

## **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: \_\_\_\_\_

EOR City: \_\_\_\_\_

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	
<input type="checkbox"/>	Submit SP to VAMC _____
<input type="checkbox"/>	SP Approved: Start date: _____
<input type="checkbox"/>	Obtain EIN _____
<input type="checkbox"/>	Scan/AF
<input type="checkbox"/>	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 _____
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**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 _____
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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: _____
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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 →	
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\_\_\_\_\_  
Veteran or Authorized Representative Signature

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Printed Name of Veteran or Authorized Representative

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Address, City, State, Zip

<i>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.</i>	
_____ 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).

<b>VETERAN INFORMATION</b>			
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.

### **RESPONSIBILITIES**

- 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:**

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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 purposefully 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.

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Veteran or Authorized Representative’s Signature Date

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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 and as the "Employer of Record" under this program. **I understand that I have the option to obtain worker's compensation insurance for my employee(s)/ worker(s)/ PA(s) in accordance with Department of Veterans Affairs guidelines.**

Should I choose the worker's compensation option, 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.

**Choose Worker's Compensation Insurance for my employee(s)?** Yes  No

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

**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: \_\_\_\_\_)

<b>Check each category</b>	<b>YES</b>	<b>NO</b>	<b>NEEDS REPAIR</b>	<b>COMMENTS</b>
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				

<b>Check each category</b>	<b>YES</b>	<b>NO</b>	<b>NEEDS REPAIR</b>	<b>COMMENTS</b>
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**

	<b>HAS</b>	<b>USES</b>	<b>NEEDS</b>	<b>COMMENTS</b>
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.

<b>BEHAVIOR PATTERN</b>	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**

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

Comments:

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

Comments:

<b>SUBTOTAL OF ADLs &amp; IADLs</b>	
-------------------------------------	--

**SUMMARY & JUDGEMENT**

<b>GRAND TOTAL SCORE</b>	
--------------------------	--

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

Assessor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Application for Employer Identification Number

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

EIN

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

<b>1</b>	Legal name of entity (or individual) for whom the EIN is being requested																	
<b>Type or print clearly.</b>	<b>2</b>	Trade name of business (if different from name on line 1)	<b>3</b>	Executor, administrator, trustee, "care of" name														
	<b>4a</b>	Mailing address (room, apt., suite no. and street, or P.O. box) <u>300 Hammond Drive</u>	<b>5a</b>	Street address (if different) (Do not enter a P.O. box.)														
	<b>4b</b>	City, state, and ZIP code (if foreign, see instructions) <u>Hopkinsville, KY 42240</u>	<b>5b</b>	City, state, and ZIP code (if foreign, see instructions)														
	<b>6</b>	County and state where principal business is located																
	<b>7a</b>	Name of responsible party	<b>7b</b>	SSN, ITIN, or EIN														
<b>8a</b>	Is this application for a limited liability company (LLC) (or a foreign equivalent)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<b>8b</b>	If 8a is "Yes," enter the number of LLC members ▶														
<b>8c</b>	If 8a is "Yes," was the LLC organized in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No																	
<b>9a</b>	<b>Type of entity</b> (check only one box). <b>Caution.</b> If 8a is "Yes," see the instructions for the correct box to check. <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Sole proprietor (SSN) _____</td> <td><input type="checkbox"/> Estate (SSN of decedent) _____</td> </tr> <tr> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> Plan administrator (TIN) _____</td> </tr> <tr> <td><input type="checkbox"/> Corporation (enter form number to be filed) ▶ _____</td> <td><input type="checkbox"/> Trust (TIN of grantor) _____</td> </tr> <tr> <td><input type="checkbox"/> Personal service corporation</td> <td><input type="checkbox"/> National Guard <input type="checkbox"/> State/local government</td> </tr> <tr> <td><input type="checkbox"/> Church or church-controlled organization</td> <td><input type="checkbox"/> Farmers' cooperative <input type="checkbox"/> Federal government/military</td> </tr> <tr> <td><input type="checkbox"/> Other nonprofit organization (specify) ▶ _____</td> <td><input type="checkbox"/> REMIC <input type="checkbox"/> Indian tribal governments/enterprises</td> </tr> <tr> <td><input checked="" type="checkbox"/> Other (specify) ▶ <u>HHCSR</u></td> <td>Group Exemption Number (GEN) if any ▶ _____</td> </tr> </table>				<input type="checkbox"/> Sole proprietor (SSN) _____	<input type="checkbox"/> Estate (SSN of decedent) _____	<input type="checkbox"/> Partnership	<input type="checkbox"/> Plan administrator (TIN) _____	<input type="checkbox"/> Corporation (enter form number to be filed) ▶ _____	<input type="checkbox"/> Trust (TIN of grantor) _____	<input type="checkbox"/> Personal service corporation	<input type="checkbox"/> National Guard <input type="checkbox"/> State/local government	<input type="checkbox"/> Church or church-controlled organization	<input type="checkbox"/> Farmers' cooperative <input type="checkbox"/> Federal government/military	<input type="checkbox"/> Other nonprofit organization (specify) ▶ _____	<input type="checkbox"/> REMIC <input type="checkbox"/> Indian tribal governments/enterprises	<input checked="" type="checkbox"/> Other (specify) ▶ <u>HHCSR</u>	Group Exemption Number (GEN) if any ▶ _____
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<input type="checkbox"/> Other nonprofit organization (specify) ▶ _____	<input type="checkbox"/> REMIC <input type="checkbox"/> Indian tribal governments/enterprises																	
<input checked="" type="checkbox"/> Other (specify) ▶ <u>HHCSR</u>	Group Exemption Number (GEN) if any ▶ _____																	
<b>9b</b>	If a corporation, name the state or foreign country (if applicable) where incorporated	State	Foreign country															
<b>10</b>	<b>Reason for applying</b> (check only one box) <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Started new business (specify type) ▶ _____</td> <td><input type="checkbox"/> Banking purpose (specify purpose) ▶ _____</td> </tr> <tr> <td><input type="checkbox"/> Hired employees (Check the box and see line 13.)</td> <td><input type="checkbox"/> Changed type of organization (specify new type) ▶ _____</td> </tr> <tr> <td><input type="checkbox"/> Compliance with IRS withholding regulations</td> <td><input type="checkbox"/> Purchased going business</td> </tr> <tr> <td><input checked="" type="checkbox"/> Other (specify) ▶ <u>HHCSR</u></td> <td><input type="checkbox"/> Created a trust (specify type) ▶ _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Created a pension plan (specify type) ▶ _____</td> </tr> </table>				<input type="checkbox"/> Started new business (specify type) ▶ _____	<input type="checkbox"/> Banking purpose (specify purpose) ▶ _____	<input type="checkbox"/> Hired employees (Check the box and see line 13.)	<input type="checkbox"/> Changed type of organization (specify new type) ▶ _____	<input type="checkbox"/> Compliance with IRS withholding regulations	<input type="checkbox"/> Purchased going business	<input checked="" type="checkbox"/> Other (specify) ▶ <u>HHCSR</u>	<input type="checkbox"/> Created a trust (specify type) ▶ _____		<input type="checkbox"/> Created a pension plan (specify type) ▶ _____				
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<input checked="" type="checkbox"/> Other (specify) ▶ <u>HHCSR</u>	<input type="checkbox"/> Created a trust (specify type) ▶ _____																	
	<input type="checkbox"/> Created a pension plan (specify type) ▶ _____																	
<b>11</b>	Date business started or acquired (month, day, year). See instructions.		<b>12</b>	Closing month of accounting year <u>December</u>														
<b>13</b>	Highest number of employees expected in the next 12 months (enter -0- if none). If no employees expected, skip line 14.		<b>14</b>	If you expect your employment tax liability to be \$1,000 or less in a full calendar year <b>and</b> want to file Form 944 annually instead of Forms 941 quarterly, check here. (Your employment tax liability generally will be \$1,000 or less if you expect to pay \$4,000 or less in total wages.) If you do not check this box, you must file Form 941 for every quarter. <input type="checkbox"/>														
	Agricultural	Household <u>4</u>	Other															
<b>15</b>	First date wages or annuities were paid (month, day, year). <b>Note.</b> If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year) ▶																	
<b>16</b>	Check <b>one</b> box that best describes the principal activity of your business. <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Construction</td> <td><input type="checkbox"/> Rental &amp; leasing</td> <td><input type="checkbox"/> Transportation &amp; warehousing</td> <td><input type="checkbox"/> Accommodation &amp; food service</td> <td><input type="checkbox"/> Wholesale-agent/broker</td> </tr> <tr> <td><input type="checkbox"/> Real estate</td> <td><input type="checkbox"/> Manufacturing</td> <td><input type="checkbox"/> Finance &amp; insurance</td> <td><input checked="" type="checkbox"/> Other (specify) ▶ <u>HHCSR</u></td> <td><input type="checkbox"/> Wholesale-other <input type="checkbox"/> Retail</td> </tr> </table>				<input type="checkbox"/> Construction	<input type="checkbox"/> Rental & leasing	<input type="checkbox"/> Transportation & warehousing	<input type="checkbox"/> Accommodation & food service	<input type="checkbox"/> Wholesale-agent/broker	<input type="checkbox"/> Real estate	<input type="checkbox"/> Manufacturing	<input type="checkbox"/> Finance & insurance	<input checked="" type="checkbox"/> Other (specify) ▶ <u>HHCSR</u>	<input type="checkbox"/> Wholesale-other <input type="checkbox"/> Retail				
<input type="checkbox"/> Construction	<input type="checkbox"/> Rental & leasing	<input type="checkbox"/> Transportation & warehousing	<input type="checkbox"/> Accommodation & food service	<input type="checkbox"/> Wholesale-agent/broker														
<input type="checkbox"/> Real estate	<input type="checkbox"/> Manufacturing	<input type="checkbox"/> Finance & insurance	<input checked="" type="checkbox"/> Other (specify) ▶ <u>HHCSR</u>	<input type="checkbox"/> Wholesale-other <input type="checkbox"/> Retail														
<b>17</b>	Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided.																	
<b>18</b>	Has the applicant entity shown on line 1 ever applied for and received an EIN? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																	

<b>Third Party Designee</b>	Complete this section <b>only</b> if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.		
	Designee's name	Designee's telephone number (include area code)	<u>270-886-9484</u>
	Address and ZIP code <u>300 Hammond Drive, Hopkinsville, KY 42240</u>	Designee's fax number (include area code)	<u>270-886-3211</u>
Under penalties of perjury, I declare that I have examined this application, and to the best of my knowledge and belief, it is true, correct, and complete.		Applicant's telephone number (include area code)	
Name and title (type or print clearly) ▶		Applicant's fax number (include area code)	
Signature ▶		Date ▶	

### Tax Information Authorization

► Information about Form 8821 and its instructions is at [www.irs.gov/form8821](http://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 <u>270-886-9484</u> 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  % Veteran Directed Care Program 300 Hammond Drive Hopkinsville, KY 42240	CAF No. _____ PTIN _____ Telephone No. <u>270-886-9484</u> Fax No. <u>270-886-3211</u> Check if new: Address <input type="checkbox"/> Telephone No. <input type="checkbox"/> Fax No. <input type="checkbox"/>
--	---

**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.**

**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)*	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Form 941, 941-PR, 941-SS (Employer's QUARTERLY Federal Tax Return)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Form 943, 943-PR (Employer's Annual Federal Tax Return for Agricultural Employees)	<input type="checkbox"/>	<input type="checkbox"/>
Form 944, 944(SP) (Employer's ANNUAL Federal Tax Return)	<input type="checkbox"/>	<input type="checkbox"/>
Form 945 (Annual Return of Withheld Federal Income Tax)	<input type="checkbox"/>	<input type="checkbox"/>
Form CT-1 (Employer's Annual Railroad Retirement Tax Return)	<input type="checkbox"/>	<input type="checkbox"/>
Form CT-2 (Employee Representative's Quarterly Railroad Tax Return)	<input type="checkbox"/>	<input type="checkbox"/>

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

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

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

**X Sign your name here**

\_\_\_\_\_

Print your name here

\_\_\_\_\_

Print your title here

\_\_\_\_\_

Date

\_\_\_\_ / \_\_\_\_ / \_\_\_\_

Best daytime phone

270-886-9484

**Now give this form to the agent to complete.** ➔

**EMPLOYER'S INITIAL STATEMENT  
WORKFORCE WEST VIRGINIA  
UNEMPLOYMENT COMPENSATION DIVISION**

Required by Article 10, Section 11 of the West Virginia Unemployment Compensation Law

**RETURN ORIGINAL WITHIN TEN DAYS**

**DO NOT WRITE IN THIS SECTION**

1. Name(s)	Telephone Number
DBA	
Business Address and Zip Code	
Mailing Address and Zip Code 300 Hammond Drive, Hopkinsville, KY 42240	
E-mail Address	
County	Federal Number

Effective Date:	
Liable Date:	
Provision:	
Decision By:	Date:
Fed ID No:	
State ID No:	
Rate:	Merit Year:

2. Physical location of business (be specific):

3. Name, street address, telephone number, and person to contact where payroll records are maintained:

4. (a) Check (X) form of organization:

<input type="checkbox"/> Individual	<input type="checkbox"/> Partnership	<input type="checkbox"/> Domestic Only	<input type="checkbox"/> Agricultural Only
<input type="checkbox"/> LLC	If you are an LLC, do you file with the IRS as a corporation? Yes <input type="checkbox"/> No <input type="checkbox"/>		
<input type="checkbox"/> Corporation	State of Incorporation _____	Date of Incorporation _____	
<input type="checkbox"/> Governmental Entity, Political Subdivision or Instrumentality	<input type="checkbox"/> Taxable	<input type="checkbox"/> Reimbursable	
<input type="checkbox"/> Nonprofit organization exempt from income tax under IRS Code Section 501(C) (3) ONLY.			
<b>Attach copy of U.S. Treasury letter giving this exemption.</b> <input type="checkbox"/> Taxable <input type="checkbox"/> Reimbursable			

(b) List Name, Social Security Number and Resident Address of Proprietor; all Partners, LLC members or Officers of the Corporation.

Name and Title	Social Security Number (Required)	Resident Address (Required)

5. Nature of Business: \_\_\_\_\_ WV Location: \_\_\_\_\_

6. If you have been assigned an Employer Account Number by this Division, please enter the number here: \_\_\_\_\_

7. Date you began operation in West Virginia: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date first wages paid in West Virginia: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Business/assets/employees acquired from another employer?  Yes  No If Yes, enter date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Give name address and zip code of predecessor; also, federal reporting and State U.I. numbers (if known)

Federal Number \_\_\_\_\_ State UI Number \_\_\_\_\_

8. Have you ever or do you expect to employ at least ONE worker in 20 different calendar weeks during a calendar year?  No  Yes Month \_\_\_\_\_ Year \_\_\_\_\_  
 If Yes, in what earliest month and year will the 20<sup>th</sup> week occur?

9. Have you or do you expect to have a quarterly payroll of \$1,500?  No  Yes Quarter \_\_\_\_\_ Year \_\_\_\_\_  
 If Yes, in what earliest quarter and year will the payroll occur?

10. Have you or do you expect to employ in any calendar year, 10 or more agricultural workers in 20 different calendar weeks?  No  Yes Month \_\_\_\_\_ Year \_\_\_\_\_  
 If Yes, in what earliest month and year will the 20<sup>th</sup> week occur?

11. Have you or do you expect to have a \$20,000 quarterly payroll of agricultural workers in any year?  No  Yes Quarter \_\_\_\_\_ Year \_\_\_\_\_  
 If Yes, in what earliest quarter and year will the payroll occur?

12. Have you or do you expect to have a \$1,000 quarterly payroll of domestic ( housekeepers, babysitters, etc) workers in any year?  No  Yes Quarter \_\_\_\_\_ Year \_\_\_\_\_  
 If Yes, in what earliest quarter and year will the payroll occur?

13. If you are a nonprofit organization with a 501 (c)(3) exemption, have you or do you expect to employ four or more workers in 20 different calendar weeks during a calendar year?  No  Yes Month \_\_\_\_\_ Year \_\_\_\_\_  
 If Yes, in what earliest month and year will the 20<sup>th</sup> week occur?  
**Please furnish a copy of exemption letter.**

14. Are you liable for the Federal Unemployment Tax?  Yes  No If Yes, in what year did you become liable?  
 In what states?

15. State the number of Individuals working in West Virginia: \_\_\_\_\_ In other states: \_\_\_\_\_

16. Enter the greatest number of employees you had in any one day in the calendar week. Include part-time and extra workers as well as your regular employees. Partners of a partnership are not employees. An individual proprietor of a proprietorship is not an employee. OFFICER'S SALARIES ARE REPORTABLE. Wages of the members of a limited liability company are reportable if the LLC files with the IRS as a corporation but are not reportable if the LLC files with the IRS as a partnership. (Work performed in the employ of a son, daughter, or spouse, or work performed by a child under 18 in the employ of his mother or father, is excluded from the definition of employment.)

FOR CALENDAR YEAR _____											FOR CALENDAR YEAR _____												
CALENDAR WEEKS											CALENDAR WEEKS												
	1ST	2ND	3RD	4TH	5TH		1ST	2ND	3RD	4TH	5TH		1ST	2ND	3RD	4TH	5TH		1ST	2ND	3RD	4TH	5TH
JAN						JUL						JAN						JUL					
FEB						AUG						FEB						AUG					
MAR						SEP						MAR						SEP					
APR						OCT						APR						OCT					
MAY						NOV						MAY						NOV					
JUN						DEC						JUN						DEC					

17. Show quarterly and yearly wages if one or more individuals are employed for any part of a day.

WEST VIRGINIA PAYROLLS	CALENDAR QUARTER ENDING MARCH 31	CALENDAR QUARTER ENDING JUNE 30	CALENDAR QUARTER ENDING SEPT. 30	CALENDAR QUARTER ENDING DEC 31	TOTAL FOR YEAR
PRECEDING YEAR _____					
CURRENT YEAR _____					

If you have not started business, check here  Give estimated start date \_\_\_\_\_ Sign on line 18.

18. CERTIFICATION: This report must be signed by owner if business is operated as an individual proprietorship; by an authorized partner if business is operated as a partnership or joint venture; by an authorized member of an LLC; by an authorized officer of an incorporated business. **Signatures of any other party will not be accepted unless this form is accompanied by a valid power of attorney.**

Date _____	Signature _____	Title _____
Date _____	Signature _____	Title _____
Date _____	Signature _____	Title _____
Date _____	Signature _____	Title _____

**GENERAL INSTRUCTIONS**

- Item 1. Enter the name, business address, mailing address if different than the business address, telephone number and federal employer identification number (FEIN) of your business. If you do not have a FEIN, contact the Internal Revenue Service at 1-800-829-4933 or at [www.irs.gov](http://www.irs.gov). Also, enter the West Virginia county where your business is located.
- Item 2. Enter the physical location of business if different than your business and/or mailing address.
- Item 3. Enter the name, address and telephone number of the individual you wish to be contacted concerning your payroll records.
- Item 4(a). Choose your appropriate form of organization.
- Item 4(b). Enter the name, title, social security number and resident address of the owner of a sole proprietorship, each partner of a Partnership, each member of a LLC or each officer of a corporation.
- Item 5. Enter the nature of your business and the city in West Virginia where your business is located.
- Item 6. Enter your West Virginia Unemployment Compensation account number if one has been issued.
- Item 7. Enter the date you began having employees in West Virginia and the date first wages were paid in West Virginia. Please furnish the month, day and year. If you acquired any assets from another business, please furnish the date of acquisition along with the name, address and account number of the predecessor.
- Items 8-13. Enter the month, year and quarter for provisions applying to your business type.
- Item 14. Enter the year you became liable for Federal Unemployment tax and in which state this occurred.
- Item 15. Enter the number of individuals working in West Virginia and the number of individuals working in other states.
- Item 16. Enter the number of employees by week. Include only employees working in West Virginia.
- Item 17. Enter the amount of quarterly and yearly wages in the current and preceding year or the estimated start date if you have not started your business.
- Item 18. Affix only proper signatures in order for application to be processed.

Please return completed form by mail or fax: Status Determination Unit  
P. O. Box 106  
Charleston, West Virginia 25321  
Fax number: 304-558-1324  
Phone number: 304-558-2677

# POWER OF ATTORNEY

**Workforce West Virginia  
Unemployment Compensation Division  
Contribution Accounting**  
P.O. BOX 106  
Charleston WV 25321  
Email Address: [uctaxunit@wv.gov](mailto:uctaxunit@wv.gov)  
Fax Number: 304-558-1550

## **KNOW ALL MEN BY THESE PRESENTS:**

That \_\_\_\_\_, Employer No. \_\_\_\_\_

FEIN: \_\_\_\_\_ an employer, having its principal office at \_\_\_\_\_

\_\_\_\_\_ does hereby appoint and changes the address of record to:

\_\_\_\_\_ **Pennyrile Area Development District** \_\_\_\_\_

\_\_\_\_\_ **300 Hammond Dr** \_\_\_\_\_

\_\_\_\_\_ **Hopkinsville, KY 42240** \_\_\_\_\_

*Its true and lawful agent with full power and authority to represent the said Employer before the **West Virginia Unemployment Compensation Division** until further notice in connection with:*

*All matters affecting Unemployment Tax, including claims, contributions, merit rating, hearings and appeals.*

**THIS AUTHORIZATION CANCELS AND SUPERSEDES ALL PRIOR AUTHORIZATIONS.**

*IN WITNESS WHEREOF, the said Employer has caused this instrument to be duly attested by the signature of its duly qualified officer this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_ .*

{Corporate Seal}

{Notary Seal}

By: \_\_\_\_\_

\_\_\_\_\_ Title: \_\_\_\_\_

Witness (Case Manager)

**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 complaint 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														
	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															
<b>Weekly Total</b>															
Saturday															
Sunday															
Monday															
Tuesday															
Wednesday															
Thursday															
Friday															
<b>Weekly Total</b>															
<b>Total Hours</b>															

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: \_\_\_\_\_

# Veteran Directed Care Program (VDC)

Instruction Reference

Pay Period 1. to 1.

Employee Number: 3. TV

Employee Name: 2.

Veteran Name: 5.

Employee Address/Zip: 4.

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
<b>6.</b>							#N/A								
Saturday	<b>7.</b>	<b>7.</b>	<b>8.</b>												
Sunday															
Monday															
Tuesday															
Wednesday															
Thursday															
Friday															
<b>Weekly Total</b>															
Saturday															
Sunday															
Monday															
Tuesday															
Wednesday															
Thursday															
Friday															
<b>Weekly Total</b>															
<b>Total Hours</b>			<b>9.</b>												

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 )
<b>(Example):</b> Personal Care	1.Meal Prep 2.Bathing 3.Dressing/Undressing	<b>Meal Prep-</b> 3x daily X 1hr = <b>21hrs weekly.</b> (Instructions- prepare meals at 9AM, 1PM, 5PM <b>Bathing-</b> 1x EOD X 1hr = <b>4hrs weekly</b> (Instructions- assist w/ bathing every other day at 6PM) <b>Dressing/Undressing-</b> 3x daily (unless more required) X 15 mins + 45 mins extra time if needed = <b>6hrs weekly.</b> (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 = <b>\$16, 120 yearly</b>
<b>(Example):</b> Specified Savings -(Ramp)	1.Need outside ramp for wheelchair	1 time purchase	Save \$50.00 month for item. Ramp: \$300.00	Ramp Cost: <b>\$300.00 (total)</b> (Available funds after 6 months of saving)
<b>(Example):</b> 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	<b>\$200.00 yearly</b>
<b>(Example):</b> Homemaking	1.Laundry 2. Washing/ Unload Dishes	<b>Laundry-</b> 2x weekly X 4hrs (Instructions- Mon & Fri, wash, dry, fold, and put up clothes) = 8hrs weekly <b>Dishes-</b> 4x weekly x 2hrs (Instructions- wash, dry, put up dishes M/W/F/Sun = <b>8hrs weekly</b>	\$10.00hr	8hrs weekly for laundry 8hrs x \$10.00 (hourly wage) = \$80.00 weekly x 52 weeks in a year = <b>\$4,160 yearly</b> <b>Dishes-</b> 8hrs weekly for dishes 8hrs x \$10.00 (hourly wage) = \$80.00 weekly x 52 weeks in a year = <b>\$4,160 yearly</b>

**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**

<b>Category</b>	<b>Example</b>
Adult Day Care	<ul style="list-style-type: none"> <li>• Adult Day Care Center Program.</li> <li>• Adult Day Care in another home other than the veteran's.</li> </ul>
Caregiver Education & Training	<ul style="list-style-type: none"> <li>• Caregiver support programs</li> <li>• A Matter of Balance</li> <li>• Chronic Disease Self- Management Class</li> <li>• Other Evidenced Based Programs</li> </ul>
Caregiver Support Coordination	<ul style="list-style-type: none"> <li>• Comprehensive caregiver assessments</li> <li>• Home and phone visit support</li> <li>• Referral to caregivers support services</li> </ul>
Chore Maintenance	<ul style="list-style-type: none"> <li>• Initial heavy-duty cleaning of home.</li> <li>• Removal of trash/debris from the home.</li> <li>• Yard cleanup</li> </ul>
Electronic Monitoring	<ul style="list-style-type: none"> <li>• Purchase of room monitors</li> <li>• Bed alarm</li> <li>• Programmable or voice-activated phones</li> <li>• Personal alarms</li> <li>• Life lines (available through VAMC)</li> <li>• Cell phones</li> </ul>
Environmental Services	<ul style="list-style-type: none"> <li>• Installation of grab bars, railings, specialized lighting, etc...</li> <li>• Minor home repair</li> <li>• Painting (interior or exterior)</li> <li>• Plumbing</li> <li>• Ramps (if denied by VA)</li> </ul>
Escort Services	<ul style="list-style-type: none"> <li>• Accompanying and personally assisting the veteran to obtain a needed service.</li> <li>• Filling out applications and explaining directions to the veteran.</li> </ul>
Health Maintenance	<ul style="list-style-type: none"> <li>• Cooking classes for caregiver (AKA PA)</li> <li>• Gym or Health Club membership</li> <li>• Health Counseling</li> <li>• Health Education</li> <li>• Massage therapy beyond services traditionally covered by insurance</li> <li>• Service/ Support Animal Health</li> <li>• Public health maintenance programs (structured weight reduction programs)</li> </ul>
Homemaking Services	<ul style="list-style-type: none"> <li>• Light Housekeeping</li> <li>• Laundry</li> <li>• Sweeping &amp; mopping floors</li> </ul>

	<ul style="list-style-type: none"> <li>• Dusting</li> <li>• Changing linens</li> <li>• Cleaning the bathroom (toilet, tubs/showers, sinks &amp; floors)</li> <li>• Cleaning the kitchen (loading/unloading dishwasher, hand washing dishes, washing off countertops, sinks, floors, and stovetops as needed).</li> </ul>
Personal Care Services	<ul style="list-style-type: none"> <li>• Assist in/out of the shower or bath tub/any assistance during the bathing process.</li> <li>• Assistance in getting on/off the toilet</li> <li>• Brushing teeth/dentures</li> <li>• Personal grooming tasks and dressing</li> <li>• 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</li> </ul>
Individually identified services or goods necessary for “Independent Living”	<ul style="list-style-type: none"> <li>• Upkeep of service animals required for veteran to stay independent.</li> <li>• What would you feel is needed in your home to keep you independently living not covered by traditional VA programs and services or insurances</li> </ul>
Information and Referral Services	<ul style="list-style-type: none"> <li>• Referral to community agencies and programs to improve quality of life.</li> </ul>
Respite Care	<ul style="list-style-type: none"> <li>• 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).</li> <li>• 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.</li> </ul>
Nutritional Services	<ul style="list-style-type: none"> <li>• Home Delivered Standard Meal- the regular menu from the standard menu that is served to the majority of participants.</li> <li>• 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).</li> </ul>
Safety Services	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Combination key box for the door, this keeps a key available for easy access to the home by emergency personnel.</li> <li>• Home Safety Evaluation by a professional person to assure safety of travel paths and needs.</li> </ul>
Shopping or Running Errands	<ul style="list-style-type: none"> <li>• Shopping with or without the veteran for the veteran.</li> </ul>
Socialization Support Services	<ul style="list-style-type: none"> <li>• Employee / worker (personal assistant) to accompany the Veteran to activities such as education or exercise classes.</li> <li>• Employee/ worker (personal assistant) taking the veteran to the movies, a Bible study, or other social engagements (verified by CM).</li> </ul>
Transportation	<ul style="list-style-type: none"> <li>• Public transportation or other transport required to go for socialization support or medical support activities with the designated caregiver (or PA) providing escort</li> <li>• A Month Public Transport Pass to get around town or the area to go to social activities.</li> <li>• An escort to a veteran who has special needs (physical or cognitive) when using regular vehicular transportation.</li> </ul>

Participant-Delegated Goods and Services	<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> </ul>
Emergency Back-Up/Planned Savings	<ul style="list-style-type: none"> <li>• Spending in a given month may exceed the average monthly case-mix rate. As long as it does not exceed the total authorized budget.</li> <li>• 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.</li> <li>• 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.</li> <li>• The emergency savings can be used for planned G&amp;S purchases, which should be approved and planned at the start of the authorization period (all purchases must be approved by the VAMC).</li> </ul>

## 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 or 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 not 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, frozen, dried, or supplemental food which provides a minimum of 1/3 of the daily recommended dietary allowance (RDA) as established 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 requirements 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 decisions 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 physically 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 services may include meal preparation, housekeeping, assistance with personal care and/or social and recreation activities.
- Out-of-home respite care programs include an array of services provided in 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 Pennyriple Area Development District (PADD), Pennyriple 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)

<input type="checkbox"/>	I do not wish to designate an authorized representative. I, the veteran, will be the employer of records. Veteran's Signature _____ Date _____
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#### 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 Pennyriple 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 Pennyriple Area Agency on Aging, other Spoke Agencies, and the Veterans Health Administration. I understand that the Pennyriple 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 →	<input type="checkbox"/>	Decline Enrollment in VDC Program →	<input type="checkbox"/>
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\_\_\_\_\_  
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.

#### RESPONSIBILITIES

- 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 purposefully 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: \_\_\_\_\_

# 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 2678 EMPLOYER APPOINTMENT OF AGENT

## What is it for?

This form tells the IRS that you give Pennyriple 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**  
 Feb. August 2018 Department of the Treasury — Internal Revenue Service

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**

Name  Street  Suite or room number   
 City  State  ZIP code   
 Foreign country name  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)	<input type="checkbox"/>	<input type="checkbox"/>
Form 941, 941-PR, 941-SS (Employer's QUARTERLY Federal Tax Return)	<input type="checkbox"/>	<input type="checkbox"/>
Form 943, 943-PR (Employer's Annual Federal Tax Return for Agricultural Employees)	<input type="checkbox"/>	<input type="checkbox"/>
Form 944, 944-PR (Employer's ANNUAL Federal Tax Return)	<input type="checkbox"/>	<input type="checkbox"/>
Form 945 (Annual Return of Withheld Federal Income Tax)	<input type="checkbox"/>	<input type="checkbox"/>
Form CT-1 (Employer's Annual Railroad Retirement Tax Return)	<input type="checkbox"/>	<input type="checkbox"/>
Form CT-2 (Employee Representative's Quarterly Railroad Tax Return)	<input type="checkbox"/>	<input type="checkbox"/>

\*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 disclosure 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   
 Date  Print your title here   
 Best daytime phone

**Now give this form to the agent to complete.**

For filing, Act and Payment: Preparer's Act/Section, see the instructions. 832.gov/irs/2018 Cat. No. 10100 Form 2678 Feb. 8-2018

# UI Application for Unemployment Insurance

## What is it for?

This form is required as every employer in the State of West Virginia 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 West Virginia, you will be assigned an employer account number. The Pennyrite Area Development District (PeADD) will be responsible for filing all wage reports, paying taxes and managing your unemployment tax account.

UC 201-B Rev. 10-22		EMPLOYER'S INITIAL STATEMENT WORKFORCE WEST VIRGINIA UNEMPLOYMENT COMPENSATION DIVISION	
Required by Article 10, Section 11 of the West Virginia Unemployment Compensation Law			
RETURN ORIGINAL WITHIN TEN DAYS		DO NOT WRITE IN THIS SECTION	
1. Name(s)		Telephone Number	
DBA			
Business Address and Zip Code			
Mailing Address and Zip Code			
E-mail Address			
County		Federal Number	
2. Physical location of business (be specific):			
3. Name, street address, telephone number, and person to contact where payroll records are maintained:			
4. (a) Check (X) form of organization:			
<input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Domestic Only <input type="checkbox"/> Agricultural Only <input type="checkbox"/> LLC    If you are an LLC, do you file with the IRS as a corporation? Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> Corporation    State of Incorporation _____ Date of Incorporation _____ <input type="checkbox"/> Governmental Entity, Political Subdivision, or Instrumentality <input type="checkbox"/> Taxable <input type="checkbox"/> Reimbursable <input type="checkbox"/> Nonprofit organization exempt from income tax under IRS Code Section 501(C) (3) ONLY. Attach copy of U.S. Treasury letter giving this exemption: <input type="checkbox"/> Taxable <input type="checkbox"/> Reimbursable			
(b) List Name, Social Security Number and Resident Address of Proprietor; all Partners, LLC members or Officers of the Corporation.			
Name and Title		Social Security Number (Required)	Resident Address (Required)
5. Nature of Business: _____ WV Location: _____			
6. If you have been assigned an Employer Account Number by this Division, please enter the number here: _____			
7. Date you began operation in West Virginia: ____/____/____ Date first wages paid in West Virginia: ____/____/____			
Business/assets/employees acquired from another employer? <input type="checkbox"/> Yes <input type="checkbox"/> No    If Yes, enter date: ____/____/____			
Give name address and zip code of predecessor, also, federal reporting and State U.I. numbers (if known)			
Federal Number		State UI Number	
8. Have you ever or do you expect to employ at least ONE worker in 20 different calendar weeks during a calendar year? <input type="checkbox"/> No <input type="checkbox"/> Yes    Month _____ Year _____			
If Yes, in what earliest month and year will the 20 <sup>th</sup> week occur?			
9. Have you or do you expect to have a quarterly payroll of \$1,500? <input type="checkbox"/> No <input type="checkbox"/> Yes    Quarter _____ Year _____			
If Yes, in what earliest quarter and year will the payroll occur?			
10. Have you or do you expect to employ in any calendar year, 10 or more agricultural workers in 20 different calendar weeks? <input type="checkbox"/> No <input type="checkbox"/> Yes    Month _____ Year _____			
If Yes, in what earliest month and year will the 20 <sup>th</sup> week occur?			
11. Have you or do you expect to have a \$20,000 quarterly payroll of agricultural workers in any year? <input type="checkbox"/> No <input type="checkbox"/> Yes    Quarter _____ Year _____			
If Yes, in what earliest quarter and year will the payroll occur?			
12. Have you or do you expect to have a \$1,000 quarterly payroll of domestic (housekeepers, babysitters, etc.) workers in any year? <input type="checkbox"/> No <input type="checkbox"/> Yes    Quarter _____ Year _____			
If Yes, in what earliest quarter and year will the payroll occur?			
13. If you are a nonprofit organization with a 501 (c)(3) exemption, have you or do you expect to employ four or more workers in 20 different calendar weeks during a calendar year? <input type="checkbox"/> No <input type="checkbox"/> Yes    Month _____ Year _____			
If Yes, in what earliest month and year will the 20 <sup>th</sup> week occur?			
Please furnish a copy of exemption letter.			
14. Are you liable for the Federal Unemployment Tax? <input type="checkbox"/> Yes <input type="checkbox"/> No    If Yes, in what year did you become liable? _____			
In what states? _____			
15. State the number of Individuals working in West Virginia: _____		In other states: _____	

# 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 West Virginia Unemployment Compensation Laws and Regulations, until such time as the appointment is terminated.

POA  
Rev.3.23

## POWER OF ATTORNEY

Workforce West Virginia  
Unemployment Compensation Division  
Contribution Accounting  
P.O. BOX 106  
Charleston WV 25321  
Email Address: [uctaxunit@wv.gov](mailto:uctaxunit@wv.gov)  
Fax Number: 304-558-1550

### KNOW ALL MEN BY THESE PRESENTS:

That \_\_\_\_\_, Employer No. \_\_\_\_\_

FEIN: \_\_\_\_\_ an employer, having its principal office at \_\_\_\_\_

\_\_\_\_\_ does hereby appoint and changes the address of record to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Its true and lawful agent with full power and authority to represent the said Employer before the **West Virginia Unemployment Compensation Division** until further notice in connection with:

All matters affecting Unemployment Tax, including claims, contributions, merit rating, hearings and appeals.

THIS AUTHORIZATION CANCELS AND SUPERSEDES ALL PRIOR AUTHORIZATIONS.

IN WITNESS WHEREOF, the said Employer has caused this instrument to be duly attested by the signature of its duly qualified officer this \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

{Corporate Seal}

{Notary Seal}

By: \_\_\_\_\_

\_\_\_\_\_  
Title: \_\_\_\_\_

Witness

# Worker's Compensation Acknowledgment Form

What is this for?

Worker's Compensation is optional for participants in the Veteran Directed Care Program. If you choose coverage, the cost of the policy will be incorporated on your plan of care. This form requires you to acknowledge your rights and elect to obtain worker's compensation insurance or not.

## Veterans Directed Care (VDC) Program Workers Compensation Acknowledgement

I, \_\_\_\_\_ (print name of Veteran or Authorized Representative) have chosen to participate in the Veterans 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 and as the "Employer of Record" under this program. **I understand that I have the option to obtain workers compensation insurance for my employee(s)/ worker(s)/ PA(s) in accordance with Department of Veterans Affairs guidelines.**

Should I choose the workers compensation option, I authorize the Pennyrile Area Development District's Financial Management staff to assist me with obtaining the workers compensation coverage, to provide the insurance carrier with any information as may be necessary to establish the workers 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 workers compensation insurance carrier to be mailed directly to Pennyrile Area Development District's Financial Management staff and/or Pennyrile AAAIL's Case Manager (if needed) who is acting on my behalf.

Choose Workers Compensation Insurance for my employee(s)? Yes

No

I understand that if I choose to terminate my participation in the Veterans Directed Care Program, the workers compensation coverage will be cancelled effective on the date that I cease to participate in the VDC Program.

I give my authorization for a copy of this acknowledgement to be forwarded to Pennyrile Area Development District's Financial Management staff and to the workers 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

# 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 <small>(Please label if costs is weekly, monthly, yearly or a one-time purchase &amp; calculate total based on that information)</small>

<b>Projected Total (Weekly, Monthly, Yearly – Please Label) = \$</b>
<b>Veteran Signature/Authorized Representative (if applicable):</b> <span style="float: right;"><b>Date:</b></span>