

Welcome to Consumer Direct Care Network (CDCN)! Please see the instructions below for filling out the Employer Enrollment Packet. Images are included as examples for how to correctly fill out each document. Fields highlighted yellow are required in order to complete your enrollment.

1. **Consumer Data Form** (Figure 1).

Consumer Information Section

Name in Program – enter the Consumer’s First Name, Middle Name, and Last Name as shown on Medicaid documents. Name may differ from Social Security card.

Consumer Physical Address – the address must be the street address where the Consumer lives and will be receiving services. **DO NOT** enter a PO Box or mailing address.

Phone and Email – Enter if you have one.

Medicaid ID, Gender, Date of Birth, Social Security # – Complete all fields.

Prior Fiscal Agent – Check one box either Yes or No as to whether the Consumer is switching services to CDCN from another fiscal agent. If yes, enter the prior agent’s name on the line provided.

Prior Employer of Record (EOR) Section

Check one box either Yes or No as to whether the Consumer is currently receiving self-directed services but is switching who will serve as their EOR. If yes, enter name of prior EOR.

New Employer of Record (EOR) Information

EOR Relationship to Consumer – If the Consumer will also serve as the EOR, check the Consumer box. If not, check the Other box and provide a description of the relationship.

Name on Social Security Card – Enter EOR’s First, Middle and Last name exactly as appears on Social Security Card. Name on Social Security card is used on all tax documents.

EOR Physical Address – Enter the EOR’s physical address. Physical address is required for tax forms.

EOR Mailing Address – Enter the EOR’s mailing address where CDCN can mail documents to.

Phone – At least one phone number, Home or Cell is required for tax documents. Enter EOR’s contact phone numbers.

Fax – Enter if exists.

Date of Birth and Social Security # – Enter both.

Email – Enter the EOR’s email address. This is the preferred method for CDCN to contact the EOR.

Prior Accounts – Check the Yes or No box as to whether the person to serve as the EOR already has established Household Employer business accounts that CDCN should link to. If accounts exist, enter account numbers on the lines provided.

Service Facilitator Section

Name – Enter your Service Facilitator’s first and last name.

Phone and Email – Enter your Service Facilitator’s preferred phone number and email address.

2. Employer of Record Attestation (Figure 2).

Enter the Consumer's name and EOR's name in the boxes at the top of the form.

Upon reading the Attestation, the EOR signs and dates the bottom of the form.

3. SS-4 Application for Employer Identification Number (Figure 3).

The SS-4 is used to obtain a Federal Employer Identification Number (FEIN) for the EOR. Only complete the line numbers described below. All others are pre-filled or do not apply to Home Care Service Recipients.

Line 1. Enter EOR's full name - First Name, Middle Initial, Last Name. After the name enter "HCSR".

5a and b. Enter EOR's physical address. No PO Box.

6. Enter County and State of EOR's residence.

7a and b. Enter name and Social Security number of the EOR. Enter name as shown on Social Security card, even if different than line 1.

11. If EOR does not have a prior FEIN, enter the same date as signature date on bottom of form. If EOR has a prior FEIN, leave blank.

18. Check NO if the applicant does not have an FEIN. Check YES, and enter the number if applicant currently holds an FEIN.

Name and Title. Print EOR's name the same as line 1 and enter the title "Home Care Service Recipient". *(Bottom left of the form above the signature line.)*

Applicant's telephone number. Enter EOR's telephone number.

Signature. The EOR signs the form. *(Bottom left of the form.)*

Date. Enter date of signature. *(To the right of the signature line.)*

4. 2678 Employer/Payer Appointment of Agent (Figure 4).

With this form the EOR appoints CDCN as their Fiscal Vendor Agent to file federal payroll tax reports on their behalf. Much of this form will be pre-populated with CDCN's contact information. Only complete the line numbers as described below.

Line 1. If you have an existing Federal Employer Identification Number, enter it on line 1 of form 2678. If you do not, leave line 1 blank.

Line 2. Enter EOR's full name - First Name, Middle Initial, Last Name. After the name, enter "HCSR".

Sign your name here. The EOR signs the form. *(Bottom left of the form.)*


Date. Enter date of signature. *(Bottom left of the form.)*

Print your name here. Enter EOR's name - First Name, Middle Initial and Last Name.

Print your title here. Enter title as "HCSR - Household Employer".

Best daytime phone. Enter EOR's telephone number.

Figure 1. Sample Consumer Data Form. Mandatory




CONSUMER DATA FORM

Consumer Information			
Name in Program	Andrew	Thomas	Jones
	<i>First</i>	<i>Middle</i>	<i>Last</i>
Consumer Physical Address	55 Beacher Drive		
	(Street address only. No PO Box. This is where service will be provided.)		
City	Anytown	State	VA
Zip	23230	County	Hill
Phone	555-555-5555	666-666-6666	Email AndrewJ@someprovider.com
	<i>Home</i>	<i>Cell</i>	Enter email address if exists
Medicaid ID	XXXXXXXX	Gender	<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth	09/16/1988	Social Security #	111 - 11 - 1111
Prior Fiscal Agent: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No – Is Consumer switching services to CDCN from another Fiscal Agent?			
If yes, Agent Name: If applicable, check Yes and enter prior Fiscal Agent name.			
Prior Employer of Record (EOR)?			
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No – Is Consumer switching their EOR? If yes, previous EOR name: If applicable, check Yes and enter prior EOR name.			
New Employer of Record (EOR) Information			
EOR Relationship to Consumer	<input type="checkbox"/> Consumer (self) <input checked="" type="checkbox"/> Other (describe): Guardian		
Name on Social Security Card	John	Frank	Smith
	<i>First</i>	<i>Middle</i>	<i>Last</i>
EOR Physical Address	123 Main Street		
	(Street address only. No PO Box. This is where service will be provided.)		
City	Anytown	State	VA
Zip	23222	County	Hill
EOR Mailing Address (Street or PO Box.)	123 Main Street		
City	Anytown	State	VA
Zip	23222		
Phone	444-444-4444	333-333-3333	none
	<i>Home</i>	<i>Cell</i>	<i>Fax</i>
Date of Birth	4/23/1964	Social Security #	999 - 99 - 9999
Prior Accounts:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No – Does EOR have an existing Sole Proprietor or Household Employer business with established accounts? If yes, provide confirmation of your Employer Identification Number from the IRS (EIN Certification Letter 147C or EIN Confirmation Letter CP575). If applicable, check Yes.		
Services Facilitator			
Name	Jane Doe		
	If known, enter Services Facilitator's phone and email contact information.		
Phone	333-333-3333	Email	janed@servicefacilitatoragency.com



Figure 2. Sample Employer of Record Attestation. **Mandatory**



EMPLOYER OF RECORD ATTESTATION

Andrew T Jones	John F Smith
Consumer Name	Employer of Record Name

Acknowledgements

As the Employer of Record (EOR), I will do the following:

1. Fill out all the forms required by Consumer Direct Care Network Virginia (CDCN).
2. Obtain a Federal Employer Identification Number. CDCN will help me with this.
3. Hire, train, and dismiss employees.
4. For each employee, I will:
 - Send new hire paperwork to CDCN.
 - Make sure they only work approved hours.
 - Make sure they do not work when the Consumer is in a hospital or nursing home.
 - Make sure they clock-in and clock-out for each shift worked using an approved Electronic Visit Verification (EVV) method.
5. Use the approved EVV manual exception process only as needed. The reasons an employee would need to adjust or correct a shift include:
 - The Attendant clocked-in or clocked-out at the wrong time.
 - The Attendant forgets to clock-in or clock-out.
 - The Attendant's phone or tablet was not working.
 - The Attendant did not have their phone or tablet.
 - The mobile app was not working.
 - The Consumer had an emergency.

The manual exception process is not EVV compliant.
6. Report abuse, neglect, or exploitation of a Consumer to the Department of Social Services.
7. Wages are from federal and state funds. I can report suspected Medicaid fraud to the CDCN Fraud Hotline or the Virginia Medicaid Fraud Hotline. Please see the Fraud brochure on the CDCN website for more information.

I understand that CDCN will serve as my fiscal agent for the purpose of payroll and payroll tax filing. I authorize CDCN to set up and manage tax accounts on my behalf with state and federal agencies. If needed, I authorize CDCN to make corrections to my SS-4 and 2678 forms prior to submitting them to the IRS. Corrections would be made based off of information provided on the Data Form or notification sent to CDCN by me.

John F Smith

Employer of Record, Printed Name

John F. Smith

Signature

2/11/2020

Date

Figure 3. Sample SS-4. **Mandatory**

Form SS-4 (Rev. December 2017) Department of the Treasury Internal Revenue Service		Application for Employer Identification Number (For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.) ▶ Go to www.irs.gov/FormSS4 for instructions and the latest information. ▶ See separate instructions for each line. ▶ Keep a copy for your records.		OMB No. 1545-0003 EIN	
Type or print clearly.	1 Legal name of entity (or individual) for whom the EIN is being requested John F Smith HCSR				
	2 Trade name of business (if different from name on line 1)		3 Executor, administrator, trustee, "care of" name		
	4a Mailing address (room, apt., suite no. and street, or P.O. box) 100 Consumer Direct Way, Suite 303-VA		5a Street address (if different) (Do not enter a P.O. box.) 123 Main Street		
	4b City, state, and ZIP code (if foreign, see instructions) Missoula, MT 59808		5b City, state, and ZIP code (if foreign, see instructions) Anytown, VA 23222		
	6 County and state where principal business is located Hill, VA				
	7a Name of responsible party John F Smith		7b SSN, ITIN, or EIN 999 - 99 - 9999		
	8a Is this application for a limited liability company (LLC) (or a foreign equivalent)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		8b If 8a is "Yes," enter the number of LLC members 0		
	8c If 8a is "Yes," was the LLC organized in the United States? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	9a Type of entity (check only one box). Caution. If 8a is "Yes," see the instructions for the correct box to check.				
	<div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <input type="checkbox"/> Sole proprietor (SSN) _____ <input type="checkbox"/> Partnership _____ <input type="checkbox"/> Corporation (enter form number to be filed) ▶ _____ <input type="checkbox"/> Personal service corporation _____ <input type="checkbox"/> Church or church-controlled organization _____ <input type="checkbox"/> Other nonprofit organization (specify) ▶ _____ <input checked="" type="checkbox"/> Other (specify) ▶ HCSR </div> <div style="width: 48%;"> <input type="checkbox"/> Estate (SSN of decedent) _____ <input type="checkbox"/> Plan administrator (TIN) _____ <input type="checkbox"/> Trust (TIN of grantor) _____ <input type="checkbox"/> Military/National Guard _____ <input type="checkbox"/> Farmers' cooperative _____ <input type="checkbox"/> REMIC _____ <input type="checkbox"/> State/local government _____ <input type="checkbox"/> Federal government _____ <input type="checkbox"/> Indian tribal governments/enterprises _____ </div> </div>				
9b If a corporation, name the state or foreign country (if applicable) where incorporated		State		Foreign country	
10 Reason for applying (check only one box)					
<input type="checkbox"/> Started new business (specify type) ▶ _____ <input type="checkbox"/> Hired employees (Check the box and see line 13.) <input type="checkbox"/> Compliance with IRS withholding regulations <input checked="" type="checkbox"/> Other (specify) ▶ HCSR					
11 Date business started or acquired (month, day, year). See instructions. 2/11/2020		12 Closing month of accounting year December			
13 Highest number of employees expected in the next 12 months (enter -0- if none). If no employees expected, skip line 14.		14 If you expect your employment tax liability to be \$1,000 or less in a full calendar year and want to file Form 944 annually instead of Forms 941 quarterly, check here. (Your employment tax liability generally will be \$1,000 or less if you expect to pay \$4,000 or less in total wages.) If you do not check this box, you must file Form 941 for every quarter. <input type="checkbox"/>			
Agricultural 0		Household 0		Other 0	
15 First date wages or annuities were paid (month, day, year). Note: If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year) N/A					
16 Check one box that best describes the principal activity of your business.					
<input type="checkbox"/> Construction <input type="checkbox"/> Rental & leasing <input type="checkbox"/> Transportation & warehousing <input type="checkbox"/> 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) ▶ HCSR					
17 Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided. HCSR					
18 Has the applicant entity shown on line 1 ever applied for and received an EIN? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
If "Yes," write previous EIN here ▶ If EOR has existing EIN, check yes and enter EIN here					
Third Party Designee	Complete this section only if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.				
	Designee's name Alisha Matt			Designee's telephone number (include area code) 406-532-1900	
	Address and ZIP code 100 Consumer Direct Way, Suite 304, Missoula, MT 59808			Designee's fax number (include area code) 406-532-8588	
Under penalties of perjury, I declare that I have examined this application, and to the best of my knowledge and belief, it is true, correct, and complete.					
Name and title (type or print clearly) ▶ John F Smith		Home Care Service Recipient		Applicant's telephone number (include area code) 444-444-4444	
Signature ▶ John F Smith		Date ▶ 2/11/2020		Applicant's fax number (include area code)	

Figure 4. Sample 2678. **Mandatory**

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

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

OMB No. 1545-0748

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

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

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

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

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)

If EOR has existing EIN, enter it here.

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

John F Smith HCSR

3 Trade name (if any)

4 Address

100 Consumer Direct Way Suite 303-VA

Number Street Suite or room number

Missoula MT 59808

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 type="checkbox"/>	<input checked="" type="checkbox"/>
Form 941, 941-PR, 941-SS (Employer's QUARTERLY Federal Tax Return)	<input type="checkbox"/>	<input checked="" 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

John F Smith

Print your name here

John F Smith

Print your title here

HCSR - Household Employer

Best daytime phone

444-444-4444

Date

2/11/2020

Now give this form to the agent to complete. ➡