Pennyrile Area Development District
Veterans Directed Home & Community Based Services (VD-HCBS) 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 Veterans Directed Home & Community Based Services Program.

The Tennessee Area Agencies on Aging and Disability (AAAD) and Kentucky Area Agencies on Aging (AAA) will provide the case management for each enrolled Veteran within the VD-HCBS 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 Employer Enrollment Packet Checklist and the summary of each form that needs to be completed. The AAADs 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

Veterans directed home and community based services 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 employer, you will:

- Complete, sign and send Employer Paperwork 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 Worker Packets 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 VF/EA FMS entity's payroll system and ensure compliance with tax and labor laws;
- Verify worker qualifications, including the participant-worker relationship;
- Choose whether to authorize Criminal background checks on your potential employees
- For Respite care, the worker cannot be the participant's guardian, conservator, parent or step-parent;
- 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. The worker should not perform prohibited services such as administering medication, dressing wounds, and tube feeding; unless authorized as a licensed nurse.
- 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 on time, and, not later than 30 days past the day service was delivered;
- Monitor your use of authorized services;
- Act in accordance with the policies and procedures outlined in your employment agreement;
- Notify worker 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.

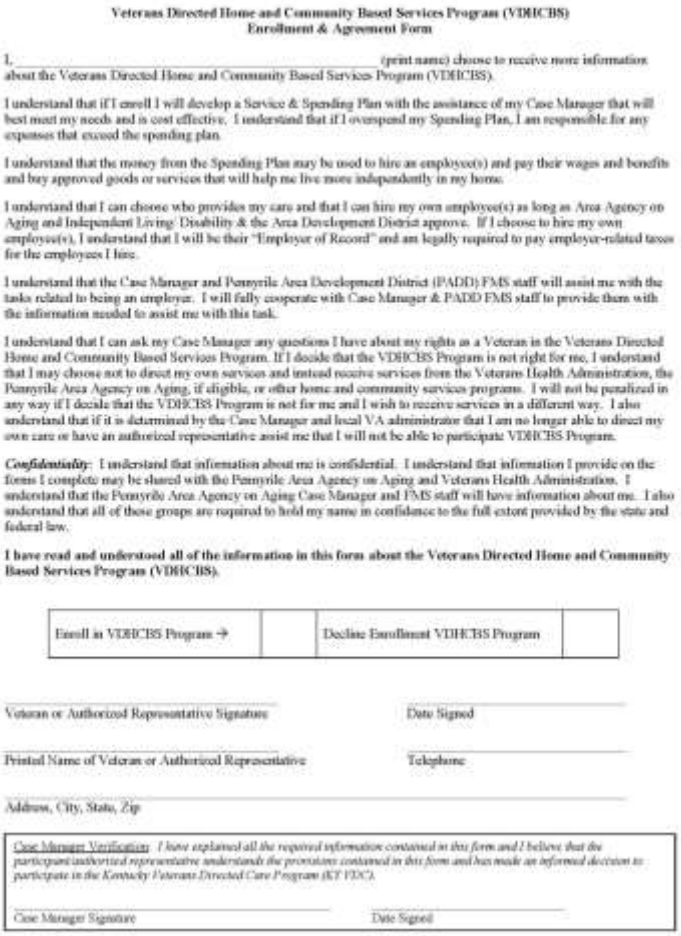
As the Financial Management Service Provider, PeADD will:

- Process timesheets and issue paychecks to workers semi-monthly.
- 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 in late January.
- Answer all questions that you and your workers have.
- Help you and your workers with the enrollment process

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 Home and Community Based Services Program (VDHCBS)
Enrollment & Agreement Form

I, _____ (print name) choose to receive more information about the Veterans Directed Home and Community Based Services Program (VDHCBS).

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 Area Agency on Aging and Independent Living/ Disability & the 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 Case Manager and Pennyrile Area Development District (PADD) FMS staff will assist me with the tasks related to being an employer. I will fully cooperate with Case Manager & PADD 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 the Veterans Directed Home and Community Based Services Program. If I decide that the VDHCBS 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 Pennyrile Area Agency on Aging, if eligible, or other home and community services programs. I will not be penalized in any way if I decide that the VDHCBS 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 VDHCBS Program.

Confidentiality: I understand that information about me is confidential. I understand that information I provide on the forms I complete may be shared with the Pennyrile Area Agency on Aging and Veterans Health Administration. I understand that the Pennyrile Area Agency on Aging Case Manager and FMS staff will have information about me. 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 Home and Community Based Services Program (VDHCBS).

Enroll in VDHCBS Program →		Decline Enrollment VDHCBS Program	

_____ _____
Veteran or Authorized Representative Signature Date Signed

_____ _____
Printed Name of Veteran or Authorized Representative Telephone

_____
Address, City, State, Zip

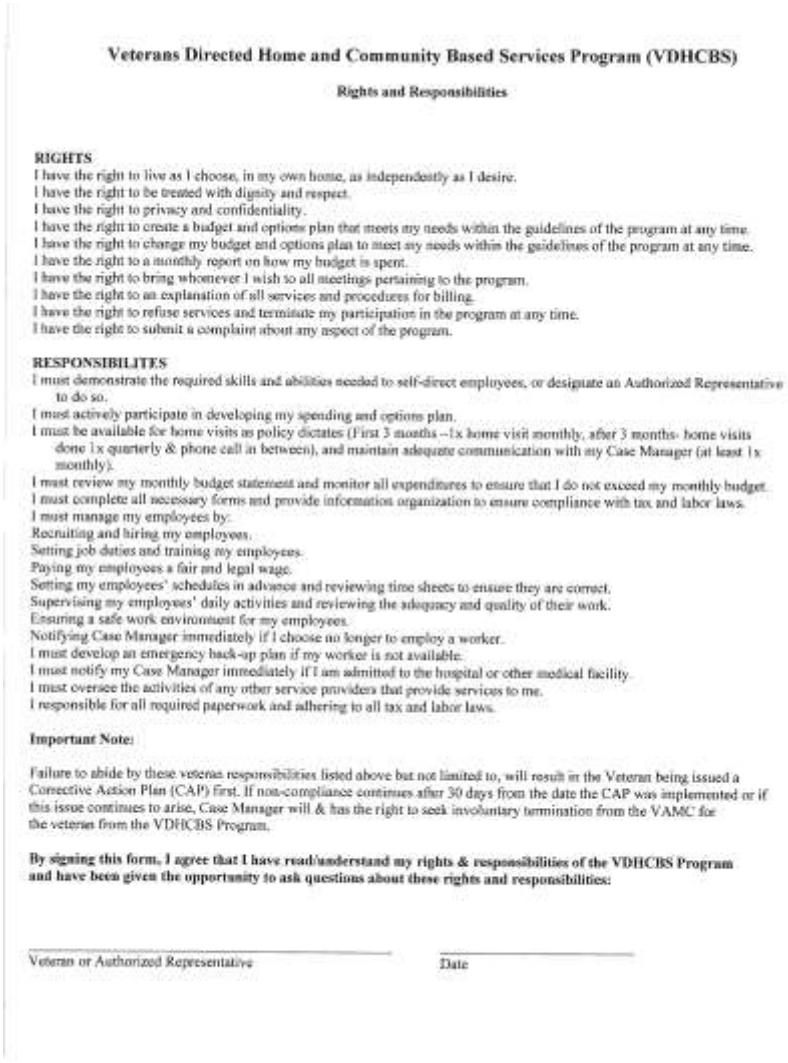
Case Manager Verification: *I have explained all the required information contained in this form and I believe that the participant/authorized representative understands the provisions contained in this form and has made an informed decision to participate in the Kentucky Veterans Directed Care Program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

_____ _____
Case Manager Signature Date Signed

Rights and Responsibilities

What is this for?

This form identifies all of your rights and responsibilities under the VD-HCBS 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 Home and Community Based Services Program (VDHCBS)

Rights and Responsibilities

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

RESPONSIBILITES
I must demonstrate the required skills and abilities needed to self-direct employees, or designate an Authorized Representative to do so.
I must actively participate in developing my spending and options plan.
I must be available for home visits as policy dictates (First 3 months --1x home visit monthly, after 3 months- home visits done 1x quarterly & phone call 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 organization to ensure compliance with tax and labor laws.
I must manage my employees by:
Recruiting and hiring my employees.
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.
I responsible for all required paperwork and adhering to all tax and labor laws.

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 VDHCBS Program.

By signing this form, I agree that I have read/understand my rights & responsibilities of the VDHCBS 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 Home and Community Based Services Program (VDHCBS)

Release of Information Form

I, _____ hereby give permission to the Area Agency on Aging, which includes the Area Development District 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 Home and Community Based Service Program (VDCHBCS)
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 for herself or some other person. In other works. 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:

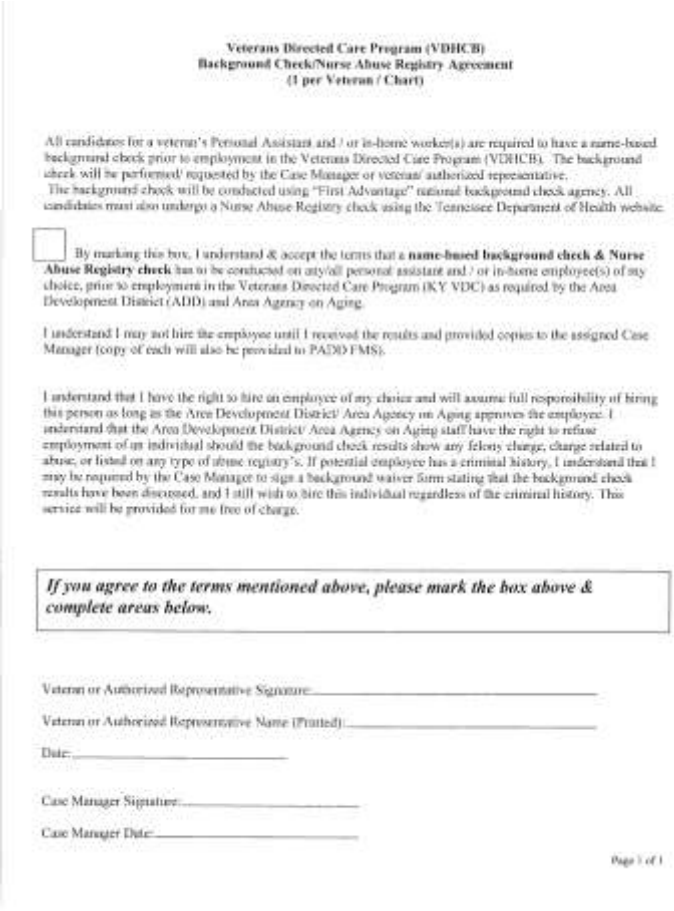
- Knowingly and/or purposefully filling out an employee's timesheet incorrectly for hours or services that were not provided during the times listed or on the day listed;
- Knowingly and/or purposefully allowing the Financial Management Service (FMS) to bill for services that were not provided;
- Knowingly and /or purposefully using the VDHCBS budget for any other purpose that what has been approved in the participant's individual spending plan.
- Knowingly and /or purposefully allowing an employee to document services or hours that were not provided
- Knowingly and/or purposefully submitting invoices to the FMS for goods and services that were not provided.
- Knowingly and/or purposefully having the FMS pay an individual for goods and/or services actually provided by someone else. (This is also tax fraud).
- Knowingly and/or purposefully making a "side deal" with an employee to split their pay check with the participant and his/her representative. (This is also tax fraud).
- Knowingly and/or purposely having the FMS pay for an approved individual-directed good included in the participants budget, and then return the approved individual-directed good to get the cash or use it for something else that has not been approved.

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

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 Program (VDHCB)
Background Check/Nurse Abuse Registry Agreement
(1 per Veteran / Chart)

All candidates for a veteran's Personal Assistant and / or in-home worker(s) are required to have a name-based background check prior to employment in the Veterans Directed Care Program (VDHCB). The background check will be performed/ requested by the Case Manager or veteran/ authorized representative.
The background check will be conducted using "First Advantage" national background check agency. All candidates must also undergo a Nurse Abuse Registry check using the Tennessee Department of Health website.

☐ By marking this box, I understand & accept the terms that a **name-based background check & Nurse Abuse Registry check** has to be conducted on any/all personal assistant and / or in-home employee(s) of my choice, prior to employment in the Veterans Directed Care Program (KY VDC) as required by the Area Development District (ADD) and Area Agency on Aging.

I understand I may not hire the employee until I received the results and provided copies to the assigned Case Manager (copy of each will also be provided to PADD FMS).

I understand that I have the right to hire an employee of my choice and will assume full responsibility of hiring this person as long as the Area Development District/ Area Agency on Aging approves the employee. I understand that the Area Development District/ Area Agency on Aging 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. This service will be provided for me free of charge.

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:_____

Page 1 of 1

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 Home and Community Based Services Program (VDHCBS)
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_____ County_____ State : KY Zip Code_____

Telephone_____ E-mail _____@_____

IRS Form SS-4
Application for Employer Identification Number

What it is for?

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

Will I receive anything from the IRS?

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

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

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

What lines do I complete?

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

IRS FORM 8821
Tax Information Authorization

What is it for?

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

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

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

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

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

Form **8821**

Tax Information Authorization

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

Taxpayer name and address

John Doe
123 Main St
Small Town, KY 12345

Daytime telephone number 270-555-1212

2 **Appointee.** If you wish to name more than one appointee, attach a list to this form. **Check here if a list of additional appointees is attached** ▶

Name and address

Kelly Allen
Pennyrile Area Development District
Veterans Directed Care Program
300 Hammond Drive, Hopkinsville, KY 42240

CAF No. / PTIN / Telephone No. / Fax No.

Check if new: Address ☐ Telephone No. ☐ Fax No. ☐

3 **Tax Information.** Appointee is authorized to inspect and/or receive confidential tax information for the type of tax, forms, periods, and specific matters you list below. See the line 3 instructions.

(a) Type of Tax Information (Income, Employment, Payroll, Excise, Estate, Gift, Civil Penalty, Sec. 4980H Payments, etc.)	(b) Tax Form Number (1040, 941, 720, etc.)	(c) Year(s) or Period(s)	(d) Specific Tax Matters
Income and Employment Tax	940, 940X, 941, 941X, 941x,W2	3Q 2017-1Q 2021	Tax Liability

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

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

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

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

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

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

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

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

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

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

Signature / Date

Print Name / Title (if applicable)

For Privacy Act and Paperwork Reduction Act Notice, see instructions.

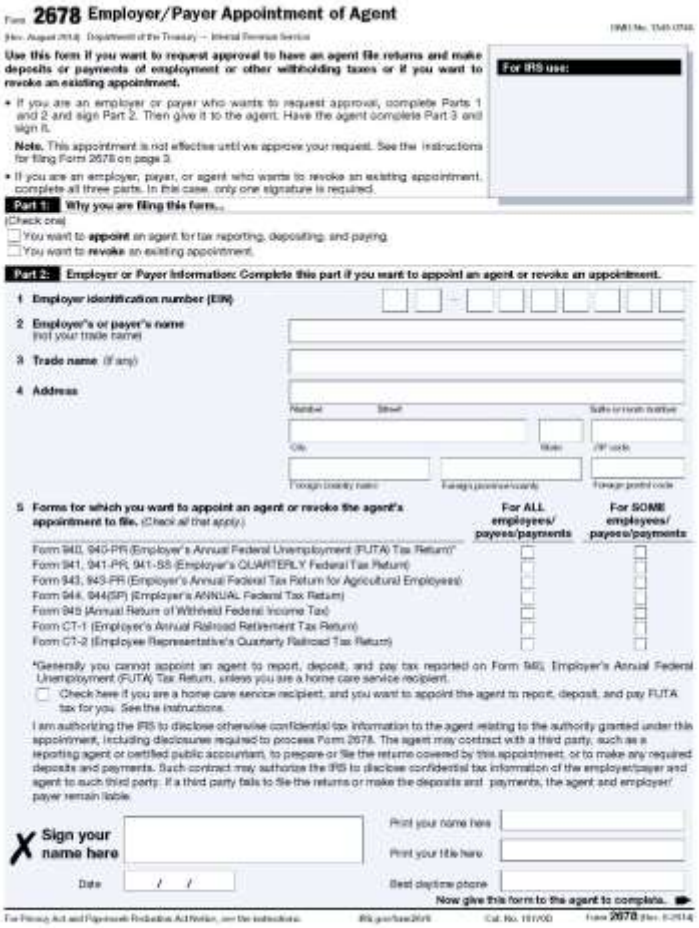
IRS Form 2678
EMPLOYER APPOINTMENT OF AGENT

What is it for?

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

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

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



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

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

OMB No. 1545-0746

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

For IRS use:

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

  Note. This appointment is not effective until we approve your request. See the instructions for filing Form 2678 on page 3.
- If you are an employer, payer, or agent who wants to revoke an existing appointment, complete all three parts. In this case, only one signature is required.

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

(Check one)

- ☐ You want to **appoint** an agent for tax reporting, depositing, and paying.
- ☐ You want to **revoke** an existing appointment.

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

1 **Employer identification number (EIN)**

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

3 **Trade name** (if any)

4 **Address**

Number | Street | Suite or room number

City | State | ZIP code

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

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

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

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

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

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

✗ **Sign your name here** | Print your name here

Print your title here

Date / / | Best daytime phone

Now give this form to the agent to complete.

For Privacy Act and Paperwork Reduction Act Notice, see the instructions. | IRS.gov/Form2678 | Cat. No. 10170D | Form **2678** (Rev. 8-2014)

UI Application for Unemployment Insurance

What is it for?

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

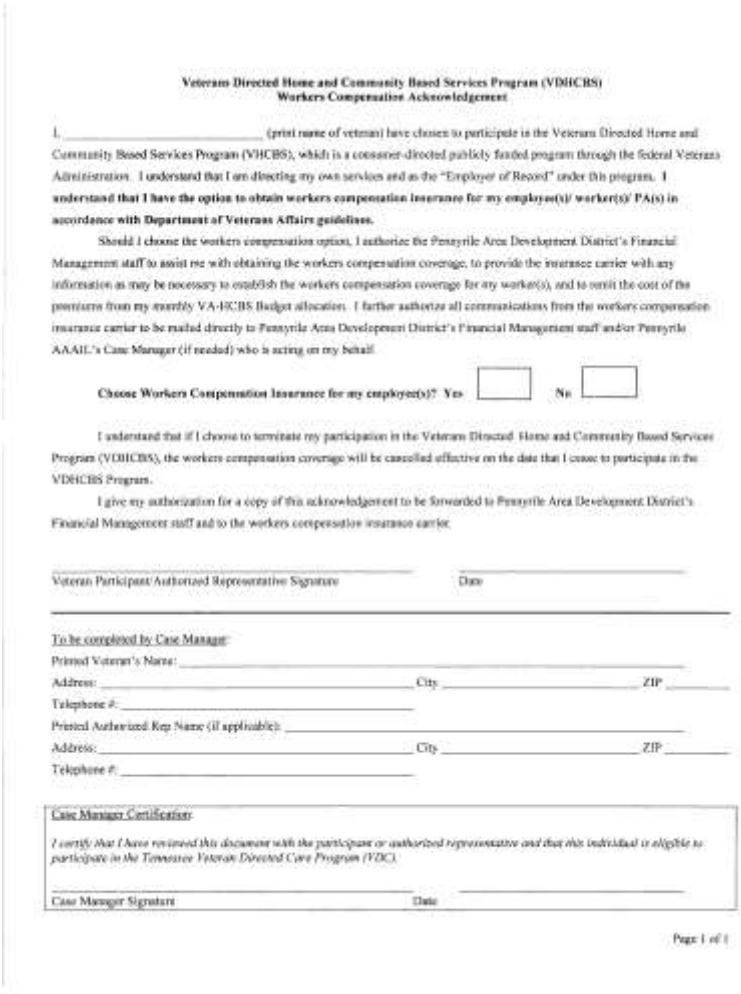
REPORT TO DETERMINE STATUS
APPLICATION FOR EMPLOYER NUMBER

PLEASE COMPLETE PAGE 2.
FAILURE TO DO SO WILL RESULT IN RECEIVING THE HIGHEST PREMIUM RATE ASSIGNABLE

Workers Compensation Acknowledgement Form

What is this for?

Workers Compensation is optional for participants in the Veterans Directed Home and Community Based 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 workers compensation insurance or not.



Veterans Directed Home and Community Based Services Program (VDHCBS)
Workers Compensation Acknowledgement

I, _____ (print name of veteran) have chosen to participate in the Veterans Directed Home and Community Based Services Program (VHCBS), 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 VA-HCBS 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 Home and Community Based Services Program (VDHCBS), the workers compensation coverage will be cancelled effective on the date that I cease to participate in the VDHCBS 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 Tennessee Veteran Directed Care Program (VDC).

_____ _____
Case Manager Signature Date

Page 1 of 1

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.

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

Example Service Plan

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

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

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: _____

Authorized Representative (AR) First Name: _____

AR Last Name: _____

AR Full Name: _____

AR SSN: _____

AR Street address: _____

AR City: _____

AR State: _____

AR Zip: _____

AR Street Address, City, State, Zip: _____

AR Phone: _____

AR Email: _____

AR Relationship to Veteran: _____

Agency: _____

Veteran Name: _____ # _____

VDHCBS Enrollment Checklist

- ☐ Welcome Letter/Explanation of Rolls distributed
- ☐ Enrollment Form Information Packet distributed
- ☐ Enrollment & Agreement From
- ☐ Veteran Set-Up form
- ☐ Rights & Responsibilities
- ☐ Release of information
- ☐ Fraud & Abuse Statement (Vet/Rep)
- ☐ Background/ Nurse Abuse Registry Agreement
- ☐ Workers Compensation Acknowledgment
- ☐ MEBH Assessment Tool
- ☐ SS-4
- ☐ 8821
- ☐ 2678
- ☐ UI Application for Unemployment Insurance
- ☐ Service Plan (optional)
- ☐ Employee packet distributed

Case Manager _____

Date _____

Please securely email entire packet to Pennyrile VA FMS
Return signed originals to
Pennyrile VA FMS
Pennyrile ADD
300 Hammond Drive
Hopkinsville, KY 42240

Retain copies for your records.

PeADD Use Only

☐ Submit SP to VAMC _____

☐ SP Approved; Start date: _____

☐ Obtain EIN _____

☐ Scan

☐ File

Veterans Directed Home and Community Based Services Program (VDHCBS)

Enrollment & Agreement Form

I, _____ (print name) choose to receive more information about the Veterans Directed Home and Community Based Services Program (VDHCBS).

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 Area Agency on Aging 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 Area Agency on Aging Case Manager and Pennyrile Area Development District (PADD) FMS staff will assist me with the tasks related to being an employer. I will fully cooperate with Case Manager & PADD 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 VDHCBS Program. If I decide that the VDHCBS 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 Area Agency on Aging, if eligible, or other home and community services programs. I will not be penalized in any way if I decide that the VDHCBS 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 VDHCBS.

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 Area Agencies on Aging, and Veterans Health Administration. I understand that the Pennyrile Area Agency on Aging/ other Area Agencies on Aging Case Managers and FMS staff will have information about me. 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 Home and Community Based Services Program (VDHCBS).

Enroll in VDHCBS Program →		Decline Enrollment VDHCBS Program	

_____ _____

Veteran or Authorized Representative Signature Date Signed

_____ _____

Printed Name of Veteran or Authorized Representative Telephone

_____

Address, City, State, Zip

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

_____ _____

Case Manager Signature Date Signed

Veterans Directed Home and Community Based Services Program (VDHCBS)
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 _____

Veterans Directed Home and Community Based Services Program (VDHCBS)

Rights and Responsibilities

RIGHTS

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

RESPONSIBILITES

I must demonstrate the required skills and abilities needed to self-direct employees, or designate an Authorized Representative to do so.
I must actively participate in developing my spending and options plan.
I must be available for home visits as policy dictates (First 3 months –1x home visit monthly, after 3 months- home visits done 1x quarterly & phone call 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 VDHCBS Program.

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

_____ _____

Veteran or Authorized Representative Date

Veterans Directed Home and Community Based Services Program (VDHCBS)

Release of Information Form

I, _____ hereby give permission to the Area Agency on Aging, which includes the Area Development District 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.

Veterans Directed Home and Community Based Services Program (VDHCBS)
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 for herself or some other person. In other works. 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 timesheet incorrectly for hours or services that were not provided during the times listed or on the day listed;
- Knowingly and/or purposefully allowing the Financial Management Service (FMS) to bill for services that were not provided;
- Knowingly and /or purposefully using the VDHCBS budget for any other purpose that what has been approved in the participant's individual spending plan.
- Knowingly and /or purposefully allowing an employee to document services or hours that were not provided
- Knowingly and/or purposefully submitting invoices to the FMS for goods and services that were not provided.
- Knowingly and/or purposefully having the FMS pay an individual for goods and/or services actually provided by someone else. (This is also tax fraud).
- Knowingly and/or purposefully making a "side deal" with an employee to split their pay check with the participant and his/her representative. (This is also tax fraud).
- Knowingly and/or purposely having the FMS pay for an approved individual-directed good included in the participants budget, and then return the approved individual-directed good to get the cash or use it for something else that has not been approved.

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

Examples of Abuse include:

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

Fraud and Abuse is a crime against all taxpayers and is both a state and federal offense. All reports or allegations of fraud and abuse within the VDHCBS program will be referred to the VA. Participants suspected of fraud or abuse also face termination from the VDHCBS 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

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

All candidates for a veteran's Personal Assistant and / or in-home worker(s) are required to have a name-based background check prior to employment in the Veterans Directed Care Program (VDHCB). The background check will be performed/ requested by the Case Manager. The background check will be conducted using "First Advantage" national background check agency. In addition, all candidates must also undergo a Nurse Abuse Registry check using the Tennessee Department of Health website.

☐ By marking this box, I understand & accept the terms that a **name-based background check & Nurse Abuse Registry check** has to be conducted on any/all personal assistant and / or in-home employee(s) of my choice, prior to employment in the Veterans Directed Care Program as required by the Area Development District (ADD) and Area Agency on Aging.

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

I understand that I have the right to hire an employee of my choice and will assume full responsibility of hiring this person as long as the Area Development District/ Area Agency on Aging approves the employee. I understand that the Area Development District/ Area Agency on Aging 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: _____

Veterans Directed Home and Community Based Services Program (VDHCBS)
Workers Compensation Acknowledgement

I, _____ (print name of veteran) have chosen to participate in the Veterans Directed Home and Community Based Services Program (VHCBS), 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 VA-HCBS 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 Home and Community Based Services Program (VDHCBS), the workers compensation coverage will be cancelled effective on the date that I cease to participate in the VDHCBS 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

Veterans Directed Home and Community Based Services Program (VDHCBS)
Mental/Emotional/Behavioral Health Assessment (MEBH)

Referral Date _____ Diagnosis Code: _____

Date Assessed _____ Date Reassessed _____

Respondent (specify relationship) _____

Case Manager _____

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

Address 1 _____

Address 2 _____

City _____ Zip Code _____ County _____

Home Phone _____ Other _____ DOB _____

Sex: ☐ Male ☐ Female Primary Language _____

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

Social Security # _____

Medicaid # _____

Medicare Number _____ ☐ A ☐ B ☐ C ☐ D

Private/Supplemental _____ Policy # _____

VA Identification #s _____

Main Support:

Name _____

Relationship _____

Phone _____

Alt. Phone _____

Back Up Support:

Name _____

Relationship _____

Phone _____

Alt. Phone _____

Emergency Contact: Check here if same as main support

Name _____

Relationship _____

Address _____

City, State, Zip _____

Phone _____ Alt. Phone _____

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

Name _____

Relationship _____

Address _____

City, State, Zip _____

Phone _____ Alt. Phone _____

Comments:

Court Appointed Conservator/Guardian (if applicable):

Name _____

Relationship _____

Address _____

City, State, Zip _____

PHYSICAL HEALTH

Date of last hospitalization _____

Reason for last hospitalization _____

Diagnosis (provide details)

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

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

Other Diagnosis (please specify):

Alcohol Use:

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

Recreational Drug Use:

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

Nutrition --- Special Diet: ☐ Yes ☐ No

If yes, specify: _____

Comments

PHYSICAL ENVIRONMENT

Living Arrangement:

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

Housing (check all that apply):

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

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

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

Additional Comments:

Is there a weapon in the home and where?

Overall review of physical environment

ASSISTIVE DEVICES & SENSORY IMPAIRMENT

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

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

List other assistive devices

Vision

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

Hearing

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

MENTAL/EMOTIONAL/BEHAVIORAL HEALTH

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

Comprehension:

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

Decision Making Ability:

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

Short Term Memory Impairment:

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

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

Mental Health Screening:

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

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

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

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

Comments

SUBTOTAL MENTAL/EMOTIONAL/BEHAVIOR HEALTH --

☐

ADL/IADL ASSESSMENT

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

Comments:

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

Comments:

SUBTOTAL OF ADLs & IADLs	

SUMMARY & JUDGEMENT

GRAND TOTAL SCORE	

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

Assessor Signature: _____ Date: _____

Form **SS-4** (Rev. January 2010)

Department of the Treasury
Internal Revenue Service

Application for Employer Identification Number

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

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

OMB No. 1545-0003

EIN

Type or print clearly.

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

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

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

4a Mailing address (room, apt., suite no. and street, or P.O. box)
300 Hammond Drive

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

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

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

6 County and state where principal business is located

7a Name of responsible party

7b SSN, ITIN, or EIN

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

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

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

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

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

Group Exemption Number (GEN) if any ▶

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

State

Foreign country

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

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

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

12 Closing month of accounting year December

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

Agricultural	Household	Other
	4	

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

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

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

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

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

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

If "Yes," write previous EIN here ▶

Third Party Designee

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

Designee's name
Hayla Swaw

Designee's telephone number (include area code)
270-886-9484

Address and ZIP code
300 Hammond Drive, Hopkinsville, KY 42240

Designee's fax number (include area code)
270-886-3211

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

Applicant's telephone number (include area code)

Name and title (type or print clearly) ▶

Applicant's fax number (include area code)

Signature ▶ Date ▶

Form **8821**

(Rev. March 2015)

Department of the Treasury
Internal Revenue Service

Tax Information Authorization

► **Information about Form 8821 and its instructions is at *www.irs.gov/form8821*.**

► **Do not sign this form unless all applicable lines have been completed.**

► **Do not use Form 8821 to request copies of your tax returns or to authorize someone to represent you.**

OMB No. 1545-1165

For IRS Use Only

Received by:

Name

Telephone

Function

Date

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

Taxpayer name and address	Taxpayer identification number(s)	
	Daytime telephone number 270-886-9484	Plan number (if applicable)

2 Appointee. If you wish to name more than one appointee, attach a list to this form. **Check here if a list of additional appointees is attached** ► ☐

Name and address	
Hayla Swaw Pennyrile Area Development District % CDO Payroll Services 2 300 Hammond Drive Hopkinsville, KY 42240	CAF No. 031-63045R PTIN Telephone No. 270-886-9484 Fax No. 270-886-3211 Check if new: Address ☐ Telephone No. ☐ Fax No. ☐

3 Tax Information. Appointee is authorized to inspect and/or receive confidential tax information for the type of tax, forms, periods, and specific matters you list below. See the line 3 instructions.

(a) Type of Tax Information (Income, Employment, Payroll, Excise, Estate, Gift, Civil Penalty, Sec. 4980H Payments, etc.)	(b) Tax Form Number (1040, 941, 720, etc.)	(c) Year(s) or Period(s)	(d) Specific Tax Matters
EIN, Number, Income and Employment Tax	SS4, 940, 940R, 941, 941R, 941z,W2		Obtain EIN, Tax Liability

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

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

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

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

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

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

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

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

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

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

Signature | Date

Print Name | Title (if applicable)

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

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

OMB No. 1545-0748

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

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

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

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

For IRS use:

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

(Check one)

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

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

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

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

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

3 Trade name (if any)

4 Address

Number Street Suite or room number

City State ZIP code

Foreign country name Foreign province/county Foreign postal code

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

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

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

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

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

✗ **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.

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

6 Agent's employer identification number (EIN) 32 – 0387566

7 Agent's name (not trade name) Pennyrile Area Development District

8 Trade name (if any) Veterans Directed Care Program

9 Address 300 Hammond Drive

Number Street Suite or room number

Hopkinsville | KY | 42240

City State ZIP code

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

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

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

X Sign your name here

Print your name here: Hayla Swaw

Print your title here: Staff Accountant

Date / /

Best daytime phone: 270-886-9484

RETURN TO: TN DEPT OF LABOR AND WORKFORCE DEVELOPMENT
DIVISION OF EMPLOYMENT SECURITY
EMPLOYER ACCOUNTS/EMPLOYER SERVICES
220 FRENCH LANDING DRIVE, 3-B
NASHVILLE TN 37243-1002
(615) 741-2486 FAX (615) 741-7214

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT

REPORT TO DETERMINE STATUS
APPLICATION FOR EMPLOYER NUMBER

1. Enter Federal Number, Business Name and Address

Federal Number ___ ___ - ___ ___ ___ ___ ___ ___ ___ ☐

Employer Name _____

Trade Name Pennyrile ADD/VDC Program

Mailing Address 300 Hammond Drive
Hopkinsville, KY 42240

PHYSICAL BUSINESS ADDRESS in Tennessee if different from above:

_____

_____

Business Website:_____

OFFICIAL USE ONLY

Tennessee ID Number	M. No.	County	Alt Zip

Liab. Org.	First Employment	Date Liable

Comp Year	NAICS	M-NAICS	Verified

Previous No.	Rate

Phone:_____ Fax:_____

Email Address: _____

2. Have you previously had an account with this department? YES ☐ NO ☒ If YES, Account Number _____

3. Is your organization a Professional Employer Organization (PEO)? YES ☐ NO ☒ If YES, **Tennessee** license number _____
Is your organization a client of a Professional Employer Organization (PEO)? YES ☐ NO ☒
If YES, STOP. STOP **Please complete LB-0910, Application for Client Number.**

NOTE: If corporation is a nonprofit, exempt from Federal Income Taxes under Section 501(C)(3) of the IRS Code, STOP. STOP
Please complete LB-0444, Report to Determine Status, Nonprofit Organization.

4. CHECK (X) FORM OF ORGANIZATION

- ☒ INDIVIDUAL
- ☐ PARTNERSHIP
- ☐ CORPORATION
- ☐ LIMITED LIABILITY COMPANY
- ☐ LIMITED PARTNERSHIP
- ☐ OTHER

5. Name of Owner, Partners, Corporate Officers, Limited Liability Company Members and Managers *(If Board Managed)*, General Partners *(Attach separate sheet if necessary.)*

Social Security Number

NOTE: If a Limited Liability Company, are you treated by IRS as a(n) ☐ Individual Proprietorship ☐ Partnership or as a ☐ Corporation?

6. Name of person responsible for payroll records _____ Phone Number _____

7. A. Number of workers you have employed (will employ) in TN 1

B. Date you first employed (will employ) a worker in TN _____

C. Date you first paid (will pay) a worker in Tennessee _____

D. Are you presently reporting for U.I. purposes in another state?
YES ☐ NO ☒ If YES, which state? _____

E. If a corporation or LLC, provide formation information.
Date _____ State _____ Control No. _____

8. REGULAR BUSINESS EMPLOYMENT *(SEPARATE REPORTS MUST BE FILED FOR EACH CALENDAR QUARTER IN WHICH WAGES WERE PAID.)*

A. Have you employed or do you expect to employ at least one worker in twenty different calendar weeks during a calendar year? YES ☐ NO ☐
If YES, give earliest month and year the twentieth week occurred (will occur). MONTH _____ YEAR _____

B. Have you had or do you expect to have a quarterly payroll of $1,500 or more? YES ☒ NO ☐
If YES, give earliest quarter and year this occurred (will occur). QUARTER _____ YEAR _____

9. HOUSEHOLD EMPLOYMENT *(SEPARATE REPORTS MUST BE FILED FOR EACH CALENDAR QUARTER IN WHICH WAGES WERE PAID.)*

A. Have you had or do you expect to have a $1,000 quarterly payroll for domestic services? YES ☐ NO ☐
If YES, give earliest quarter and year this occurred (will occur). QUARTER _____ YEAR _____

10. AGRICULTURAL EMPLOYMENT *(SEPARATE REPORTS MUST BE FILED FOR EACH CALENDAR QUARTER IN WHICH WAGES WERE PAID.)*

A. Have you employed or do you expect to employ at least ten or more workers in some part of a day in twenty different weeks during a calendar year?
YES ☐ NO ☐ If YES, give earliest month and year this occurred (will occur). MONTH _____ YEAR _____

B. Have you had or do you expect to have a quarterly payroll of $20,000 or more? YES ☐ NO ☐
If YES, give earliest quarter and year this occurred (will occur). QUARTER _____ YEAR _____

C. Is all activity performed on a farm? YES ☐ NO ☐ If NO, what percentage is? _____ Please explain in 13A on page 2.

Must be signed by owner, partner, authorized limited liability company member or manager, or officer of the corporation.

Signature _____ Title _____ Date _____

PLEASE COMPLETE PAGE 2.
FAILURE TO DO SO WILL RESULT IN RECEIVING THE HIGHEST PREMIUM RATE ASSIGNABLE. LB-0441

11. (A) Name and Address of predecessor employer _____

_____

_____

(B) Account Number of predecessor employer _____ **(C)** Date of acquisition _____

(D) Did you acquire all of your predecessor's business in Tennessee? YES ☐ NO ☐ If No, what percentage did you acquire? _____

(E) Did your predecessor continue in business in Tennessee? YES ☐ NO ☐

(F) Tennessee Employment Security Law provides for the mandatory transfer of an employer's benefit and premium experience whenever there is any common ownership, management or control between the predecessor and successor employers.
Did any owner or manager of this company have an ownership interest in or participate in the management or control of the business acquired? YES ☐ NO ☐

If "YES," please explain: _____
Per TCA 50-7-403(b)(2)(C)(ii) "Common ownership, management or control" includes any individual who has at least a 10% ownership interest in - or who participates in the management or control of - the predecessor's trade or business and has a relative with a 10% ownership interest in - or who participates in the management or control of - the successor's trade or business.

Does anyone who had a 10% or more ownership interest in the previous company - or who participated in its management or control - have a relative with a 10% or more interest in this company or who participates in its management or control?

YES ☐ NO ☐ If "YES," please explain: _____
If you are not subject to a mandatory transfer of experience but wish to succeed to the experience of the predecessor employer, Form LB-0483, Application for Transfer of Experience Rating Record, must be submitted by no later than the end of the quarter following the quarter in which the acquisition occurred.

12. Enter below the amount of total payroll for each quarter in which you have had or expect to have employment.

YEAR	JAN-MAR	APR-JUNE	JUL-SEPT	OCT-DEC	YEAR	JAN-MAR	APR-JUNE	JUL-SEPT	OCT-DEC

13. FAILURE TO PROPERLY COMPLETE THIS SECTION WILL RESULT IN RECEIVING THE HIGHEST PREMIUM RATE ASSIGNABLE.

(A) Describe the major business activity of the account to be covered, listing any products manufactured or sold, or service provided.
Be as descriptive as possible. _____

_____

_____

(B) In what **Tennessee County** is your company located? _____
(If account covers sales reps or other personnel working from home, list county or city of residence.)

(C) Is the primary purpose of the employee(s) covered by this application to **support other locations of your company**? YES ☐ NO ☒
If YES, then check the category that best applies. Add comments as necessary.

- ☐ HEADQUARTERS (e.g., corporate or regional management offices) _____
- ☐ ADMINISTRATIVE (e.g., bookkeeping, accounting, payroll, HR, PR) _____
- ☐ WAREHOUSING (e.g., storage, distribution, equipment yard) _____
- ☐ SALESMAN (indicate product) _____
- ☐ INFORMATION TECHNOLOGY (e.g., software publication, programming, systems design, data processing) _____
- ☐ OTHER (e.g., repair shop, security office, maintenance, employee recreation facility) _____

(D) Below are some industries that often need additional clarification. This section may not apply to every employer. If you see your industry, please answer the corresponding question(s).

Construction: What type of construction? _____ ***Mostly*** ☐ residential or ☐ non-residential?

Property Mgmt.: Does this business manage property for ☐ others or for ☐ itself? ***Mostly*** ☐ residential or ☐ non-residential?

Trucking: Is the main trucking activity ☐ local or ☐ long distance? ***Mostly*** ☐ truckload or ☐ less than truckload?

Empl. Agency: Is this a ☐ Temporary Staffing Service or an ☐ Employment Placement Agency?

Health Care: Is this a ☐ Doctor's Office, ☐ Multi-Disciplinary Clinic, ☐ Freestanding Urgent Care Center or ☐ Other?
Please specify. _____

Info Tech (IT): Which category best fits your business? ☐ Software Publication, ☐ Programming, ☐ Systems Design, ☐ Data Processing

Restaurant: Is the restaurant ☐ Full Service, ☐ Fast Food, ☐ Cafeteria/Buffet, ☐ Snack Bar, ☐ Other? Please specify. _____

Consulting: What is the primary type of consulting? ☐ Administrative, ☐ Human Resources, ☐ Marketing, ☐ Process/Logistics,
☐ Environmental, or ☐ Other - Please specify. _____

Home Health: Does the care involve skilled nursing? YES ☐ NO ☐

Retail: What is the primary product? _____

Wholesale: What is the primary product? _____

Mining: What is the primary product? _____

Convenience Store: Does the store sell gasoline? YES ☐ NO ☐

Manufacturing: What is the primary product? _____

Veterans Directed Home and Community Based Services Program (VDHCBS) 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 VDHCBS Program Manual for Veterans

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

Example Service Plan

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

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

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

VDHCBS Program Service Plan Template for Veteran

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

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

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

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

(Page #4 If Applicable)

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

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

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

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

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

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

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

Shopping or Running Errands	• Shopping with or without the veteran for the veteran.
Socialization Support Services	• Employee / worker (personal assistant) to accompany the Veteran to activities such as education or exercise classes. • Employee/ worker (personal assistant) taking the veteran to the movies, a Bible study, or other social engagements (verified by CM).
Transportation	• Public transportation or other transport required to go for socialization support or medical support activities with the designated caregiver (or PA) providing escort

	• A Month Public Transport Pass to get around town or the area to go to social activities • An escort to a veteran who has special needs (physical or cognitive) when using regular vehicular transportation.

Participant-Delegated Goods and Services	• Funds from your budget may be spent on services/and or items that would make life easier for you, meaning that you would need less assistance from others due to this item or service increasing your independence. • For example, a fax machine which helps you facilitate a timely submission of timesheets for your employees. Or perhaps a microwave oven might make it easier for you to prepare your own meals as opposed to paying someone to prepare them for you.
Savings Funds (Specified Savings)	• These are savings that are directed toward a specific purchase. There is no limit on how large these savings can get, but the full cost and amount of savings per month must be specified in your Spending Plan. Once the full amount of the item is saved, the item must be purchased. For example, if you need a ramp installed in the house that will cost $300, you may save $50 a month. Once you have saved the $300, the ramp must be purchased.
Savings Funds (Savings for emergencies and backup services)	• These are savings for costs that might arise, or for emergency backup planning. **If a veteran has a personal assistant, the veteran is required to save for emergency in home services provided through an agency unless a reliable informal caregiver is identified to serve as the emergency provider**. Savings may not exceed the monthly Spending Plan amount less $100.

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.

Area Agency on Aging and Independent Living (AAAIL): The AAAIL holds a contract with the Department of Veterans Affairs, hires individual Case Managers and trains these Case Managers to work at the local level and provide supports to individual VDC participants

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Information and Referral Service: Consists of activities such as assessing the needs of the Veteran, evaluation appropriate resources, assessing appropriate response modes, including organizations capable of meeting those needs, providing information about each organization to help the veteran make an informed choice, helping the veteran for whom services are no available by location alternative resources when necessary, actively participating in linking the veteran to needed services and following up on referrals to ensure the service was received or provided.

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

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

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

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

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

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

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

- Personal Emergency Response System includes the installation of the individual monitoring unit, training associated with the use of the system, periodic checking to insure that the unit is functioning properly, equipment maintenance calls, response to an emergency call by a medical professional, paramedic, or volunteer, and follow-up with the veteran.

- Combination key box for the door, this keeps a key available for easy access to the home by emergency personnel.
- Home safety Evaluation by a professional person to assure safety of travel paths and needed durable medical equipment that may create a safer environment for the veteran.

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