVA _____
- ☐ Myocardial Infarction _____
- ☐ Heart Disease _____
- ☐ Emphysema/COPD _____
- ☐ Other Lung Disease _____
- ☐ Neuromuscular Disease _____
- ☐ Rheumatoid/Ostoe _____

- [ ] Osteoporosis _____
- [ ] Alzheimer's/Dementia _____
- [ ] Chronic Head Aches _____
- [ ] Eating Disorder _____
- [ ] Amputation _____
- [ ] Blood Disorder/Disease _____
- [ ] Diabetes _____
- [ ] Hazardous Exposure _____
- [ ] Infectious Disease _____
- [ ] Cancer _____
- [ ] Digestive Disorder _____
- [ ] UTI _____
- [ ] Agent Orange Exposure _____
- [ ] Spinal Cord Injury _____
- [ ] Mental Illness _____
- [ ] PTSD _____
- [ ] Traumatic Brain Injury _____
- [ ] Fracture/Injury _____
- [ ] Decubitus/Stasis Ulcer _____
- [ ] CHF _____
- [ ] Incontinence _____

Other Diagnosis (please specify):

Alcohol Use:

- [ ] N/A
- [ ] Occasional
- [ ] Almost Every Day
- [ ] Every Day

Recreational Drug Use:

- [ ] N/A
- [ ] Occasional
- [ ] Almost Every Day
- [ ] Every Day

Nutrition --- Special Diet: ☐ Yes ☐ No

If yes, specify: _____

Comments

PHYSICAL ENVIRONMENT

Living Arrangement:

☐ Alone ☐ With Child(ren) ☐ With Spouse
☐ With Relatives ☐ With Non-Relatives

Housing (check all that apply):

☐ Apartment ☐ Low-Income Housing ☐ Boarding House
☐ Home of Relatives ☐ Owns Home ☐ Subsidized
☐ Senior Housing ☐ Condominium ☐ Residential Care
☐ Mobile Home ☐ Other (Please specify: _____)

Check each category	YES	NO	NEEDS REPAIR	COMMENTS
Sound building	☐	☐	☐	
Sound furnishings	☐	☐	☐	
Running water (hot/cold)	☐	☐	☐	
Adequate heating/cooling	☐	☐	☐	
Tub/shower/commode (accessible & useable)	☐	☐	☐	
Stove/microwave	☐	☐	☐	
Refrigerator	☐	☐	☐	
Freezer Space	☐	☐	☐	
Telephone	☐	☐	☐	
TV/Radio	☐	☐	☐	
Washer/Dryer	☐	☐	☐	
Adequate space	☐	☐	☐	

Check each category	YES	NO	NEEDS REPAIR	COMMENTS
Adequate lighting	☐	☐	☐	
Adequate locks	☐	☐	☐	
Neighborhood safe/secure	☐	☐	☐	
Free of insects/rodents	☐	☐	☐	
Smoke Detectors	☐	☐	☐	
Free of architectural barriers	☐	☐	☐	
CO2 detectors	☐	☐	☐	

Additional Comments:

Is there a weapon in the home and where?

Overall review of physical environment

ASSISTIVE DEVICES & SENSORY IMPAIRMENT

	HAS	USES	NEEDS	COMMENTS
Bed Pan	☐	☐	☐	
Bedside Commode	☐	☐	☐	
Elevated Toilet Seat	☐	☐	☐	
Tub Seat	☐	☐	☐	
Grab Bars	☐	☐	☐	
Cane/Crutches	☐	☐	☐	
Walker	☐	☐	☐	
Hospital Bed	☐	☐	☐	
Lift Chair	☐	☐	☐	

	HAS	USES	NEEDS	COMMENTS
Wheelchair	☐	☐	☐	
Prosthesis	☐	☐	☐	

List other assistive devices

Vision

- ☐ Adequate
- ☐ Moderate Loss
- ☐ Severe Loss
- ☐ Total Blindness

Hearing

- ☐ Adequate
- ☐ Moderate Loss
- ☐ Severe Loss
- ☐ Total Deafness

MENTAL/EMOTIONAL/BEHAVIORAL HEALTH

Cognitive Functioning: ☐ 0 – Alert ☐ 1 - Confused ☐ 2 – Forgetful ☐ 3 - Disoriented

Comprehension:

- ☐ 0 – Understands – clear comprehension.
- ☐ 1 – Usually understands – misses some part/intent of message, but comprehends most conversation with little or no prompting.
- ☐ 2 – Often understands – misses some part/intent of message, with prompting can often comprehend conversation.
- ☐ 3 – Rarely/never understands.

Decision Making Ability:

- ☐ 0 - Consumer makes consistent, reasonable decisions.
- ☐ 1 - Consumer makes simple decisions without assistance.
- ☐ 2 - Consumer makes poor decisions and needs cues/supervision.
- ☐ 3 - Consumer is severely impaired and rarely makes his/her decisions.

Short Term Memory Impairment:

- ☐ 0 - N/A
- ☐ 1 - Consumer has short term memory impairment.
- ☐ 2 - Memory lapses resulting in frequently not performing tasks even with reminders.
- ☐ 3 - Memory lapses resulting in inability to perform routine tasks on daily basis.

BEHAVIOR PATTERN	No Problem (0)	Moderate Problem (1) (but not daily)	Serious Problem (2) (nearly every day)
Physically/verbally abusive or assaultive	☐	☐	☐
Angry, threatening behaviors	☐	☐	☐
Threats to health and safety	☐	☐	☐
Wandering	☐	☐	☐
Repetitive Actions	☐	☐	☐
Rummaging, hoarding, hiding, losing items	☐	☐	☐
Suspicious	☐	☐	☐
Sundowners	☐	☐	☐
Inappropriate Behaviors	☐	☐	☐

Mental Health Screening:

☐ 0 – No ☐ 1- Yes During the last six months, have you had a lack of interest in most activities?

☐ 0 – No ☐ 1- Yes During the last six months, have you had problems sleeping?

☐ 0 – No ☐ 1- Yes During the last six months, have you felt down, depressed, hopeless?

☐ 0 – No ☐ 1- Yes During the last six months, have you felt devalued as a person?

Comments

SUBTOTAL MENTAL/EMOTIONAL/BEHAVIOR HEALTH --

☐

ADL/IADL ASSESSMENT

ADLs Help Needed	None (0 pt)	Mild (1)	Severe (2)	Total (3)	Needs Met By	Needs Unmet	Totally Met	Partially Met	Freq.
Feed Self						☐	☐	☐	☐
Transfer						☐	☐	☐	☐
Toileting						☐	☐	☐	☐
Peri Care						☐	☐	☐	☐
Bathing						☐	☐	☐	☐
Grooming						☐	☐	☐	☐
Trim Nails						☐	☐	☐	☐
Dressing						☐	☐	☐	☐
Walking						☐	☐	☐	☐
Balance Problems						☐	☐	☐	☐
TOTAL SCORES									

Comments:

IADLs Help Needed	None (0 pt)	Mild (1)	Severe (2)	Total (3)	Needs Met By	Needs Unmet	Totally Met	Partially Met	Freq.
Meal Prep									
Open Jars, Cans, Bottles									
Shopping/ Errands									
Light Housework									
Heavy Housework									
Handling Finances									
Telephone Use									
Med. Mgmt.									
Laundry									
Trans-portation									
TOTAL SCORES									

Comments:

SUBTOTAL OF ADLs & IADLs	

SUMMARY & JUDGEMENT

GRAND TOTAL SCORE	

Provide a copy of MEBH assessment to Veteran after completed fully if requested (may have to mail a copy)

Assessor Signature: _____ Date: _____

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

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)
300 Hammond Drive

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

4b City, state, and ZIP code (if foreign, see instructions)
Hopkinsville, KY 42240

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) ▶ _____
- ☐ Hired employees (Check the box and see line 13.)
- ☐ Compliance with IRS withholding regulations
- ☑ Other (specify) ▶ HHCSR
- ☐ 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 December

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
	4	

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) ▶ HHCSR

17 Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided.

18 Has the applicant entity shown on line 1 ever applied for and received an EIN? ☐ Yes ☑ No

If "Yes," write previous EIN here ▶

Third Party Designee

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

Designee's name: Hayla Swaw
Designee's telephone number (include area code): 270-886-9484
Address and ZIP code: 300 Hammond Drive, Hopkinsville, KY 42240
Designee's fax number (include area code): 270-886-3211

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.

Name and title (type or print clearly) ▶

Applicant's telephone number (include area code)

Applicant's fax number (include area code)

Signature ▶ Date ▶

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 270-886-9484	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	
Hayla Swaw % Veteran Directed Care Program 300 Hammond Drive Hopkinsville, KY 42240	CAF No. 031-63045R PTIN Telephone No. 270-886-9484 Fax No. 270-886-3211 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
EIN, Number, Income and Employment Tax	SS4, 940, 940R, 941, 941R, 941z,W2		Obtain EIN, Tax Liability

4 Specific use not recorded on Centralized Authorization File (CAF). If the tax information authorization is for a specific use not recorded on CAF, check this box. See the instructions. If you check this box, skip lines 5 and 6 . . . . . ▶ ☐

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

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

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

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

6 Retention/revocation of prior tax information authorizations. If the line 4 box is checked, skip this line. If the line 4 box is not checked, the IRS will automatically revoke all prior Tax Information Authorizations on file unless you check the line 6 box and attach a copy of the Tax Information Authorization(s) that you want to retain. . . . . ▶ ☐

To revoke a prior tax information authorization(s) without submitting a new authorization, see the line 6 instructions.

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

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

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

Signature | Date

Print Name | Title (if applicable)

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**

Date / /

Print your name here

Print your title here

Best daytime phone 270-886-9484

Now give this form to the agent to complete.

Ohio Department of Job and Family Services
Office of Unemployment Insurance Operations

REPORT TO DETERMINE LIABILITY

Congratulations on starting a business in Ohio. To obtain an unemployment insurance tax account immediately, please visit unemployment.ohio.gov. As an alternative, you may complete this form and mail it to the address below. If you complete and send a paper form, we will notify you in writing of your Employer ID within 4 to 6 weeks.

Contact Information

First and Last Name: Kim Choate			Job Title: Payroll Clerk
Street Address: 300 Hammond Dr			City: Hopkinsville
State: KY	ZIP: 42211	County: Christian	Country: United States of America
Email: kim.choate@ky.gov			Telephone Number: 270-886-9484

Initial Questions

Federal Employer Identification Number (FEIN) *(Please do not use your SSN)*		Are you registering as a church or organization operated primarily for religious purposes? ☐ Yes ☒ No
Have you paid, or do you anticipate paying, wages to individuals, including corporate officers, for services performed in Ohio? ☒ Yes ☐ No		
If yes, enter the date work was first performed in Ohio.	If yes, enter the date covered wages were or will be first paid in Ohio.	How many employees are currently being paid, or will be paid, for work performed in Ohio?

Employment Information. What type of business are you engaged in?
Please check only one and answer the questions below it.

☐ Regular NA

Have you or do you expect to have a quarterly gross payroll of $1,500 or more in any quarter of the current or preceding calendar year(s)? ☐ Yes ☐ No

Enter the date the business first paid/will pay a gross payroll of $1,500 or more.

Have you or do you expect to employ at least one worker in 20 different calendar weeks during a calendar year?
☐ Yes ☐ No

If yes, enter the date the business reached/will reach the 20th week for the first time with one or more workers. Note: The 20 weeks do not have to be consecutive, but they must be within the same calendar year.

Enter the first pay date in the year the threshold was met:

Is the business liable for Federal Unemployment Tax Act (FUTA) taxes in another state? ☐ Yes ☐ No

☐ Nonprofit NA

Nonprofit organizations can elect to reimburse the state for any benefits paid, instead of paying quarterly unemployment insurance taxes. You can elect to do this by selecting "Reimbursable," below. If you do not elect to be reimbursable, you will, by default, be designated a contributory employer.

Choose Contributory or Reimbursable: ☐ Contributory ☐ Reimbursable

You must include your 501(c)(3) letter from the U.S. Internal Revenue Service to register as a nonprofit employer.

You must include your board resolution letter if you elect to be a reimbursable employer.

Is the business waiting for or currently holding a 501(c)(3) exemption letter? ☐ Yes ☐ No

Have you or do you expect to employ at least four workers in 20 different calendar weeks during a calendar year?
☐ Yes ☐ No

If yes, enter the date the business reached/will reach the 20th week for the first time with four or more workers. Note: The 20 weeks do not have to be consecutive, but they must be within the same calendar year.

Enter the first pay date in the year the threshold was met:

☐ Agricultural NA

During any calendar quarter of the current or preceding year(s), have you or will you pay a gross payroll of $20,000 or more to individuals performing agricultural work? ☐ Yes ☐ No

Enter the date you first paid/will pay a gross payroll of $20,000 or more:

Have you or do you expect to employ 10 or more individuals for a portion of a day in any 20 weeks during a calendar year?
☐ Yes ☐ No

If yes, enter the date the business reached/will reach the 20th week for the first time with 10 or more workers. Note: The 20 weeks do not have to be consecutive, but they must be within the same calendar year.

Enter the first pay date in the year the threshold was met:

Is the business liable for Federal Unemployment Tax Act (FUTA) taxes in another state? ☐ Yes ☐ No

☒ Household Domestic

Have you or do you as an individual or local college club, college fraternity or sorority expect to have a quarterly gross payroll of $1,000 or more for domestic workers (housekeepers, baby sitters, etc.) in any quarter of the current or preceding calendar year(s)? ☒ Yes ☐ No

If yes, enter the date the domestic employer first paid/will pay $1,000 or more in gross payroll:

Enter the first pay date in the year the threshold was met:

☐ Public Entity or Indian Tribe NA

Per state statute, government entities are by default reimbursable employers, which means they do not pay quarterly unemployment insurance taxes. However, government entities can elect to become contributory employers if they choose. If you represent a government entity and would like to become a contributory employer, select the "Contributory" option below.

Choose Contributory or Reimbursable: ☐ Contributory ☐ Reimbursable

Employer Information

Business Entity Type

☒ Sole Proprietor	☐ LLP	☐ LLC (Partnership)	☐ Federal Government
☐ Partnership	☐ LLC (Corporation)	☐ LLC (Unknown)	☐ State Government
☐ Corporation	☐ LLC (Individual)	☐ Association	☐ Local Government

☐ Other (*Explain*):

Legal Entity Name	Trade Name (DBA)
	Pennyrile ADD-VDC
Liquor Permit Number	Date and state the business was formed or incorporated
What is your preferred method of communication? ☒ Email ☐ Postal Mail	If email, provide an email address kim.choate@ky.gov

Will this employer act as a professional employer organization? ☐ Yes ☒ No

The state of Ohio requires professional employer organizations to report at the client level. Refer to 4141.24(K) for reporting requirements.

Is this business registering because the FEIN has changed? ☐ Yes ☒ No

If yes, enter the old FEIN:

Is this business registering because of an acquisition, merger, entity change or consolidation with another business operating in the state? ☐ Yes ☒ No *If yes, complete the Acquisitions section, below.*

How many business locations are currently operating in the state?

Business Addresses

Physical Location. Enter the street address of the location in Ohio where the work is being performed. The address cannot be a P.O. box.

Street Address		
City	State	ZIP
County	Country	Phone
	United States of America	

Legal Address. Enter the legal address of the business. This is the address registered with the Secretary of State.

Street Address		
300 Hammond Dr		
City: Hopkinsville	State: KY	ZIP: 42240
County: Christian	Country: United States of America	Phone: 270-886-9484

Mailing Address. Enter the address where you would like correspondence mailed

☐ Same as Physical Location ☒ Same as Legal Address

Street Address		
300 Hammond Dr		
City: Hopkinsville	State: KY	ZIP: 42240
County: Christian	Country: United States of America	Phone: 270-886-9484

NAICS Classification

Describe the type of services performed or products made or sold.

621610 Home Health Care Services

Ownership Information.

List ALL owners or corporate officers. Must equal 100% ownership or a minimum of 3.

Owner Type

☒ Sole Proprietor ☐ Partner ☐ Member ☐ Corporate Officer ☐ Director ☐ Trustee
☐ Executor ☐ Receiver ☐ Other *(Explain)*

First and Last Name	Social Security Number *(Please do not use your FEIN)*	Job Title
		HCSR
Street Address		
City	State	ZIP
County	Country	Phone
	United States of America	
Owner or Officer compensated for services in Ohio? ☐ Yes ☒ No	Percent of Ownership: 100%	Date of Ownership

Owner Type ☐ Sole Proprietor ☐ Partner ☐ Member ☐ Corporate Officer ☐ Director ☐ Trustee ☐ Executor ☐ Receiver ☐ Other *(Explain)*		
First and Last Name NA	Social Security Number *(Please do not use your FEIN)*	Job Title
Street Address		
City	State	ZIP
County	Country	Phone
Owner or Officer compensated for services in Ohio? ☐ Yes ☐ No	Percent of Ownership	Date of Ownership

Owner Type ☐ Sole Proprietor ☐ Partner ☐ Member ☐ Corporate Officer ☐ Director ☐ Trustee ☐ Executor ☐ Receiver ☐ Other *(Explain)*		
First and Last Name NA	Social Security Number *(Please do not use your FEIN)*	Job Title
Street Address		
City	State	ZIP
County	Country	Phone
Owner or Officer compensated for services in Ohio? ☐ Yes ☐ No	Percent of Ownership	Date of Ownership

Acquisitions, Transferred Assets, Mergers, Change of Entity or Other Changes in Ownership

Did your business obtain, in full or part, the trade or business of another company through an acquisition, change of entity, merger or transfer?

☐ Yes ☐ No *If yes, complete the information below.* NA

1. What type of acquisition occurred? NA

☐ Sale or Lease ☐ Merger/Reorganization ☐ Bankruptcy/Court Order/ Foreclosure ☐ Change of Legal Entity (proceed to question #4)
☐ Death of Owner ☐ Stock Sale

☐ Other *(please explain)*

What was the date of the acquisition?	Was the business operating at the time of the acquisition? ☐ Yes ☐ No
If no, enter the date business operations ceased.	Was all or part of the business purchased? ☐ All ☐ Part

2. If you selected "ALL" in question #1, answer the questions below: NA

Did you acquire all of the predecessor's business locations in Ohio? ☐ Yes ☐ No	If no, list the locations in Ohio that were not acquired.
Did you acquire all of the predecessor's trade or business in Ohio? ☐ Yes ☐ No	If no, list the trade or business that was not acquired.
Is there common ownership, management, or control between both businesses? ☐ Yes ☐ No	If yes, list the name, title and SSN/FEIN of the person, corporation or other legal entity that serves as an owner, officer, member or partner for your business.

3. If you selected "Part" in question #1, answer the questions below: NA

What percentage of the business was purchased?	Provide the address, location and a description of the transferred portion as it existed before the transfer.
Is there common ownership, management, or control between both businesses? ☐ Yes ☐ No	If yes, list the name, title and SSN/FEIN of the person, corporation or other legal entity that serves as an owner, officer, member or partner for your business.
Will the previous owner continue to operate with employees in Ohio? ☐ Yes ☐ No **You <u>must</u> submit a list of the names and Social Security numbers of employees who were transferred from the buyer to the seller on the transfer date. Failure to provide this information will result in a delay in processing your paperwork. This information is required to proceed with your partial transfer application.**	

4. If you selected "Change of Legal Entity" in question #1, answer the questions below: NA

Are you changing your entity due to a new FEIN? ☐ Yes ☐ No	
If yes, please enter your old FEIN	Effective Date of Change of Entity

Please provide supporting documentation (if applicable).

5. If you selected "Death of Owner" in question #1, answer the questions below: NA

What was the date of death?	Name of the deceased?

NOTE: You will be required to submit a separate transfer of business form for each business you acquire.

Please provide information regarding the previous owner.

Employer Legal Name NA		Employer ID Number
Employer FEIN		Employer Phone
Street Address		
City	State	ZIP
County	Country	Contact Phone
Contact Name		Contact Email

Certification

I hereby certify that the information given in this report is true to the best of my knowledge and belief.

Signature	Title HCSR
Printed Name	Date
Email Address	Phone Number

Ohio Department of Job and Family Services

EMPLOYER'S REPRESENTATIVE AUTHORIZATION

P.O. BOX 182059
Columbus, OH 43215-2059
(614) 466-4047
EMPCHRG@jfs.ohio.gov

Section I - Benefits Authorization for Representation or Dissolution of Representation

☐ I hereby authorize the Ohio Department of Job and Family Services to allow the representative named in Section II to act on my behalf for all matters pertaining to the service functions(s) identified in Section III.

NOTE: If correspondence should be sent on a regular basis to the representative, please choose representative for question #1.b in Section III.

☐ I am hereby notifying the Ohio Department of Job and Family Services that I wish to dissolve my relationship with the representative named in Section II. The Ohio Department of Job and Family Services should no longer allow the representative named in Section II to act on my behalf for matters pertaining to the service function(s) identified in Section III or send them any information pertaining to my account.

Section II - Employer and Representative Information

When completing this form, please print using block capital letters in black ink. For example: A B C D E F G H I

Employer Name

Employer Address

City

State | Zip | Country

Country: United States

Employer Account Number | FEIN

Employer Phone Number

Representative or Third Party Administrator Name

Pennyrile Area Development District

Representative or Third Party Administrator Number | Representative or Third Party Administrator Phone Number

Representative or Third Party Administrator Phone Number: 270 - 886 - 9484

Representative Address Line 1

300 Hammond Dr

Representative Address Line 2 - Please enter P.O. Box here

City

Hopkinsville

State | Zip | Country

State: KY

Zip: 42240

Country: United States

Province - International addresses only | Postal Delivery Code - International addresses only

Section III - Service Function and Correspondence

1.a To what service function(s) does the authorization or dissolution selected in Section II apply? *(Please check all that apply)*	1.b For the service function(s) selected in question #1 a, where should the correspondence be sent on a regular basis? *(Choose only one)*	
☐ Monthly Benefit Charge Statement	☐ Employer	☐ Representative or Third Party Administrator
☐ Request for Information	☐ Employer	☐ Representative or Third Party Administrator
☐ Request for Separation Information	☐ Employer	☐ Representative or Third Party Administrator
☐ Determinations	☐ Employer	☐ Representative or Third Party Administrator
☐ Appeals	☐ Employer	☐ Representative or Third Party Administrator

Section IV - Signature

I hereby acknowledge that by signing this document I relieve the Ohio Department of Job and Family Services from any liability arising from the exercise of rights and causes of action on account of or growing out of failure of the undersigned to receive any correspondence sent to the representative as indicated in Section III, including but not limited to:

1. Notification required by Section 4141.26
2. Injury cased by untimely appeal

This authorization, voluntarily given by the undersigned, shall remain in full force and effect until such time as the agency is notified in writing by the undersigned or by the designated representative that the relationship has been dissolved.

Employer Signature
NOTE: Must be owner, partner, member or corporate officer

Title

__ / __ / ____

Employer Name

Employer Phone Number
___ – ___ – ____

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES

P.O. Box 182404
Columbus, Ohio 43218-2404
(614) 466-2319
http://unemployment.ohio.gov

FOR 0006A

AGENT AUTHORIZATION FORM

To immediately authorize an agent (third party administrator, accountant, payroll company, etc) to act on your behalf regarding your account, please visit http://unemployment.ohio.gov. If you prefer, you may submit your information by completing this form and your account will be updated within 2-3 weeks. When completing this form, please print, using block capital letters in black ink. For example:

A	B	C	D	E	F	G	H

Section I - Employer and Representative Information

Employer Legal Name

Employer ID

Plant Number (If none, please leave blank.)

Employer Phone Number

Agent Name

Pennyrile Area Development District-Veterans Directed Care Program

Agent ID

6000015512

Agent Phone Number

270 - 886 - 9484

Agent Address Line 1 - Enter street address or P.O. box information here (for example, 123 Main St., P.O. Box 123.)

300 Hammond Dr

Agent Address Line 2 - Enter secondary address information here (for example, STE 123, APT A, 1st FL. If none, please leave blank.)

City

Hopkinsville

State

KY

ZIP

42211 -

Country

United States of America

Province - International addresses only

Postal Delivery Code – International addresses only

Section II - Assign Roles and Responsibilities

To give a new agent access to your account, check the role(s) you want the agent to have and enter the "Access Begin Date" (must be the beginning of a quarter for "Wage Submission") and "Access End Date" (optional) for the selected roles.

For all roles except "Wage Submission," once an end date is entered, the agent will no longer have access to those roles after the "Access End Date" provided. If no end date is entered, the access will continue indefinitely.

For "Wage Submission," the dates of access will allow the agent to update your wage records for all quarters within the access dates, regardless of the current date. For example, if you give an agent access for the first quarter of the year, the agent will be able to access the wage records for that quarter at any time. If you wish to completely remove access for the agent, which would prevent them from accessing quarters they were previously authorized for, select the "Remove Access" box for the agent.

You cannot grant two agents access to the same role during the same time period. If you want to change agents, you must remove the role from the existing agent by entering an "Access End Date."

1a. To what role does the authorization or dissolution selected in Section II apply? (Please check all that apply.)

- [X] Wage Submission
- [X] Payment Submission
- [X] Account Maintenance Updates
- [X] Appeals
- [X] Tax Rates

1b. For the roles selected in question 1a, provide "Access Begin Date" and "Access End Date" (Optional)

Access Begin Date

/ /

Access End Date

/ /

☐ Remove Access

Section III - Signature

I hereby acknowledge that by signing this document I relieve the Ohio Department of Job and Family Services from any liability arising from the exercise of rights and causes of action on account of or growing out of failure of the undersigned to receive any correspondence sent to the representative indicated in Section III, including, but not limited to:

1. Notification required by Section 4141.26;
2. Injury caused by untimely appeal.

This authorization, voluntarily given by the undersigned, shall remain in full force and effect until such time as the agency is notified in writing by the undersigned or by the designated representative that the relationship has been dissolved.

Employer Signature

NOTE: Must be owner, partner, member, or corporate officer

Title: Owner

Date: / /

GRIEVANCE PROCEDURES
Pennyrile Area Agency on Aging and Independent Living

GRIEVANCE/COMPLAINT PROCEDURES

Policy:

Any individual with a complaint or grievance will have the right to make that grievance known at any time and be afforded assistance in submitting this formal complaint if requested. All formal complaints will be reviewed by the correct party and a follow up will be provided.

Procedures:

This form will be used to make a formal written complaint. An HCB participant, guardian, representative, staff, or agency may use this form and follow the procedures listed below for its submission. Please ensure that the person who the complaint or grievance is on is listed clearly on the form.

1. **(Complaint on Social Services Case Manager):** Should a compliant be made on a Social Services Case Manager please submit the complaint to the following individual:

   Harley McCarty (Veteran Directed Care Coordinator)
   Pennyrile Area Development District
   300 Hammond Drive
   Hopkinsville, KY 42240

2. **(Complaint on VDC Coordinator):** Should a complaint be made on the Participant Directed Services Coordinator please submit the complaint to the following individual:

   Payton Kidd (Director of Long Term Services and Supports, LTSS)
   Pennyrile Area Development District
   300 Hammond Drive
   Hopkinsville, KY 42240

3. **(Complaint on Financial Management Staff):** Should a complaint be made on the Financial Management Staff (FMS) please submit the complaint to the following individual:

   Hayla Swaw (Deputy Chief Financial Officer)
   Pennyrile Area Development District
   300 Hammond Drive
   Hopkinsville, KY 42240

4. **(Complaint on Aging Director or Chief Financial Officer):** Should a complaint be made on the Aging Director or Chief Financial Officer please submit the complain to the following individual:

   Jason Vincent (PADD Executive Director)
   Pennyrile Area Development District
   300 Hammond Drive
   Hopkinsville, KY 42240

Person the Complaint or Grievance is on:

_____ _____

Name Date

Complaint Details

Individual Issuing Complaint/ Grievance

_____ _____

Name Date

PENNYRILE AREA DEVELOPMENT DISTRICT
NOTICE OF PRIVACY PRACTICES

THIS DOCUMENT DESCRIBES HOW HEALTH OR MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY.

WHAT IS THIS NOTICE?

This Notice of Privacy Practices is required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

This notice tells you:

- How PADD and its contracted business partners may use and give out your protected health information (PHI) to carry out services, payment or health care operations and for other purposes permitted or required by law.
- What YOUR rights are regarding the access and control of your health information. How PADD protects your health information.

If you have any questions about your privacy rights, contact:

PADD
ATTN: AAAIL
300 Hammond Drive
Hopkinsville, KY 42240
Phone: 1-866-844-4396

PADD'S PRIVACY RESPONSIBILITIES

PADD is required to:

- Follow the terms of this Notice.
- Support your Privacy Rights under the law.
- Give you a paper copy of this Privacy Notice and post it on our website.
- Mail out a new Notice if our privacy practices change.
- Treat your data as confidential by not using or giving out your information without your written permission, except to support normal business or under the allowable circumstances given in this Notice.
- Tell you what types of information we collect on you.
- Release your health information without your permission in the event of an emergency.
- The release of your data must be in your best interest.
- Follow State laws regarding the release of your data in the instances where State law provides stronger protection of your data than the HIPAA law.

You have the right to:

Request a restriction on certain uses and sharing of your information (though we are not required to agree to any such request). This means you may ask us not to use or share any part of your PHI for purposes of treatment, payment or healthcare operation. You may also ask that this information not be disclosed to family members or friends who may be involved in your care.

Request that we send you confidential communications by alternative means or at alternative locations.

Obtain a paper copy of this notice of privacy practices upon request.

Inspect and obtain a copy of your health record.

Request that your health record containing PHI be changed.

Obtain a listing of certain health information we were authorized to share for purposes other than treatment, payment or health care operations after April 14, 2003.

Take back your authorization to use or share health information except to the extent that action has already been taken.

HOW PADD MAY USE OR GIVE OUT YOUR INFORMATION

PADD can use and give out your information without an Authorization (special permission from you) for our normal business and where required by law. This document tells you of some of the ways this can occur. All the ways PADD may use and give out your information without your express permission will fall within one of the groups listed below.

Data for Treatment, Payment and Billing Purposes

PADD will use your PHI for treatment, payment and billing purposes.

Information obtained by a nurse, case management personnel, PADD AAAIL staff, and/or service providers will be recorded in your record and used to determine the services that should work best for you.

Your case manager will document in your plan of care the expectations of the service providers. Members of the provider agencies may then record the actions they took and their observations.

A bill or payment may be sent to you or a third-party. The information on or accompanying the bill or payment may include information that identifies you, as well as the services provided, and supplies used.

Data for Regular Business Operations

We may use/disclose your PHI in the course of operating PADD and fulfilling its responsibilities. We may use your information to determine your eligibility for publicly funded services.

PADD staff may look at your record when reviewing the quality of services, you are provided. PADD staff may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used to continually improve the quality and effectiveness of the healthcare and services.

Inspector General, and Cabinet for Health Services Office of Aging Services for activities such as audits, investigations, inspections and compliance with civil rights laws. We may disclose your PHI to doctors and nurses to help improve your care. Kentucky Department of Medicaid Services staff, committees and outside agencies that monitor Medicaid quality of care may also see your PHI.

Individuals Involved with Payment of Your Care: We may disclose your PHI to a friend or family member who is helping with your care or with payment for your care if necessary.

Law Enforcement: We may disclose PHI for law enforcement only where allowed by federal or state law or required under a court order.

Lawsuits and Disputes: We will disclose your PHI in response to a court order, valid subpoena, discovery request, or other lawful process.

Public Health: We may disclose your PHI to public health agencies charged with preventing or controlling disease, injury or disability; reporting child abuse or neglect; and reporting domestic violence. We may share your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may be at risk of getting or spreading the disease or condition. Information will be released to avert a serious threat to health or safety. Any disclosure, however, would only be to someone authorized to receive that information pursuant to law.

Public Safety: We may disclose PHI to prevent a serious threat to the health or safety of a person or to the general public.

Research: We may disclose PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

Worker's Compensation: We may disclose PHI as necessary to comply with worker's compensation or similar laws.

WHEN PADD MAY NOT USE OR DISCLOSE YOUR HEALTH INFORMATION WITHOUT AUTHORIZATION

Other than for the allowed reasons listed above, PADD will not use or disclose your PHI without written permission (Authorization) from you. If you do authorize us to use or disclose your PHI in other ways, you may revoke your permission in writing at any time. Once you revoke your permission, PADD will no longer be able to use or disclose your PHI for the reasons stated in your original authorization. Uses and disclosures of your PHI beyond treatment and operations will be made only with your written authorization, unless otherwise permitted or required by law described below.

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's authorization.

Veteran Directed Care Program (VDC)

Pay Period _____ to _____ Employee Number: _____ KY

Employee Name: _____ Veteran Name: _____

Employee Address/Zip: _____

Date Service Provided	Service Provided			Service Provided			Service Provided			Service Provided			Service Provided		
	Time IN	Time OUT	Total Time	Time IN	Time OUT	Total Time	Time IN	Time OUT	Total Time	Time IN	Time OUT	Total Time	Time IN	Time OUT	Total Time
Saturday															
Sunday															
Monday															
Tuesday															
Wednesday															
Thursday															
Friday															
Weekly Total															
Saturday															
Sunday															
Monday															
Tuesday															
Wednesday															
Thursday															
Friday															
Weekly Total															
Total Hours															

GROSS TOTAL AMOUNT FOR PAY PERIOD			
Service & Billing Code	Hours	Rate	Total

Employee Signature **Date**

Veteran/ Authorized Representative Signature **Date**

Case Manager Signature _____ **Date** _____

Was Veteran Hospitalized this pay period? Yes No If yes dates: _____

Instruction Reference

Veteran Directed Care Program (VDC)

Pay Period 1. to 1. Employee Number: 3. Tb

Employee Name: 2. Veteran Name: 5.

Employee Address/Zip: 4.

Date Service Provided	Service Provided			Service Provided			Service Provided			Service Provided			Service Provided		
	6.						#N/A								
	Time IN	Time OUT	Total Time	Time IN	Time OUT	Total Time	Time IN	Time OUT	Total Time	Time IN	Time OUT	Total Time	Time IN	Time OUT	Total Time
Saturday	7.	7.	8.												
Sunday															
Monday															
Tuesday															
Wednesday															
Thursday															
Friday															
Weekly Total															
Saturday															
Sunday															
Monday															
Tuesday															
Wednesday															
Thursday															
Friday															
Weekly Total															
Total Hours			9.												

GROSS TOTAL AMOUNT FOR PAY PERIOD			
Service & Billing Code	Hours	Rate	Total

10.

Employee Signature **Date**

11.

Veteran/ Authorized Representative Signature **Date**

Case Manager Signature _____ **Date** _____ **Was Veteran Hospitalized this pay period? Yes No If yes dates:** _____

Veteran Directed Care Program (VDC)

DIRECTIONS: You may submit timesheets to your assigned case manager by fax, mail, or encrypted email.

Important Notes:

1. Time sheets may be scanned & emailed, faxed, or original mailed
2. Proper way to correct an error is 1 line through error, initial, date in which corrections were made, and correction

Failure to fix an error correctly will result in the timesheet being sent back & may delay payment.

Case Manager Signature _____ **Date** _____ **Was Veteran Hospitalized this pay period? Yes No If yes dates:** _____

Timesheet Instructions and Required Fields

All of these fields must be completed for the timesheet to be paid. This list corresponds to the template included.

1. **Pay Period.** You are given a pay period and check schedule Please enter the beginning date and end date to clearly mark which pay period this timesheet represents.
2. **Employee Name.** Ensure the employee name is correct.
3. **Employee Number.** This is the number assigned to the provider. Please do not change.
4. **Employee Address.** Ensure the employee address is correct. If it is not, please provide an updated address form.
5. **Veteran Name.** Ensure the name of the person receiving services (Veteran) is correct.
6. **Service Type.** Ensure the services provided are approved on the Veteran Spending Plan. Any column with hours should be labeled appropriately. Examples include Personal Care, Respite, Homemaking, etc.
7. **Time In/Time Out.** Enter the time you started working and the time you finished working under each service provided. Please reference AM/PM on your time in/out.
8. **Total Time.** Please input the total hours worked on the appropriate day under each service provided. Make sure to round minutes to quarter hours:
   15 minutes = .25
   30 minutes = .50
   45 minutes = .75
   60 minutes (1 hrs) = 1.00
   For example, 1 hour & 30 minutes = 1.5
9. **Total Hours**. Add the total number of hours worked per service category to calculate your total hours.
10. **Employee Signature & Date.** The provider (employee) would sign and date the time sheet.
11. **Veteran/Authorized Representative Signature & Date.** The person receiving services (Veteran or Authorized Representative) will sign and date.

Suggestions

- Fill timesheets out clearly with black or blue ink.
- Fill in all required fields. You will not be paid unless all of the fields are filled in.
- **If Veteran is admitted to a medical facility or institution, hours cannot be submitted for the days that the Veteran is hospitalized.**
- If you make an error, please mark a single line through the error, initial it and make the correction nearby.
- Timesheets are to be submitted to participant (Veteran) for signature. Veteran will then forward to assigned case manager.

Obtaining Timesheets

- You can make copies of timesheets we give you, or
- You can contact your assigned case manager or VDC FMS Staff, at (270)886-9484 or 1-800-928-7233.

Veterans Directed Care Program (VDC)

FY 2026 TIME SHEET DUE DATES: BI-WEEKLY

Pay Period Beginning Date	Pay Period Ending Date	Timesheet Due to Representative	Timesheet Due to Case Manager	Paydate (Direct Deposit or Check Date)
7/12/2025	7/25/2025	7/26/2025	7/29/2025	8/8/2025
7/26/2025	8/8/2025	8/9/2025	8/12/2025	8/22/2025
8/9/2025	8/22/2025	8/23/2025	8/26/2025	9/5/2025
8/23/2025	9/5/2025	9/6/2025	9/9/2025	9/19/2025
9/6/2025	9/19/2025	9/20/2025	9/23/2025	10/3/2025
9/20/2025	10/3/2025	10/4/2025	10/7/2025	10/17/2025
10/4/2025	10/17/2025	10/18/2025	10/21/2025	10/31/2025
10/18/2025	10/31/2025	11/1/2025	11/4/2025	11/14/2025
11/1/2025	11/14/2025	11/15/2025	11/18/2025	11/28/2025
11/15/2025	11/28/2025	11/29/2025	12/2/2025	12/12/2025
11/29/2025	12/12/2025	12/13/2025	12/16/2025	12/26/2025
12/13/2025	12/26/2025	12/27/2025	12/30/2025	1/9/2026
12/27/2025	1/9/2026	1/10/2026	1/13/2026	1/23/2026
1/10/2026	1/23/2026	1/24/2026	1/27/2026	2/6/2026
1/24/2026	2/6/2026	2/7/2026	2/10/2026	2/20/2026
2/7/2026	2/20/2026	2/21/2026	2/24/2026	3/6/2026
2/21/2026	3/6/2026	3/7/2026	3/10/2026	3/20/2026
3/7/2026	3/20/2026	3/21/2026	3/24/2026	4/3/2026
3/21/2026	4/3/2026	4/4/2026	4/7/2026	4/17/2026
4/4/2026	4/17/2026	4/18/2026	4/21/2026	5/1/2026
4/18/2026	5/1/2026	5/2/2026	5/5/2026	5/15/2026
5/2/2026	5/15/2026	5/16/2026	5/19/2026	5/29/2026
5/16/2026	5/29/2026	5/30/2026	6/2/2026	6/12/2026
5/30/2026	6/12/2026	6/13/2026	6/16/2026	6/26/2026
6/13/2026	6/26/2026	6/27/2026	6/30/2026	7/10/2026
6/27/2026	7/10/2026	7/11/2026	7/14/2026	7/24/2026
7/11/2026	7/24/2026	7/25/2026	7/28/2026	8/7/2026

If Pay Date falls on holiday, you will be paid on the preceding business day. Indicated in Orange.

If Timesheet Due Date falls on a holiday, timesheets will be due the preceding business day. Indicated in Orange.

Veterans Directed Care (VDC) Program
Service Plan

Please use the attached forms to select services, supports and goods that meet the following rules:

- Help you require in order for your functional, medical and/or social needs to be met.
- Help you to reach the goals you may have set for yourself
- Not be prohibited by federal and state laws and regulations
- Not be available through another VA source AND
- Do one or more of the following:
    - Make it easier for you to do things that are hard because of your disability or health issues
    - Increase your safety in your home environment; and/or
    - Lessen your need for other publicly funded services

Forms include: Examples Service Plan, categories & examples of approved services/supports/goods, and a glossary of terms for you to reference when you complete your Service Plan. Same information can be located in your VDC Program Manual for Veterans

Important: In developing your budget, keep in mind that your annual available funding must cover your needs for a whole year. This includes planning and budgeting for a special, higher-cost item, along with the services and goods you require on a regular basis.

Example Service Plan

Important: You may create your Service Plan however is easily understandable to you, but please use the template on the following page when completing. *You're able to break down utilization of funds weekly, monthly, or yearly on this Service Plan, however finalized Spending Plan (which will be sent to VAMC for approval) must be broken down into "MONTHLY" cost. If possible, completing this plan in monthly cost is ideal but is NOT required. Please complete however you find it easier. Case Manger & PADD FMS staff will be able to assist if needed.*

Services/ Supports/ Goods Required	**Tasks/Duties Requiring Assistance**	**Frequency (Hours Weekly) & Instructions**	**Projected Hourly Wage or Cost**	**Projected Cost Weekly, Monthly or Yearly or Item Cost** (Please label if costs is weekly, monthly yearly or a one-time purchase & calculate total)
(Example): Personal Care	1.Meal Prep 2.Bathing 3.Dressing/Undressing	**Meal Prep**- 3x daily X 1hr = **21hrs weekly**. (Instructions- prepare meals at 9AM, 1PM, 5PM **Bathing**- 1x EOD X 1hr = **4hrs weekly** (Instructions- assist w/ bathing every other day at 6PM) **Dressing/Undressing**- 3x daily (unless more required) X 15 mins + 45 mins extra time if needed = **6hrs weekly**. (Instructions- dress in morning, undress for bath, and dress for night	$10.00hr	31hrs weekly total for Personal Care 31hrs x 10.00 (hourly wage) = $310.00 weekly x 52 weeks in a year = **$16, 120 yearly**
(Example): Specified Savings -(Ramp)	1.Need outside ramp for wheelchair	1 time purchase	Save $50.00 month for item. Ramp: $300.00	Ramp Cost: **$300.00 (total)** (Available funds after 6 months of saving)
(Example): Health Maintenance	1.Gym Membership fee	1 fee for a 6 month membership (Instructions-Paid 2x for full-year membership	$100.00 per 6mon months	**$200.00 yearly**
(Example): Homemaking	1.Laundry 2. Washing/ Unload Dishes	**Laundry**- 2x weekly X 4hrs (Instructions- Mon & Fri, wash, dry, fold, and put up clothes) = 8hrs weekly **Dishes**- 4x weekly x 2hrs (Instructions- wash, dry, put up dishes M/W/F/Sun = **8hrs weekly**	$10.00hr	8hrs weekly for laundry 8hrs x $10.00 (hourly wage) = $80.00 weekly x 52 weeks in a year = **$4,160 yearly** Dishes- 8hrs weekly for dishes 8hrs x $10.00 (hourly wage) = $80.00 weekly x 52 weeks in a year = **$4,160 yearly**

Projected Total (Weekly, Monthly, Yearly) = $ 24,940 (yearly)

VDC Program Service Plan Template for Veteran

You're able to break down utilization of funds weekly, monthly, or yearly on this Service Plan, however finalized Spending Plan (which will be sent to VAMC for approval) must be broken down into "MONTHLY" cost. If possible, completing this plan in monthly cost is ideal but is NOT required. Please complete however you find it easier. Case Manger & PADD FMS staff will be able to assist if needed. **If you need additional spaces, page #4 will be a continuation of page #3.**

Services/ Supports/ Goods Required	**Tasks/Duties Requiring Assistance**	**Frequency (Hours Weekly) & Instructions**	**Projected Hourly Wage or Cost**	**Projected Cost Weekly, Monthly or Yearly or Item Cost** (Please label if costs is weekly, monthly, yearly or a one-time purchase & calculate total based on that information

Projected Total (Weekly, Monthly, Yearly – Please Label) = $

Veteran Signature/Authorized Representative (if applicable): **Date:**

(Page #4 If Applicable)

You're able to break down utilization of funds weekly, monthly, or yearly on this Service Plan, however finalized Spending Plan (which will be sent to VAMC for approval) must be broken down into "MONTHLY" cost. If possible, completing this plan in monthly cost is ideal but is NOT required. Please complete however you find it easier. Case Manger & PADD FMS staff will be able to assist if needed. **If you need additional spaces, page #4 will be a continuation of page #3**

Services/ Supports/ Goods Required	**Tasks/Duties Requiring Assistance**	**Frequency (Hours Weekly) & Instructions**	**Projected Hourly Wage or Cost**	**Projected Cost Weekly, Monthly or Yearly or Item Cost** (Please label if costs is weekly, monthly, yearly or a one-time purchase & calculate total based on that information

Projected Total (Weekly, Monthly, Yearly – Please Label) = $

Veteran Signature / Authorized Representative (if applicable): **Date:**

Below are categories of services, supports, and goods along with some, but not all examples of each category

Category	Example
Adult Day Care	• Adult Day Care Center Program. • Adult Day Care in another home other than the veteran's.
Caregiver Education & Training	• Caregiver support programs • A Matter of Balance • Chronic Disease Self- Management Class • Other Evidenced Based Programs
Caregiver Support Coordination	• Comprehensive caregiver assessments • Home and phone visit support • Referral to caregivers support services
Chore Maintenance	• Initial heavy-duty cleaning of home. • Removal of trash/debris from the home. • Yard cleanup
Electronic Monitoring	• Purchase of room monitors • Bed alarm • Programmable or voice-activated phones • Personal alarms • Life lines (available through VAMC) • Cell phones
Environmental Services	• Installation of grab bars, railings, specialized lighting, etc… • Minor home repair • Painting (interior or exterior) • Plumbing • Ramps (if denied by VA)
Escort Services	• Accompanying and personally assisting the veteran to obtain a needed service. • Filling out applications and explaining directions to the veteran.
Health Maintenance	• Cooking classes for caregiver (AKA PA) • Gym or Health Club membership • Health Counseling • Health Education • Massage therapy beyond services traditionally covered by insurance • Service/ Support Animal Health • Public health maintenance programs (structured weight reduction programs)
Homemaking Services	• Light Housekeeping • Laundry • Sweeping & mopping floors

	• Dusting • Changing linens • Cleaning the bathroom (toilet, tubs/showers, sinks & floors) • Cleaning the kitchen (loading/unloading dishwasher, hand washing dishes, washing off countertops, sinks, floors, and stovetops as needed).
Personal Care Services	• Assist in/out of the shower or bath tub/any assistance during the bathing process. • Assistance in getting on/off the toilet • Brushing teeth/dentures • Personal grooming tasks and dressing • Providing verbal prompts to taking medication or placing pills from the medication minder into the hands of the Veteran and verbally reminding or physically guiding the veteran to take them
Individually identified services or goods necessary for "Independent Living"	• Upkeep of service animals required for veteran to stay independent. • What would you feel is needed in your home to keep you independently living not covered by traditional VA programs and services or insurances
Information and Referral Services	• Referral to community agencies and programs to improve quality of life.
Respite Care	• In-home services can be provided by volunteer or paid help, occasionally or on a regular basis. Respite services may include meal preparation, housekeeping, assistance with personal care and/or social and recreational activities (verified by CM). • Out-of-home respite care programs may include contracted short stay at an area nursing home or other specialized facilities, for up to 30 days, that provide emergency and planned overnight services, allowing caretakers (or PA's) 24-hour relief.
Nutritional Services	• Home Delivered Standard Meal- the regular menu from the standard menu that is served to the majority of participants. • Therapeutic meal or liquid supplement – a special meal or liquid supplement that has been prescribed by a physician and is specifically ordered for the participant by the dietician (i.e. diabetic diet, renal diet, pureed diet, tube feeding).
Safety Services	• Personal Emergency Response System includes the installation of the individual monitoring unit, training associated with the use of the system, periodic checking to insure that the unit is functioning properly, equipment maintenance calls, response to an emergency call by a medical professional, paramedic, or volunteer, and follow-up with the veteran. • Combination key box for the door, this keeps a key available for easy access to the home by emergency personnel. • Home Safety Evaluation by a professional person to assure safety of travel paths and needs.

Shopping or Running Errands	• Shopping with or without the veteran for the veteran.
Socialization Support Services	• Employee / worker (personal assistant) to accompany the Veteran to activities such as education or exercise classes. • Employee/ worker (personal assistant) taking the veteran to the movies, a Bible study, or other social engagements (verified by CM).
Transportation	• Public transportation or other transport required to go for socialization support or medical support activities with the designated caregiver (or PA) providing escort • A Month Public Transport Pass to get around town or the area to go to social activities. • An escort to a veteran who has special needs (physical or cognitive) when using regular vehicular transportation.

Participant-Delegated Goods and Services	• Funds from your budget may be spent on services/and or items that would make life easier for you, meaning that you would need less assistance from others due to this item or service increasing your independence. • For example, a fax machine which helps you facilitate a timely submission of timesheets for your employees. Or perhaps a microwave oven might make it easier for you to prepare your own meals as opposed to paying someone to prepare them for you.
Emergency Back-Up/Planned Savings	• Spending in a given month may exceed the average monthly case-mix rate. As long as it does not exceed the total authorized budget. • When funds spent in a given month are less than the monthly budget amount these funds are placed in the Emergency Back-Up/Planned Savings, these funds can be used anytime until the authorization renewal date. • When funds spent in a given month are more that the monthly budget amount this is reflected in the Emergency Back-Up/Planned Savings account. • The emergency savings can be used for planned G&S purchases, which should be approved and planned at the start of the authorization period (all purchases must be approved by the VAMC).

Glossary of Terms (For your reference)

Adult Day Care: Daytime care of any part of the day, less than 24-hour care. The program provides a structured, comprehensive program that is designed to meet the needs of adults when functional impairments through an individual plan of care by providing health, social, and related support services in a protective setting other than the veterans home.

Budget: The amount of available funding for each individual participant. The participants Care Coordinator receives the individual budget from the VAMC and informs the participant when he/she is deciding whether to select self-direction over traditional VA services and during the planning process. Any request for adjustments to the budget, based on a change in the Veterans participant's needs, are initiated by the participant through his/her Care Coordinator.

Caregiver Education and Training: Access to a resource library, informational resources, support groups, seminars and focus groups, individual or group counseling. And education services to employees/ workers (personal assistants) of veteran.

Caregiver Support Coordinator: Employees/ workers (personal assistants) of veteran often give more hours than they are paid for in additional service to the veteran. Caregiver support coordinator begins with compressive caregiver assessments through home or office visits and phone follow-up. A plan of care is created based on the assessment and staff assist in coordinating necessary care and services to include caregiver trainings and support groups to help support caregivers in their roles. This may also include individual or group counseling services to assist caregivers with problem solving and emotional support.

Chore Maintenance: Initial and/or periodic heavy cleaning chores. Some initial assessments may reveal that a home is unhealthy due to prior neglect of household chores by the veteran. Chore Maintenance allows a heavy-duty level of cleaning to get the home into a health environment for the veteran. This may include removal of trash and debris from the home, heavy cleaning (scrubbing floors, washing walls, washing outside windows) moving heavy furniture, yard clean-up, and walk maintenance and repair.

Case Manager: A trained individual who assists individual VDC participants with understand the VDC requirements, developing a service and spending plan/ budget, and identifying where or how the developed service and spending plan/budget can be implemented.

Consumer Direction: A belief that emphasized the ability of older person, persons with disabilities and, where appropriate, with the veterans approval, their families, to decide about their own needs and make choices about what services would best meet those needs. Consumer direction and self-direction are sometimes used interchangeably.

Electronic Monitoring: This may include the purchase of room monitors similar to baby monitors to place in the room of the veteran and a family member to enable movement monitoring, motion monitors, and other monitor services not otherwise covered by VA or other insurance programs.

Environmental Services: Gutter cleaning, home injury control (installation of grab bars, railings, specialized lighting, etc…), minor home repair (windows, screens, shower pans, etc. as indicated by veteran), painting (interior or exterior), plumbing), ramps, leaf removal & lawn care (mowing, flower planting, shrub trimming), and specialized lighting (motion sensors, outside lighting, etc…)

Escort Services: Accompanying and personally assisting the veteran to obtain a needed service. This may be provided by a paid caregiver, a paid escort, or service provider. It may include assisting the veteran in understanding and filling out applications for services (i.e. social security benefits, veteran's benefits, food stamps, etc…)

PADD Financial Management Staff: PADD FMS staff are housed within the Pennyrile Area Development District, and will act on behalf of each KY VDC participant to handle employer-related functions, pay participants'' workers, taxes, and help the participants keep track of his/her funds.

Health Maintenance: The provision of services prescription and medications, and /or other assistive devices which will prevent, alleviate, and/or cure the onset of acute or chronic illness, increase awareness of special health needs, and/or improve the emotional well-being of the veteran. This may include the cost of a caregiver to escort the veteran to facilitate participation as needed. Some health maintenance services include the following:

- Continued health maintenance and monitoring not available through insurance or veteran's benefits.
- Cooking classes for employee / worker (personal assistant).
- Gym of Health Club membership
- Health Counseling
- Health Education
- Massage therapy beyond services traditionally covered by insurance.
- Pet Therapy
- Public health maintenance programs (like water exercise classes or cardio-aerobic exercise classes).
- Structured weight reduction programs.

Homemaking Service: These include but are not limited to laundry, sweeping and mopping floors, dusting, changing linens, cleaning the bathroom (toilet tubs/showers, sinks & floors), cleaning the kitchen (loading/unloading dishwasher, hand washing dishes, washing off countertops, sinks, floors, and stovetops as needed). This may also include the preparation of meals, home management, and/or escort services.

Hub Agency: The Hub agency holds a contract with the Department of Veterans Affairs, and is ultimately responsible for reporting ensuring services are occurring within regulations either locally or by the spoke agencies. They perform primary communication with the VAMC.

Individually identified services or Goods Necessary for Independent Living: These services and goods are not covered by traditional VA or other resources but are deemed to be necessary for the veteran to remain independent with the best quality of life as defined by the Veteran.

Information and Referral Service: Consists of activities such as assessing the needs of the Veteran, evaluation appropriate resources, assessing appropriate response modes, including organizations capable of meeting those needs, providing information about each organization to help the

veteran make an informed choice, helping the veteran for whom services are no available by location alternative resources when necessary, actively participating in linking the veteran to needed services and following up on referrals to ensure the service was received or provided.

Nutritional Services: Hot, cold, froze, dried, or supplemental food which provides a minimum of 1/3 of the daily recommended dietary allowanced (RDA) as stabled by the Food and Nutrition Board of the National Academy of Sciences- National Resource Council.

- Home Delivered Standard Meal- the regular menu from the standard menu that is served to the majority of participants'.
- Therapeutic meal or liquid supplement- a special meal or liquid supplement that has been prescribed by a physician and is specifically for the participant by the dieting (i.e. diabetic diet, renal diet, pureed diet, tube feeding).

Participants in VDC: All veterans enrolled in the VA Health System are eligible to participate in the VDC program who meet requirement for the program and state an interest in Consumer Directed services. Where participants have cognitive impairments, the participant may designate a person (family member or trusted friend) as long as it abides by VDC policy & applicable VAMC policy, to be their "Designated Representative" to make decision or take action for them.

Personal Care Services: These are service tasks provided directly for the veteran's person and include but not limited to assistance in/out of the shower or bath tub, any assistance during the bathing process, assistance in getting on/off the toilet, brushing teeth/dentures, personal grooming tasks and dressing as well as providing verbal prompts to taking medication or placing pills from the medication minder into the hands of the veteran and verbally reminding or physical guiding the veteran to take them.

Respite Care: Respite care provides short-term breaks that relieve stress, restore energy, and promote balance in caregivers of the Veteran

- In-home services can be provided by volunteer or paid help, occasionally or on a regular basis. Services may last from a few hours to overnight, and may be arranged directly with an individual, family member, or through an agency. Respite series may include meal preparation, housekeeping, assistance with persona care and/or social and recreation activities.
- Out-of-home respite care programs include an array of series provide din a congregate or residential setting (nursing home, assisted living center, adult day care center) to the veteran in need of supervision. Services may include contracted short stay at an area nursing home or other specialized facilities that provide emergency and planned overnight services, allowing caretakers 24-hour relief. In addition to supervised services, the facility will be expected to provide meals, social and recreational activities, personal care, monitoring of health status, medical procedures and/or transportation (limited to 30 days per episode).

Safety Services: These may include a Personal Emergency Response System) or a combination key box for the door (keeps a key available for easy access to the home by emergency personnel). Safety Services may include a home safety evaluation by a professional person to assure safety of travel paths and needed durable medical equipment that may create a safer environment for the veteran.

- Personal Emergency Response System includes the installation of the individual monitoring unit, training associated with the use of the system, periodic checking to insure that the unit is functioning properly, equipment maintenance calls, response to an emergency call by a medical professional, paramedic, or volunteer, and follow-up with the veteran.
- Combination key box for the door, this keeps a key available for easy access to the home by emergency personnel.
- Home safety Evaluation by a professional person to assure safety of travel paths and needed durable medical equipment that may create a safer environment for the veteran.

Spoke Agency: The spoke agency holds a contract with the Hub Agency. The Hub agency holds a contract with the Department of Veterans Affairs. The spoke agency hires individual Case Managers and trains these Case Managers to work at the local level and provide supports to individual VDC participants

Self- Determination: A broad concept that means veteran participants have overall control of their lives and ability to take part in society. The Veteran has the ability to succeed or fail on his/her own decisions. Self-determination rests on five basic principles: 1) freedom to lead a meaningful life in the community; 2) authority over dollars needed for support; 3) support to organize resources in ways that are life-enhancing and meaningful; 4) responsibility for the wise use of public dollars; and 5) confirmation of the important leadership that self-advocates must hold in a newly designed system

Self-Direction: A process by whereby older persons, individuals with disabilities and, where appropriate, families have high levels of direct involvement, control and choice in identifying, accessing and managing the services they obtain to meet their personal assistance and other health-related needs. Self-direction and consumer direction are sometimes used interchangeably.

Services & Spending Plans: A participant's plan that contains the services that he participant chooses; the service(s)'s projected cost, frequent and duration; and the type of provider who furnishes each service. The plans also includes other services and informal supports that complement services in meeting the participant's needs.

Shopping or Running Errands: Shopping with or without the veteran. If the caregiver (or PA) uses the veteran's private vehicle, no mileage is paid. If the caregiver (or PA) uses their own private vehicle for travel, mileage and travel may be reimburses as greed up with the veteran.

Socialization Support Services: Caregiver (or PA) to accompany the veteran to activities such as education or exercise classes, support groups, movies, or other social engagements as indicated by the veteran. Counseling and support advisory counseling is provided that is beyond services traditionally reimbursed by VA or other insurance.

Transportation: The local Medicaid transporter, or other transporter, required to accompany the veteran to travel for socialization support or medical support activities with the designated caregiver may be reimbursed as agreed upon with the veteran. Provision of transportation assistance may include an escort to a veteran who has special needs (physical or cognitive) when using regular vehicular transportation.

Veteran Affair Medical Center (VAMC): The VDC Program initiated by the VAMC. The VAMC is responsible for making referrals and ensuring eligibility and monitoring services received by the eligible veteran. Primary communication is with the Hub Agency, whom the VAMC holds a contract with for the VDC Program.

Veteran Directed Care (VDC) Program: The VDC Program is a partnership program with Pennyrile Area Development District (PADD), Pennyrile Area Agency on Aging and Independent Living (PAAAIL), and the United States Department of Veterans Affairs through which eligible participants will have the option to control and direct services, supports and Medicaid funds, using the essential elements of person-centered planning, individual budgeting, participant protections, and quality assurance and quality improvement.

Authorized Representative Form

What is it for?

This form provides the Pennyrile ADD with required information about the participant who is receiving services and declines or authorizes a representative to serve as the employer on behalf of the program participant and defines the roles and responsibilities of the representative under the program. This form is required. The representative may not be an employee.
When a representative is designated, the representative must complete and sign all forms as the employer.

Veterans Directed Care Program (VDC)
Authorized Representative Form/Employer Agreement Form

The **Employer of Records** must:

- Work with the Case Manager to develop the Service & Spending Plan (budget) at startup and throughout the Veterans Directed Care Program (VDC)
- Use the VDC Budget for goods and services within the guidelines of the program
- Maintain records, complete all required paperwork, and adhere to all tax and labor laws

Authorized Representative Description – An Authorized Representative may be a family member or any other individual, **but not an employee, who willingly accepts responsibility for performing cash management tasks that the veteran is unable to perform for him or herself**. An Authorized Representative must demonstrate a commitment to the participant and must be willing to follow his or her wishes and respect the veteran's preferences while using sound judgment to act on his or her behalf. An Authorized Representative receives no monetary compensation for this service and may not serve as an employee of the veteran. All Authorized Representatives are required to report a background check and receive approval from the Spoke agency. Upon approval, the Authorized Representative will become the **"Employer of Records."**

Name of Veteran _____

Address _____

City _____, State____ Zip _____ Phone # _____

Decline of an Authorized Representative (check if applicable)

	I do not wish to designate an authorized representative. I, the veteran, will be the employer of records. Veteran's Signature _____ Date _____

Designation for Authorized Representative (complete if applicable)

I hereby appoint_____ to serve as my Authorized Representative in the VDC Program. This person is authorized to complete and sign all forms and to serve on my behalf as the employer of records for any personal employees under this program. This person will authorize payments from my monthly-approved spending plan, approve employee timesheets, communicate as needed with my Case Manager regarding the care I receive while participating in this program, and meet all documentation requirements as may be required. If I decide I no longer want to participate in the program, this designation expires on the date of my disenrollment from the VDC.

Veteran's Signature _____ Date _____

I hereby agree to serve as the Authorized Representative for the above name veteran and understand my responsibilities and duties under the VDC Program. I understand that I cannot pay myself for this role and that I cannot become a paid personal attendant of the above named veteran.

Authorized Representative's Signature _____
Date_____

Printed Name _____

Address
_____

City _____ , State_____ Zip _____ Phone #: _____

Relationship to veteran: _____

Case Manager Signature _____ Date _____

Enrollment & Agreement Form

What is it for?

The enrollment and agreement form is needed as it outlines the responsibilities of each party under the self-directed program. The employer must read this document and agree to the terms and conditions described.

Veterans Directed Care (VDC) Program

Enrollment & Agreement Form

I, _____ (print name) choose to receive more information about the Veterans Directed Care (VDC) Program.

I understand that if I enroll I will develop a Service & Spending Plan with the assistance of my Case Manager that will best meet my needs and is cost effective. I understand that if I overspend my Spending Plan, I am responsible for any expenses that exceed the spending plan.

I understand that the money from the Spending Plan may be used to hire an employee(s) and pay their wages and benefits and buy approved goods or services that will help me live more independently in my home.
I understand that I can choose who provides my care and that I can hire my own employee(s) as long as the Spoke and Area Development District approve. If I choose to hire my own employee(s), I understand that I will be their "Employer of Record" and am legally required to pay employer-related taxes for the employees I hire.

I understand that the Spoke Agency Case Manager and Pennyrile Area Development District (PeADD) FMS staff will assist me with the tasks related to being an employer. I will fully cooperate with Case Manager & PeADD FMS staff to provide them with the information needed to assist me with this task.

I understand that I can ask my Case Manager any questions I have about my rights as a Veteran in VDC Program. If I decide that the VDC Program is not right for me, I understand that I may choose not to direct my own services and instead receive services from the Veterans Health Administration, the Spoke Agency, if eligible, or other home and community services programs. I will not be penalized in any way if I decide that the VDC Program is not for me and I wish to receive services in a different way. I also understand that if it is determined by the Case Manager and local VA administrator that I am no longer able to direct my own care or have an authorized representative assist me that I will not be able to participate in the VDC Program.

Confidentiality: I understand that information about me is confidential. I understand that information I provide on the forms I complete will be shared with the Pennyrile Area Agency on Aging, other Spoke Agencies, and the Veterans Health Administration. I understand that the Pennyrile Area Agency on Aging/ Spoke Agency Case Managers and FMS staff will have access to this information. I also understand that all of these groups are required to hold my name in confidence to the full extent provided by the state and federal law.

I have read and understood all of the information in this form about the Veterans Directed Care (VDC) Program.

Enroll in VDC Program →		Decline Enrollment in VDC Program→	

_____ _____
Veteran or Authorized Representative Signature Date Signed

_____ _____
Printed Name of Veteran or Authorized Representative Telephone

_____
Address, City, State, Zip

Case Manager Verification: *I have explained all the required information contained in this form and I believe that the participant/authorized representative understands the provisions contained in this form and has made an informed decision to participate in the Veterans Directed Care Program.*

_____ _____
Case Manager Signature Date Signed

Veteran Set-Up Form

What is it for?

This form is required to be completed so that the Pennyrile ADD can obtain all necessary information to set the Veteran up for services.

Veterans Directed Care (VDC) Program
Veteran Set-Up Form

DIRECTIONS: Complete & provide to assigned Case Manager (copy of form will be submitted to PADD FMS staff).

VETERAN INFORMATION			
Last Name:		First Name:	
SSN:		Gender:	
Date of Birth:		Status:	ACTIVE
Residence Address:			
City:		County:	
State:		Zip Code:	
Email:		Job Title:	
Home Phone:		Cell Phone:	

AUTHORIZED REPRESENTATIVE INFORMATION (AS APPLICABLE)

Rep. Last Name _____ First Name_____

Address _____

City _____ State _____ Zip Code_____

Telephone _____ Email _____

SSN _____ Relationship to Vet:_____

Rights and Responsibilities

What is this for?

This form identifies all of your rights and responsibilities under the VDC Program. By signing this form you are in agreement that you have the opportunity to ask questions and have a clear understanding of your rights and responsibilities.

Veterans Directed Care (VDC) Program

Rights and Responsibilities

RIGHTS

I have the right to live as I choose, in my own home, as independently as I desire.
I have the right to be treated with dignity and respect.
I have the right to privacy and confidentiality.
I have the right to create a budget and options plan that meets my needs within the guidelines of the program at any time.
I have the right to change my budget and options plan to meet my needs within the guidelines of the program at any time.
I have the right to a monthly report on how my budget is spent.
I have the right to bring whomever I wish to all meetings pertaining to the program.
I have the right to an explanation of all services and procedures for billing.
I have the right to refuse services and terminate my participation in the program at any time.
I have the right to submit a complaint about any aspect of the program.

RESPONSIBILITES

I must demonstrate the required skills and abilities needed to self-direct employees or designate an Authorized Representative to do so.
I must actively participate in developing my spending and options plan.
I must be available for home visits as policy dictates (Home visits done 1x quarterly & monthly phone calls in between) and maintain adequate communication with my Case Manager (at least 1x monthly).
I must review my monthly budget statement and monitor all expenditures to ensure that I do not exceed my monthly budget.
I must complete all necessary forms and provide information to ensure compliance with tax and labor laws.
I must manage my employees by:
- Recruiting and hiring my employees, understanding that employment is contingent on the worker providing all information required to successfully enroll the worker in the VF/EA FMS entity's payroll system.
- Setting job duties and training my employees.
- Paying my employees a fair and legal wage.
- Setting my employees' schedules in advance and reviewing time sheets to ensure they are correct.
- Supervising my employees' daily activities and reviewing the adequacy and quality of their work.
- Ensuring a safe work environment for my employees.
- Notifying Case Manager immediately if I choose no longer to employ a worker.

I must develop an emergency back-up plan if my worker is not available.
I must notify my Case Manager immediately if I am admitted to the hospital or other medical facility.
I must oversee the activities of any other service providers that provide services to me.

Important Note:

Failure to abide by these veteran responsibilities listed above but not limited to, will result in the Veteran being issued a Corrective Action Plan (CAP) first. If non-compliance continues after 30 days from the date the CAP was implemented or if this issue continues to arise, Case Manager will & has the right to seek involuntary termination from the VAMC for the veteran from the VDC Program.

By signing this form, I agree that I have read/understand my rights & responsibilities of the VDC Program and have been given the opportunity to ask questions about these rights and responsibilities:

_____ _____

Veteran or Authorized Representative Date

Release of Information Form

What is this for?

This form allows the Pennyrile Area Development District to obtain your protected health information from the Veterans Medical Center.

Veterans Directed Care (VDC) Program
Release of Information Form

I, _____ hereby give permission to the Spoke Agency and FMS Agency, which includes the Area Development Districts, to release or obtain (not limited to) the Veteran's Protected Health Information.

Name of Area Agency on Aging: _____

Agency Address:	
Agency City:	
Agency Zip:	
Agency Telephone:	

Veteran or Authorized Representative Signature: _____

Veteran or Authorized Representative Name (Printed): _____

Date: _____

Case Manager Signature: _____

Date: _____

The Veteran, Authorized Representative, or Case Manager may complete this form. The Case Manager will keep the originally signed form in the veterans file, give a copy to the veteran, and give a copy to the appropriate organization to obtain or release information.

Fraud and Abuse Form

What is it for?

This form is required to be signed and returned so that you have an understanding of what is considered fraud and abuse. This form must be signed by Veteran, Veteran's representative if applicable, and case manager.

Veterans Directed Care (VDC) Program
Fraud & Abuse Statement

Fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. Fraud includes obtaining 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 Fraud include, but are not limited to:

- Knowingly and/or purposefully filling out an employee's time sheet incorrectly for hours or services that were not provided during the times listed or on the day listed.
- Knowingly and/or purposefully allowing the Financial Management Service (FMS) to bill for services that were not provided.
- Knowingly and /or purposefully using the VDC budget for any other purpose than what has been approved in the participant's individual spending 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 FMS for goods and services that were not provided.
- Knowingly and/or purposefully having the FMS pay an individual 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 participant and his/her representative. (This is also tax fraud).
- Knowingly and/or purposely having the FMS pay for an approved individual-directed good included in the participants budget, and then return the approved individual-directed 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 the program, 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 program.

Examples of Abuse include:

- Making errors when filling out timesheets and not immediately reporting the error to the FMS to remedy the situation.
- Being late in handing in participant/representative-employer related paperwork to the FMS or the participants Case Manager.

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 VDC Program will be referred to the VAMC. Participants suspected of fraud or abuse also face termination from the VDC program.

I have read the Fraud and Abuse Statement, I understand it and agree to comply with it.

_____

Veteran or Authorized Representative's Signature Date

_____

Case Manager's Signature Date

Background Check/Nurse Abuse Registry Agreement

What is this for?

This form is required to be completed verifying that you are aware that background checks must be conducted on all employees.

Veterans Directed Care (VDC) Program
Background Check/Nurse Abuse Registry Agreement
(1 per Veteran / Chart)

All candidates for a veteran's Personal Assistant and/or in-home employee(s) are required to have a name-based background check prior to employment in the Veterans Directed Care (VDC) Program. The background check will be performed/requested by the Case Manager. The background check will be conducted using data from the Administrative Office of the Courts (Frankfort, KY). In addition, all candidates must also undergo a Kentucky Nurse Abuse Registry check.

☐ By marking this box, I understand & accept the terms that a **name-based background check & Nurse Abuse Registry check** has to be conducted on all personal assistant(s) and/or in-home employee(s) of my choice, prior to employment in the VDC Program as required by the Spoke and FMS agencies.

I understand I may not hire the employee until I have received and reviewed the results with my case manager, who will maintain a copy of each and provide additional copies to PeADD FMS.

I understand that I have the right to hire an employee of my choice and will assume full responsibility of hiring this person if the Spoke agency, FMS agency and VAMC approves the employee. I understand that the Spoke, FMS and VAMC staff have the right to refuse employment of an individual should the background check results show any felony charge, charge related to abuse, or listed on any type of abuse registry's. If potential employee has a criminal history, I understand that I may be required by the Case Manager to sign a background waiver form stating that the background check results have been discussed, and I still wish to hire this individual regardless of the criminal history.

If you agree to the terms mentioned above, please mark the box above & complete areas below.

Veteran or Authorized Representative Signature: _____

Veteran or Authorized Representative Name (Printed): _____

Date: _____

Case Manager Signature: _____

Case Manager Date: _____

Kentucky

Worker's Compensation Acknowledgment Form

What is this for?

Worker's Compensation is required for participants in the Veteran Directed Care Program in Ohio. The cost of the policy will be incorporated on your plan of care. This form requires you to acknowledge and obtain workers compensation insurance with the FMS staff.

Veteran Directed Care (VDC) Program
Worker's Compensation Acknowledgment

I, _____ (print name of Veteran or Authorized Representative) have chosen to participate in the Veteran Directed Care (VDC) Program, which is a consumer-directed publicly funded program through the federal Veterans Administration. I understand that I am directing my own services as the "Employer of Record" under this program. **I understand that I am required to obtain worker's compensation insurance for my employee(s)/ worker(s)/ PA(s) in accordance with Department of Veterans Affairs guidelines and the regulations of the state of Ohio Department of Labor.** I authorize the Pennyrile Area Development District's Financial Management staff to assist me with obtaining the worker's compensation coverage, to provide the insurance carrier with any information as may be necessary to establish the worker's compensation coverage for my worker(s), and to remit the cost of the premiums from my monthly VDC Budget allocation. I further authorize all communications from the worker's compensation insurance carrier to be mailed directly to Pennyrile Area Development District's Financial Management staff and/or Pennyrile AAAIL's VDC Coordinator (if needed) who is acting on my behalf.

I understand that if I choose to terminate my participation in the Veteran Directed Care Program, the worker's compensation coverage will be canceled effective on the date that I cease to participate in the VDC Program.

I give my authorization for a copy of this acknowledgment to be forwarded to Pennyrile Area Development District's Financial Management staff and to the worker's compensation insurance carrier.

_____ _____
Veteran Participant/Authorized Representative Signature Date

To be completed by Case Manager:

Printed Veteran's Name: _____

Address: _____ City _____ ZIP _____

Telephone #: _____

Printed Authorized Rep Name (if applicable): _____

Address: _____ City _____ ZIP _____

Telephone #: _____

Case Manager Certification:

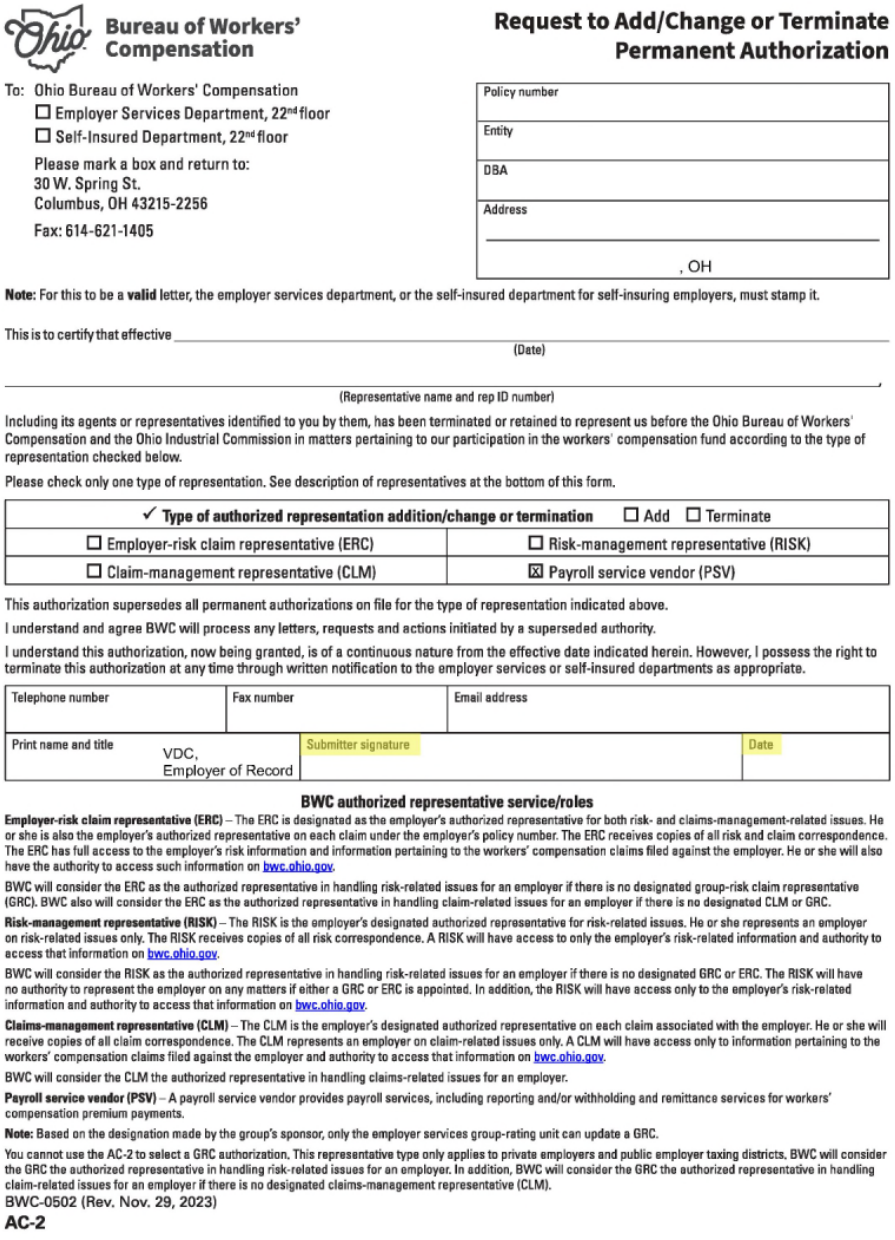
I certify that I have reviewed this document with the participant or authorized representative and that this individual is eligible to participate in the Veteran Directed Care Program (VDC).

_____ _____
Case Manager Signature Date

Request to Add/Change or Terminate Permanent Authorization (AC-2)

What is this for?

To apply for workers' compensation on the employer of record's behalf, this authorization must be completed. This form will be used to complete the application online. Once this is approved, the FMS agent will apply for and finalize the workers' compensation policy as required by the state of Ohio Depart of Labor.



Bureau of Workers' Compensation

Request to Add/Change or Terminate Permanent Authorization

To: Ohio Bureau of Workers' Compensation
☐ Employer Services Department, 22nd floor
☐ Self-Insured Department, 22nd floor

Please mark a box and return to:
30 W. Spring St.
Columbus, OH 43215-2256

Fax: 614-621-1405

Policy number
Entity
DBA
Address _____ , OH

Note: For this to be a **valid** letter, the employer services department, or the self-insured department for self-insuring employers, must stamp it.

This is to certify that effective _____ (Date)

_____ (Representative name and rep ID number)

Including its agents or representatives identified to you by them, has been terminated or retained to represent us before the Ohio Bureau of Workers' Compensation and the Ohio Industrial Commission in matters pertaining to our participation in the workers' compensation fund according to the type of representation checked below.

Please check only one type of representation. See description of representatives at the bottom of this form.

✓ **Type of authorized representation addition/change or termination** ☐ Add ☐ Terminate	
☐ Employer-risk claim representative (ERC)	☐ Risk-management representative (RISK)
☐ Claim-management representative (CLM)	☒ Payroll service vendor (PSV)

This authorization supersedes all permanent authorizations on file for the type of representation indicated above.

I understand and agree BWC will process any letters, requests and actions initiated by a superseded authority.

I understand this authorization, now being granted, is of a continuous nature from the effective date indicated herein. However, I possess the right to terminate this authorization at any time through written notification to the employer services or self-insured departments as appropriate.

Telephone number	Fax number	Email address	
Print name and title VDC, Employer of Record	Submitter signature		Date

BWC authorized representative service/roles

Employer-risk claim representative (ERC) – The ERC is designated as the employer's authorized representative for both risk- and claims-management-related issues. He or she is also the employer's authorized representative on each claim under the employer's policy number. The ERC receives copies of all risk and claim correspondence. The ERC has full access to the employer's risk information and information pertaining to the workers' compensation claims filed against the employer. He or she will also have the authority to access such information on bwc.ohio.gov.

BWC will consider the ERC as the authorized representative in handling risk-related issues for an employer if there is no designated group-risk claim representative (GRC). BWC also will consider the ERC as the authorized representative in handling claim-related issues for an employer if there is no designated CLM or GRC.

Risk-management representative (RISK) – The RISK is the employer's designated authorized representative for risk-related issues. He or she represents an employer on risk-related issues only. The RISK receives copies of all risk correspondence. A RISK will have access to only the employer's risk-related information and authority to access that information on bwc.ohio.gov.

BWC will consider the RISK as the authorized representative in handling risk-related issues for an employer if there is no designated GRC or ERC. The RISK will have no authority to represent the employer on any matters if either a GRC or ERC is appointed. In addition, the RISK will have access only to the employer's risk-related information and authority to access that information on bwc.ohio.gov.

Claims-management representative (CLM) – The CLM is the employer's designated authorized representative on each claim associated with the employer. He or she will receive copies of all claim correspondence. The CLM represents an employer on claim-related issues only. A CLM will have access only to information pertaining to the workers' compensation claims filed against the employer and authority to access that information on bwc.ohio.gov.

BWC will consider the CLM the authorized representative in handling claims-related issues for an employer.

Payroll service vendor (PSV) – A payroll service vendor provides payroll services, including reporting and/or withholding and remittance services for workers' compensation premium payments.

Note: Based on the designation made by the group's sponsor, only the employer services group-rating unit can update a GRC.

You cannot use the AC-2 to select a GRC authorization. This representative type only applies to private employers and public employer taxing districts. BWC will consider the GRC the authorized representative in handling risk-related issues for an employer. In addition, BWC will consider the GRC the authorized representative in handling claim-related issues for an employer if there is no designated claims-management representative (CLM).

BWC-0502 (Rev. Nov. 29, 2023)
AC-2

Application for Ohio Workers' Compensation Coverage

What is it for?

Instructions for this application are included with this packet (4 pages). This application allows us to help you process the application for worker's compensation coverage. This is required in accordance with the regulations of the state of Ohio Department of Labor. The expenses related therein will be processed by the FMS agent, Pennyrile Area Development District, and will be drawn from the VDC budget that the veteran is provided.

Bureau of Workers' Compensation

Application for
Ohio Workers' Compensation Coverage

Have questions? Need assistance? We are here to help!

- **Call 1-800-644-6292 and listen to the options to reach a customer service representative available Monday through Friday from 7:30 a.m. to 5:30 p.m. EST.**
- **International callers please call 1-614-367-5743.**
- **Visit our website for more information at bwc.ohio.gov.**
- **Complete all required fields (*) to avoid processing delays.**
- ***BWC will return applications without the $120 non-refundable application fee.***

***General information**

*Legal business name/Homeowner	*Federal employer identification number/Social Security number
Doing business as	
*Do you currently have any Ohio employees? Or do you plan on hiring Ohio employees within the next 12 months? ☒ Yes ☐ No (**Note:** *If you do not have employees and will not be hiring any, complete the No Employee Questionnaire at the end of this form.*)	*First hire date

***Business address**

*Primary physical location (Ohio preferred) address line 1 (P.O. Box not allowed)	Address line 2	
*City	*State	*ZIP code

Mailing address ☐ Check if your mailing address is the same as above.

*Mailing address line 1		
300 Hammond Dr		
*City	*State	*ZIP code
Hopkinsville	KY	42240

Additional Ohio business name		
Additional Ohio physical location address line 1 (P.O. Box not allowed)	Address line 2	
City	State	ZIP code
	OH	

Note: List any additional locations at the end of this form.

***Business communication**

*Business email	*Business phone	Is this a cell phone? ☐ Yes ☒ No
vdcfms@ky.gov	270-886-9484	

Mailing address attention to	Business website	Business fax
VDC FMS		

Contacts

*Primary contact name (First, Middle Initial, Last, and Suffix)		
Stephanie E Starr		
*Contact email	*Contact phone	Is this a cell phone? ☐ Yes ☐ No
vdcfms@ky.gov	270-886-9484	
*Title/Contact type		
Senior Staff Accountant, Pennyrile Area Development District/FMS for Veterans Directed Care Program		
Secondary contact name		
Hayla J Swaw		
Contact email	Contact phone	Is this a cell phone? ☐ Yes ☒ No
vdcfms@ky.gov	270-886-9484	

BWC-7503 (Rev. Nov. 5, 2024)
U-3

IRS Form SS-4
Application for Employer Identification Number

What it is for?

This form tells the IRS that you are going to be an Employer and is used to obtain an Employer Identification number (EIN) from the IRS. This EIN is used to open state employer accounts and assign all tax deposit and filing responsibility to PeADD. This form is kept on file at the PeADD office as documentation for obtaining the EIN on your behalf via the IRS website.

Will I receive anything from the IRS?

Yes. You will receive a letter from the IRS that documents your EIN. It will describe your financial responsibilities as the employer. The PeADD stands in for these responsibilities as designated in Form 2678, described below. Please retain this letter for your records if anyone should ask for your EIN, but know that the PeADD will be filing taxes and distributing payroll on your behalf.

Who are the people listed in the 'Third Party Designee' section?

Those are PeADD staff members who are experienced with obtaining EINs on behalf of participants/employers.

What lines do I complete?

PeADD has completed the SS-4 in a way that notifies the IRS that even though you will be the official employer of your service providers, you will be using PeADD to file and deposit your employer taxes. The form will be prepopulated with the participant information if there is no representative or if a representative is elected, his/her information will be prepopulated. If the designated employer has applied for an EIN in the past, please complete line 18.

IRS FORM 8821
Tax Information Authorization

What is it for?

This form allows PeADD to discuss your employer withholding account with the IRS. It also further designates authority to obtain an EIN on your behalf. It does not allow these representatives to sign any documents.

Will the PeADD be able to discuss my personal tax account with the IRS?

No. PeADD will only be able to discuss the employer tax forms listed in Section 3b. PeADD will never be able to obtain any personal income tax information with this form.

I make all decisions about my life. If I sign this, what decision can PeADD make for me?

This form only lets the PeADD talk and write to the IRS. PeADD cannot make decisions about your personal situation.

Form **8821**

Tax Information Authorization

▶ 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.

1 **Taxpayer information.** Taxpayer must sign and date this form on line 7.

Taxpayer name and address: John Doe, 123 Main St, Small Town, KY 12345

Taxpayer identification number(s)

Daytime telephone number: 210-555-1212 | 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: Kelly Allen, Pennyrile Area Development District, Veterans Directed Care Program, 300 Hammond Drive, Hopkinsville, KY 42240

CAF No.

PTIN

Telephone No.

Fax No.

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
Income and Employment Tax	940, 940R, 941, 941R, 941x, W2	3Q 2017-1Q 2021	Tax Liability

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 _______________

Sally Doe (- -) _______________ Representative

Print Name _______________ Title (if applicable)

For Privacy Act and Paperwork Reduction Act Notice, see instructions. Form **8821**

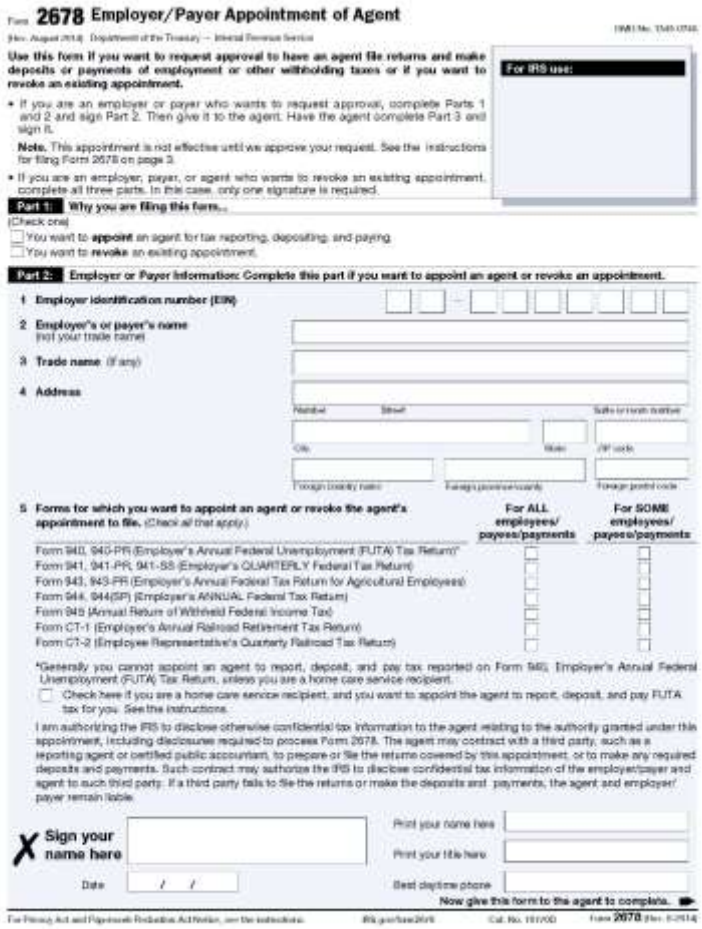
IRS Form 2678
EMPLOYER APPOINTMENT OF AGENT

What is it for?

This form tells the IRS that you give Pennyrile Area Development District permission to complete tax forms for you. By signing this form, you authorize PeADD to withhold taxes from your employees' paychecks and deposit those taxes with the IRS. With this form, you delegate the employer tax responsibility to PeADD.

Does the IRS Form 2678 authorize you to file my personal income taxes?

No. PeADD only deposits withholding taxes for your Employees. PeADD cannot handle any of your personal Income tax matters.



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

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.

For IRS use:

- 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.

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.

✗ **Sign your name here**

Print your name here

Print your title here

Date / /

Best daytime phone

Now give this form to the agent to complete.

For Privacy Act and Paperwork Reduction Act Notice, see the instructions. IRS.gov/form2678 Cat. No. 10170D Form **2678** (Rev. 8-2014)

UI Application for Unemployment Insurance

What is it for?

This form is required as every employer in the State of Ohio is required to fill out a report to determine status. Submitting this form will determine the status of your liability for unemployment insurance. If you are liable for unemployment insurance premiums in Ohio, you will be assigned an employer account number. The Pennyrile Area Development District (PeADD) will be responsible for filing all wage reports, paying taxes and managing your unemployment tax account.

Ohio Department of Job and Family Services
Office of Unemployment Insurance Operations
REPORT TO DETERMINE LIABILITY

Congratulations on starting a business in Ohio. To obtain an unemployment insurance tax account immediately, please visit unemployment.ohio.gov. As an alternative, you may complete this form and mail it to the address below. If you complete and send a paper form, we will notify you in writing of your Employer ID within 4 to 6 weeks.

Contact Information

First and Last Name			Job Title HCSR
Street Address			City
State	ZIP	County	Country United States
Email			Telephone Number

Initial Questions

Federal Employer Identification Number (FEIN) *(Please do not use your SSN)*		Are you registering as a church or organization operated primarily for religious purposes? ☐ Yes ☐ No
Have you paid, or do you anticipate paying, wages to individuals, including corporate officers, for services performed in Ohio? ☐ Yes ☐ No		
If yes, enter the date work was first performed in Ohio.	If yes, enter the date covered wages were or will be first paid in Ohio.	How many employees are currently being paid, or will be paid, for work performed in Ohio?

Employment Information. What type of business are you engaged in?
Please check only one and answer the questions below it.

☐ Regular

Have you or do you expect to have a quarterly gross payroll of $1,500 or more in any quarter of the current or preceding calendar year(s)? ☐ Yes ☐ No

Enter the date the business first paid/will pay a gross payroll of $1,500 or more.

Have you or do you expect to employ at least one worker in 20 different calendar weeks during a calendar year?
☐ Yes ☐ No

If yes, enter the date the business reached/will reach the 20th week for the first time with one or more workers. Note: The 20 weeks do not have to be consecutive, but they must be within the same calendar year.

Enter the first pay date in the year the threshold was met:

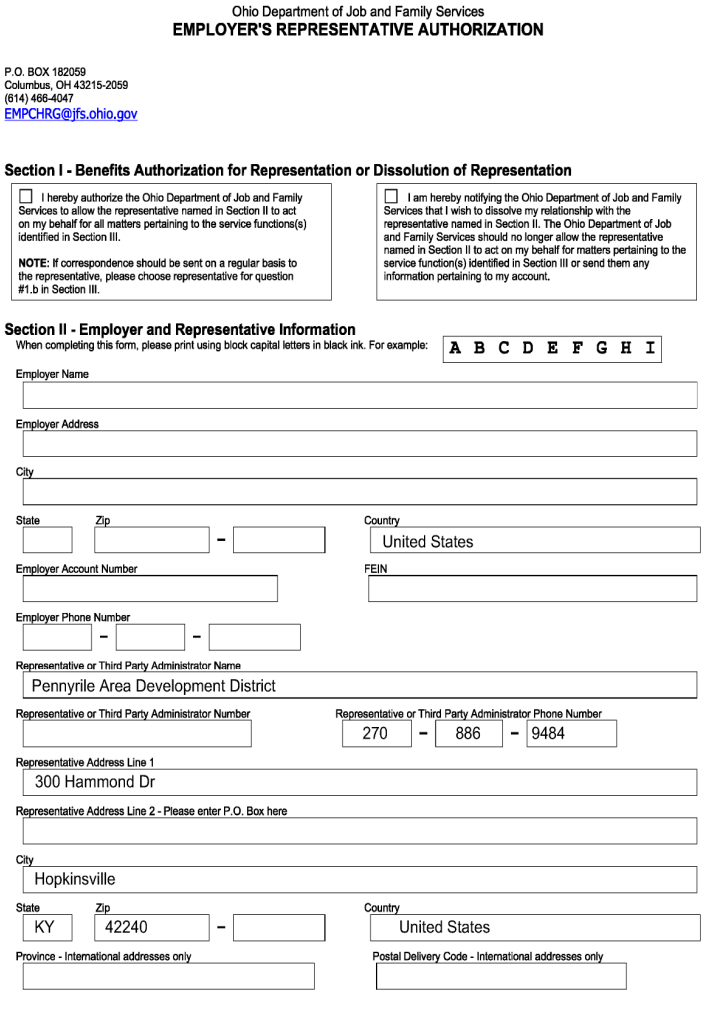
Is the business liable for Federal Unemployment Tax Act (FUTA) taxes in another state? ☐ Yes ☐ No

☐ Nonprofit

Power of Attorney for Representing Employer for Unemployment Insurance Related Matters

What is this for?

This form allows the Office of Unemployment Insurance to send or share confidential information about your unemployment insurance account with PADD. It allows PADD to represent the Employer before the Office of Unemployment Insurance in any and all matters, to act in the Employer's stead with the same consequences as the Employer, and to receive any and all information requested by said Representative pertaining to the Employer's liability for the payment of contributions, interest and penalties under the Ohio Unemployment Compensation Laws and Regulations, until such time as the appointment is terminated.



Ohio Department of Job and Family Services
EMPLOYER'S REPRESENTATIVE AUTHORIZATION

P.O. BOX 182059
Columbus, OH 43215-2059
(614) 466-4047
EMPCHRG@jfs.ohio.gov

Section I - Benefits Authorization for Representation or Dissolution of Representation

☐ I hereby authorize the Ohio Department of Job and Family Services to allow the representative named in Section II to act on my behalf for all matters pertaining to the service functions(s) identified in Section III.

NOTE: If correspondence should be sent on a regular basis to the representative, please choose representative for question #1.b in Section III.

☐ I am hereby notifying the Ohio Department of Job and Family Services that I wish to dissolve my relationship with the representative named in Section II. The Ohio Department of Job and Family Services should no longer allow the representative named in Section II to act on my behalf for matters pertaining to the service function(s) identified in Section III or send them any information pertaining to my account.

Section II - Employer and Representative Information

When completing this form, please print using block capital letters in black ink. For example: A B C D E F G H I

Employer Name

Employer Address

City

State | Zip | Country: United States

Employer Account Number | FEIN

Employer Phone Number

Representative or Third Party Administrator Name: Pennyrile Area Development District

Representative or Third Party Administrator Number | Representative or Third Party Administrator Phone Number: 270 - 886 - 9484

Representative Address Line 1: 300 Hammond Dr

Representative Address Line 2 - Please enter P.O. Box here

City: Hopkinsville

State: KY | Zip: 42240 | Country: United States

Province - International addresses only | Postal Delivery Code - International addresses only

JFS 00501 (Rev. 3/2024) Page 1 of 2

Unemployment Insurance Agent Authorization From

What is this for?

This is an additional form that allows the Office of Unemployment Insurance to send or share confidential information about your unemployment insurance account with PADD. It allows PADD to represent the Employer before the Office of Unemployment Insurance in any and all matters, to act in the Employer's stead with the same consequences as the Employer, and to receive any and all information requested by said Representative pertaining to the Employer's liability for the payment of contributions, interest and penalties under the Kentucky Unemployment Compensation Laws and Regulations, until such time as the appointment is terminated.

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES

P.O. Box 182404
Columbus, Ohio 43218-2404
(614) 466-2319
http://unemployment.ohio.gov

FOR 0006A

AGENT AUTHORIZATION FORM

To immediately authorize an agent (third party administrator, accountant, payroll company, etc) to act on your behalf regarding your account, please visit http://unemployment.ohio.gov. If you prefer, you may submit your information by completing this form and your account will be updated within 2-3 weeks. When completing this form, please print, using block capital letters in black ink. For example:

A B C D E F G H

Section I - Employer and Representative Information

Employer Legal Name

Employer ID

Plant Number (If none, please leave blank.)

Employer Phone Number

Agent Name

Pennyrile Area Development District-Veterans Directed Care Program

Agent ID

6000015512

Agent Phone Number

270 - 886 - 9484

Agent Address Line 1 - Enter street address or P.O. box information here (for example, 123 Main St., P.O. Box 123.)

300 Hammond Dr

Agent Address Line 2 - Enter secondary address information here (for example, STE 123, APT A, 1st FL. If none, please leave blank.)

City

Hopkinsville

State

KY

ZIP

42211 -

Country

United States of America

Province - International addresses only

Postal Delivery Code – International addresses only

T JFS 20106 (Rev. 12/2022) Page 1 of 2 T

Optional Form

Service Plan

This form is optional and is a tool used to develop your proposed plan of care, which will include services & tasks, frequency of hours, hourly wage, and projected costs.

VDC Program Service Plan Template for Veteran

You're able to break down utilization of funds weekly, monthly, or yearly on this Service Plan, however finalized Spending Plan (which will be sent to VAMC for approval) must be broken down into "MONTHLY" cost. If possible, completing this plan in monthly cost is ideal but is NOT required. Please complete however you find it easier. Case Manger & PADD FMS staff will be able to assist if needed. **If you need additional spaces, page #4 will be a continuation of page #3.**

Services/ Supports/ Goods Required	Tasks/Duties Requiring Assistance	Frequency (Hours Weekly) & Instructions	Projected Hourly Wage or Cost	Projected Cost Weekly, Monthly or Yearly or Item Cost (Please label if costs is weekly, monthly, yearly or a one-time purchase & calculate total based on that information

Projected Total (Weekly, Monthly, Yearly – Please Label) = $

Veteran Signature/Authorized Representative (if applicable): **Date:**