

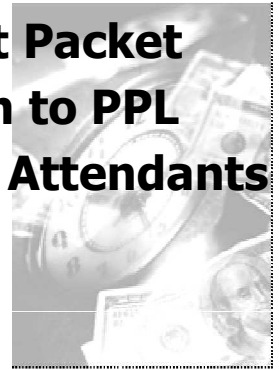
You can send a 1 page hire sheet to PPL to have them pre-populate this document.

**\*\*\*Always call PPL 1-week after mailing to make sure they've received it and are processing it\*\*\***

Public Partnerships, LLC  
Fiscal Agent Services  
4991 Lake Brook Drive, Suite 90  
Glen Allen, VA 23060

Toll Free Numbers  
Phone: 1-866-259-3009  
TTY: 1-800-360-5899  
Administrative Fax: 1-866-709-3319  
Timesheet Fax: 1-888-564-1532

## Employment Packet Introduction to PPL Information for Attendants



Dear Attendant:

Welcome aboard! You have received this packet because a consumer who receives support through the Virginia Department of Medical Assistance Services (DMAS) is interested in hiring you.

First, here is an important Program Regulation that may affect employment. **The United States Department of Health and Human Services-Office of the Inspector General (HHS-OIG) maintains the List of Excluded Individuals/Entities (LEIE) which includes persons with convictions for program-related fraud, patient abuse or licensing board actions. Medicaid payments cannot be made for services furnished by an excluded person who is on the LEIE. DMAS in coordination with Public Partnerships, LLC (PPL) is screening prospective and current attendants monthly to assure compliance with federal law. Additional details about LEIE can be found on Page 5 of the packet.**

DMAS has contracted with PPL to make all payments on behalf of consumers who utilize attendants. Your timesheets will be submitted to PPL for payment.

Listed below are 3 categories of forms to become an attendant. Some are required and some are not. The forms include:

- **Forms Required for All Attendants**- These forms must be completed and submitted to PPL as soon as possible so that PPL can pay you and are required even if you already provide services to another consumer through DMAS – THESE FORMS WILL ALL BE INCLUDED IN APPENDIX A – REQUIRED FORMS
- **Optional Forms** - These forms are not required by PPL but may be useful to you – THESE FORMS WILL ALL BE INCLUDED IN APPENDIX B – OPTIONAL FORMS
- **Forms to Keep** – You will use these forms for the program and will help you to successfully submit timesheets to PPL for payment - THESE FORMS WILL ALL BE INCLUDED IN APPENDIX C – FORMS TO KEEP

***There is new information at the end of the Provider/Attendant Packet that updates you on new laws related to the Earned Income credit. Please review this information because it will impact on you as an Attendant as of January 2011.***

You must complete a separate employment packet for each consumer who employs you, even if you are hired by two people in the same household. **PPL cannot pay for any services until a completed packet is received for your work with each employer. It is especially important to accurately and completely fill out the I-9 Form before you begin to work.** PPL will issue your paychecks to you based on properly completed timesheets. These paychecks will reflect tax withholdings. If you have any questions, please call us toll free at 1-866-259-3009.

Thank you



# Employment Eligibility Verification

Department of Homeland Security  
U.S. Citizenship and Immigration Services

USCIS  
Form I-9

OMB No. 1615-0047  
Expires 03/31/2016

▶ **START HERE.** Read instructions carefully before completing this form. The instructions must be available during completion of this form.

**ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

**Section 1. Employee Information and Attestation** (Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)

Last Name (Family Name) <b>Aide competes</b>		First Name (Given Name)		Middle Initial	Other Names Used (if any) <b>Aide competes</b>	
Address (Street Number and Name) <b>Aide competes</b>			Apt. Number <b>Aide competes</b>	City or Town <b>Aide competes</b>		State <b>Aide competes</b>
Date of Birth (mm/dd/yyyy) <b>Aide competes</b>	U.S. Social Security Number <b>Aide competes</b>		E-mail Address <b>Aide competes</b>			Telephone Number <b>Aide competes</b>

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following): **Aide competes**

- A citizen of the United States
- A noncitizen national of the United States (See instructions)
- A lawful permanent resident (Alien Registration Number/USCIS Number): \_\_\_\_\_
- An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) \_\_\_\_\_. Some aliens may write "N/A" in this field. (See instructions)

For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:

1. Alien Registration Number/USCIS Number: \_\_\_\_\_

**OR**

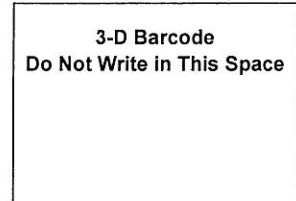
2. Form I-94 Admission Number: \_\_\_\_\_

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: \_\_\_\_\_

Country of Issuance: \_\_\_\_\_

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (See instructions)



Signature of Employee: <b>Aide competes</b>	Date (mm/dd/yyyy): <b>Aide competes</b>
---	---

**Preparer and/or Translator Certification** (To be completed and signed if Section 1 is prepared by a person other than the employee.)

I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct. **Only complete if someone helped employee with I-9 (not necessary in most cases)**

Signature of Preparer or Translator:		Date (mm/dd/yyyy):	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State
			Zip Code

**STOP** Employer Completes Next Page **STOP**

## Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1: **Employer complete (1 item from list A only or 1 item from both B & C)**

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title: <b>ie. "Drivers License"</b>		Document Title: <b>ie. "Social Security Card"</b>
Issuing Authority:		Issuing Authority: <b>ie. "State of VA"</b>		Issuing Authority: <b>ie. "Social Security Administration"</b>
Document Number:		Document Number: <b>ie. Driver's License Number</b>		Document Number: <b>ie. SSN</b>
Expiration Date (if any)(mm/dd/yyyy):		Expiration Date (if any)(mm/dd/yyyy): <b>if applicable</b>		Expiration Date (if any)(mm/dd/yyyy): <b>if applicable</b>
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date (if any)(mm/dd/yyyy):				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date (if any)(mm/dd/yyyy):				

**3-D Barcode  
Do Not Write in This Space**

### Certification

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment (mm/dd/yyyy): **mm/dd/yyyy** (See instructions for exemptions.)

Signature of Employer or Authorized Representative <b>Employer of Record signs</b>		Date (mm/dd/yyyy) <b>mm/dd/yyyy</b>	Title of Employer or Authorized Representative <b>"Employer Of Record"</b>	
Last Name (Family Name) <b>Employer Completes</b>		First Name (Given Name) <b>Employer Completes</b>		Employer's Business or Organization Name <b>Employer's name</b>
Employer's Business or Organization Address (Street Number and Name) <b>Employer Completes (no PO Boxes)</b>			City or Town <b>Employer Completes</b>	State <b>Employer Completes</b>
				Zip Code <b>Employer Completes</b>

### Section 3. Reverification and Rehires (To be completed and signed by employer or authorized representative.)

A. New Name (if applicable) Last Name (Family Name) First Name (Given Name) <b>Not usually applicable.</b>	Middle Initial	B. Date of Rehire (if applicable) (mm/dd/yyyy):
---	----------------	---

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

Document Title:	Document Number:	Expiration Date (if any)(mm/dd/yyyy):
-----------------	------------------	---------------------------------------

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative:	Date (mm/dd/yyyy):	Print Name of Employer or Authorized Representative:
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## LISTS OF ACCEPTABLE DOCUMENTS

All documents must be unexpired

### LIST A

**Documents that Establish Both  
Identity and Employment  
Authorization**

### LIST B

**Documents that Establish  
Identity**

### LIST C

**Documents that Establish  
Employment Authorization**

	OR	AND
1. U.S. Passport or U.S. Passport Card	1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address	1. Social Security Account Number card other than one that specifies on the face that the issuance of the card does not authorize employment in the United States
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa	2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address	2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
4. Employment Authorization Document that contains a photograph (Form I-766)	3. School ID card with a photograph	3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
5. In the case of a nonimmigrant alien authorized to work for a specific employer incident to status, a foreign passport with Form I-94 or Form I-94A bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, as long as the period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form	4. Voter's registration card	4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
	5. U.S. Military card or draft record	
	6. Military dependent's ID card	5. Native American tribal document
	7. U.S. Coast Guard Merchant Mariner Card	
	8. Native American tribal document	
9. Driver's license issued by a Canadian government authority	6. U.S. Citizen ID Card (Form I-197)	
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI	<b>For persons under age 18 who are unable to present a document listed above:</b>	7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
	10. School record or report card	8. Employment authorization document issued by the Department of Homeland Security
	11. Clinic, doctor, or hospital record	
	12. Day-care or nursery school record	

**Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)**

# Form W-4 (2013)

**Purpose.** Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

**Exemption from withholding.** If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2013 expires February 17, 2014. See Pub. 505, Tax Withholding and Estimated Tax.

**Note.** If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$1,000 and includes more than \$350 of unearned income (for example, interest and dividends).

**Basic instructions.** If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

**Head of household.** Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

**Tax credits.** You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

**Nonwage income.** If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity

income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

**Two earners or multiple jobs.** If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

**Nonresident alien.** If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

**Check your withholding.** After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2013. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

**Future developments.** Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at [www.irs.gov/w4](http://www.irs.gov/w4).

## Personal Allowances Worksheet (Keep for your records.)

<b>A</b>	Enter "1" for <b>yourself</b> if no one else can claim you as a dependent . . . . .	<b>A</b> _____
<b>B</b>	Enter "1" if: { • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. } . . . . .	<b>B</b> _____
<b>C</b>	Enter "1" for your <b>spouse</b> . But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . .	<b>C</b> _____
<b>D</b>	Enter number of <b>dependents</b> (other than your spouse or yourself) you will claim on your tax return . . . . .	<b>D</b> _____
<b>E</b>	Enter "1" if you will file as <b>head of household</b> on your tax return (see conditions under <b>Head of household</b> above) . . . . .	<b>E</b> _____
<b>F</b>	Enter "1" if you have at least \$1,900 of <b>child or dependent care expenses</b> for which you plan to claim a credit . . . . .	<b>F</b> _____
<b>G</b>	<b>Child Tax Credit</b> (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than \$65,000 (\$95,000 if married), enter "2" for each eligible child; then <b>less</b> "1" if you have three to six eligible children or <b>less</b> "2" if you have seven or more eligible children. • If your total income will be between \$65,000 and \$84,000 (\$95,000 and \$119,000 if married), enter "1" for each eligible child . . . . .	<b>G</b> _____
<b>H</b>	Add lines A through G and enter total here. ( <b>Note.</b> This may be different from the number of exemptions you claim on your tax return.) ▶	<b>H</b> _____
	For accuracy, <b>complete all worksheets that apply.</b> { • If you plan to <b>itemize</b> or <b>claim adjustments to income</b> and want to reduce your withholding, see the <b>Deductions and Adjustments Worksheet</b> on page 2. • If you are <b>single and have more than one job</b> or are <b>married and you and your spouse both work</b> and the combined earnings from all jobs exceed \$40,000 (\$10,000 if married), see the <b>Two-Earners/Multiple Jobs Worksheet</b> on page 2 to avoid having too little tax withheld. • If <b>neither</b> of the above situations applies, <b>stop here</b> and enter the number from line H on line 5 of Form W-4 below.	

----- Separate here and give Form W-4 to your employer. Keep the top part for your records. -----

<b>Form W-4</b> Department of the Treasury Internal Revenue Service		<b>Employee's Withholding Allowance Certificate</b>		OMB No. 1545-0074 <b>2013</b>	
▶ <b>Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</b>					
<b>1</b> Your first name and middle initial Aide completes		Last name Aide completes		<b>2</b> Your social security number Aide completes	
Home address (number and street or rural route) Aide completes			<b>3</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> <b>Married, claiming a higher Single rate.</b> <b>Note.</b> If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.		
City or town, state, and ZIP code Aide completes			<b>4</b> If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/>		
<b>5</b> Total number of allowances you are claiming (from line <b>H</b> above or from the applicable worksheet on page 2)				<b>5</b> Aide completes	
<b>6</b> Additional amount, if any, you want withheld from each paycheck				<b>6</b> \$ Aide completes	
<b>7</b> I claim exemption from withholding for 2013, and I certify that I meet <b>both</b> of the following conditions for exemption. • Last year I had a right to a refund of <b>all</b> federal income tax withheld because I had <b>no</b> tax liability, <b>and</b> • This year I expect a refund of <b>all</b> federal income tax withheld because I expect to have <b>no</b> tax liability. If you meet both conditions, write "Exempt" here . . . . . ▶				<b>7</b> Aide completes	
Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.					
<b>Employee's signature</b> (This form is not valid unless you sign it.) ▶ Aide completes				<b>Date</b> ▶ Aide completes	
<b>8</b> Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		<b>9</b> Office code (optional)		<b>10</b> Employer identification number (EIN)	
<b>EOR's name and address here.</b>					

# FORM VA-4

**COMMONWEALTH OF VIRGINIA  
DEPARTMENT OF TAXATION  
PERSONAL EXEMPTION WORKSHEET**  
(See back for instructions)

1. If you wish to claim yourself, write "1" .....
2. If you are married and your spouse is not claimed on his or her own certificate, write "1" .....
3. Write the number of dependents you will be allowed to claim on your income tax return (do not include your spouse).....
4. Subtotal Personal Exemptions (add lines 1 through 3).....
5. Exemptions for age
  - (a) If you will be 65 or older on January 1, write "1" .....
  - (b) If you claimed an exemption on line 2 and your spouse will be 65 or older on January 1, write "1" .....
6. Exemptions for blindness
  - (a) If you are legally blind, write "1" .....
  - (b) If you claimed an exemption on line 2 and your spouse is legally blind, write "1" .....
7. Subtotal exemptions for age and blindness (add lines 5 through 6) .....
8. Total of Exemptions - add line 4 and line 7 .....

-----  
 Detach here and give the certificate to your employer. Keep the top portion for your records  
**FORM VA-4 EMPLOYEE'S VIRGINIA INCOME TAX WITHHOLDING EXEMPTION CERTIFICATE**

Your Social Security Number <b>Aide completes</b>	Name <b>Aide completes</b>		
Street Address <b>Aide completes</b>			
City <b>Aide completes</b>	State <b>Aide completes</b>	Zip Code <b>Aide completes</b>	

**COMPLETE THE APPLICABLE LINES BELOW**

1. If subject to withholding, enter the number of exemptions claimed on:
  - (a) Subtotal of Personal Exemptions - line 4 of the Personal Exemption Worksheet..... **Aide completes**
  - (b) Subtotal of Exemptions for Age and Blindness line 7 of the Personal Exemption Worksheet ..... **Aide completes**
  - (c) Total Exemptions - line 8 of the Personal Exemption Worksheet..... **Aide completes**
2. Enter the amount of additional withholding requested (see instructions)..... **Aide completes**
3. I certify that I am not subject to Virginia withholding. I meet the conditions set forth in the instructions (check here) ..... **Aide completes**

**Aide completes**

**Aide completes**

2601064 Rev. 11/07

**AGREEMENT BETWEEN CONSUMER (“EMPLOYER”) AND ATTENDANT (“EMPLOYEE”)**

Name of Consumer: Person Being Served Consumer ID: Their PPL/Medicaid ID

Name of Employer of Record: Person signing timesheets (not employee)

Name of Attendant: Aide Attendant ID: usually not available at

Attendant Address: Aide this point.

Attendant Phone: Aide

Attendant E-mail Address: Aide

**SECTION 1: TO BE COMPLETED BY ATTENDANT: Aide**

Are you the spouse of the Consumer?  Yes  No

Are you the parent of the Consumer?  Yes  No

Are you at least 18 years of age?  Yes  No

This agreement is made as of Date between the Employer of Record and the Attendant to establish the responsibilities of the parties to each other. As the Attendant, I recognize my employment is contingent upon the Consumer’s enrollment in the VA DMAS Consumer-Directed Services Program. If the Consumer is no longer in the Consumer-Directed Services Program, I may no longer be employed and wages will not be payable under the DMAS Consumer-Directed Services Program.

**SECTION 2:**

This agreement will be effective when it is signed by both parties. Either party may terminate this agreement. Notice may be provided either orally or in writing to the Employer of Record (EOR) at least (5) five days prior to notice. When employment is terminated, the Employer must send a “Notice of Discontinued Employment” form to PPL.

I will be compensated for services at the hourly rate of \$ rate/hr. The hourly rate is subject to adjustment as determined by the Virginia Department of Medical Assistance Services in accordance with rates established by the Virginia General Assembly.

If I am unable to work a scheduled time, I shall provide at least 24 hours advance notice to the Employer, in order for the Employer to find an alternative.

A change in scheduled time by the Employer or me must be scheduled at least 24 hours in advance. In case of emergency, I will notify the Employer. If I am knowingly going to be late, I will call my Employer. In order to acknowledge the terms of my employment, as the Attendant, I understand and agree to the following:

Basic Qualifications:

1. I am at least 18 years of age or older.
2. I have the required skills to perform Attendant services as specified in the Consumer's Service Plan and have basic math, reading, and writing skills.
3. I have a valid Social Security Number and I am authorized to work in the United States.
4. I agree to protect the health and safety of the Consumer by providing authorized services in accordance with the policies and standards of the Elderly or Disabled with Consumer-Direction, Individual and Family Developmental Disabilities Support, and Intellectual Disability waivers and Children's Mental Health (CMH), and Early and Periodic Screening, Diagnosis and Treatment Programs including the Minimum Qualifications for the Employment as an Attendant.
5. I agree to be punctual, neatly dressed, and respectful of all family members.

Background Reviews and Communications:

6. I understand and consent to having State Police criminal background checks and Department of Social Services/Child Protective Services records checks (when required), completed on me and understand that my employment is contingent upon the results of the background checks. I acknowledge that I will not be paid for services performed after failed results of the checks have been communicated to the Employer of Record.
7. I understand the results of my background checks will be made available to my prospective employer and other program administrators as necessary and/or required.
8. I understand that PPL will verify that I do not appear on the U.S. Department of Health and Human Services Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE). In the event I appear on this list, I will not be permitted to work or be paid in this program.
9. The Employer agrees to employ the Attendant on a contingent basis for no more than 30 days pending the results of the criminal history record check, child abuse and neglect background check and the LEIE database search results.

Reporting Abuse and Neglect:

10. I agree to immediately report all incidents to the Department of Social Services, including suspected abuse, neglect, and exploitation.

Reporting of Incidents in Service Implementation

11. I agree to immediately report all incidents to my Consumer's Services Facilitator for any event involving error in service/support implementation, critical events involving personal injury, illness, medical emergency or any event determined to be unusual.



Requirements:

12. I agree to correctly complete all required paperwork and be approved prior to providing and being paid for any services under this DMAS program.
13. I agree to take part in any meetings if requested by and/or regarding the Consumer.
14. I agree to review any/all programmatic updates made available to me by my employer.
15. I understand that in consideration of the above stated agreement, I shall be compensated through this program for only those services approved by my employer and authorized in the Consumer-Directed Services Program.
16. I understand and acknowledge wages are from federal and state funds. Any untruthful submission of services provided in an attempt to obtain improper payment is subject to investigation as Medicaid Fraud. Medicaid Fraud is a felony and can lead to substantial penalties and/or imprisonment.
17. I understand Federal Income, Medicare, Social Security and Virginia Income Tax (as applicable) shall be withheld from my wages per IRS Form W-4 and Virginia Form VA-4. Garnishments, support orders, liens and processing fees could be withheld from my pay.
18. I agree to maintain confidentially of all information regarding the Consumer and to respect the Consumer's privacy. This includes but is not limited to social media.
19. The Employer's property, including the telephone and computer, is not to be used for personal use. All private matters discussed during work times shall be kept confidential.
20. The Attendant and Employer understand the following requirements:
  - a. EDCD Waiver – The Attendant is not the spouse, parent, or stepparent if the Consumer is a minor.
  - b. IFDDS and ID Waiver – The Attendant is not the spouse, or parent, if Consumer is a minor.
  - c. CMH Program – The Attendant is not the spouse, parent, or paid caregiver.
  - d. The Attendant understands that he/she may not be paid for services furnished if he/she is another family member/caregiver living under the same roof unless there is objective written documentation by the Service Facilitator as to why there are no other attendants available to provide the care.
  - e. Attendant care services may not be provided to other people in the Consumer's household unless they are also eligible for Medicaid authorized Consumer-Directed Services.
  - f. Simultaneous sharing of the Attendant is disallowed (i.e. the caring and double billing for two Consumers by one Attendant at the same time.)

Payment

21. Timesheets must be accurately completed and signed by the Employer and the Attendant. Hours recorded on the timesheet cannot exceed the authorized number of hours.
22. Timesheets are due to PPL within two (2) business days after the end of the pay period. Timesheets received after two (2) business days from the end of the pay period will be paid within the next payroll cycle.
23. Timesheets submitted through use of the electronic timesheet capability are due prior to 5pm on the Tuesday following the end of the pay period.

24. Incorrect timesheets will be returned and no paycheck will be issued.
25. Incorrect or missing paperwork will delay payment and a paycheck will not be issued.
26. I understand the Consumer may be required to pay the Attendant a “Patient Pay”. If so, I understand this amount will not be included in the payment received from PPL. PPL will, however, withhold applicable taxes on this amount. The Consumer is responsible for reimbursement to the attendant for the “Patient Pay”.
27. All wages are paid by check or Electronic Funds Transfer (EFT).
28. I understand this agreement does not guarantee employment or payment of wages for any time period.

Employment Understanding:

29. I understand and acknowledge that Public Partnerships, LLC. is not my employer.
30. I understand that the Consumer or their appointed representative (Employer of Record) is my employer. My employer is not PPL, DMAS, or any other entity involved with the Consumer-Directed Services Program.
31. The EOR agrees to provide training and direct the Attendant in providing services that are within the Consumer’s service plan.
32. I understand that my timesheets and paychecks will be processed by PPL. PPL is considered a Financial Management Service (FMS) Organization. I understand that PPL is not authorized to pay for any service not authorized by DMAS or the service authorization contractor; services provided during periods of Medicaid or Waiver ineligibility; or any request that exceeds the Consumer’s service authorization for the service.
33. I understand, any work performed over the amount authorized by the Department of Medical Assistance or if the Consumer is not approved for the Long-Term Care Waiver allowing for Consumer-Directed Services, the attendant will not be paid under the Consumer-Directed Services Program. The Attendant will need to seek payment directly from the Employer. This includes when a Consumer is hospitalized, in a Nursing, or medical facility.
34. I understand payments are authorized by the Commonwealth of Virginia Department of Medical Assistance Services. I shall only perform work within the authorized service hours in the Plan of Care and will not be compensated by the Commonwealth of Virginia, Department of Medical Assistance Services for work performed in excess of the authorized amount. Authorized hours are approved for the Consumer prior to the Attendant starting services.

The parties agree to follow the policies and procedures set forth by DMAS and the Waiver Programs. The Attendant and the Employer agree to hold harmless, release and forever discharge the Virginia Department of Medical Assistance Services, the Services Facilitator and Public Partnerships, LLC. from any claims and/or damages that might arise out of any action or omissions by the Attendant, Employer of Record, or Consumer.

By signing below, I attest that I have read this agreement in its entirety. I understand I must sign and return this entire agreement as a condition of employment in this program, and that I cannot begin working until this entire agreement is completed and returned to PPL. In addition, I have

completed and returned all forms in the Attendant Enrollment Forms Packet and the EOR has completed and returned all forms in the Employer of Record Enrollment Forms Packet before I can be paid within this program. I further attest by signing below, that I understand what is being requested of me, and I agree to abide by these terms and conditions. I further understand and agree that violation of any of the terms and/or conditions of this agreement may result in termination of this agreement and employment, including payment for services provided to any Medicaid Individual in this program.

aide \_\_\_\_\_ aide \_\_\_\_\_  
Attendant/Employee Signature Date

EOR \_\_\_\_\_ EOR \_\_\_\_\_  
Employer of Record Signature Date

**NOTE: Please ensure both you and the employer sign this form before sending it to PPL.**

**Application for Tax Exemptions Based on Age, Student Status, and Family Relationship**

State: VA Program: Consumer Directed PAS

Participant Name: Person being served Employer Name: EOR (can be the same as participant)

Employee Name: Person being hired Employee Date of Birth: person being hired

Employees providing domestic services such as personal assistance may be exempt from paying certain federal and state taxes based on the employee’s age, student status or family relationship to the employer. In some cases, the employer may also be exempt from paying certain taxes based on the employee’s status. These exemptions are not optional. If you and your employer qualify for these exemptions you must take them. Public Partnerships will determine the tax exemptions that apply to you and to your employer (see attached).

**IMPORTANT: You must notify Public Partnerships if your student status or family relationship changes.**

Employee: Answer the following questions based on your age, student status, and relationship to the employer.  
**\*\*\*based on relationship to employer (not necessarily person getting services)\*\*\*** Answer all relevant questions

1. **Are you a non-resident alien temporarily in the United States on an F-1, J-1, M-1, or Q-1 visa admitted to the US for the purpose of providing domestic services?**  
 Yes, that description fits my status.  No, that description does not fit my status.
2. **Are you the child of the employer?**  
 Yes, my employer is my parent (mother or father).  No, my employer is not my parent.
3. **Are you the spouse of the employer?**  
 Yes, my employer is my spouse (husband, wife).  No, my employer is not my spouse.
4. **Are you the parent of the employer?**  
 Yes, my employer is my child (son or daughter).  No, my employer is not my child.
5. **If you answered “Yes”, answer the following questions. If you answered “No” skip this section.**  
 Yes, I also provide care for my grandchild or step-grandchild in my child’s home.  
 Yes, my grandchild or step-grandchild is under age 18, or has a physical or mental condition that requires personal care of an adult for at least four continuous weeks during the calendar quarter in which services are performed.  
 Yes, my child (son or daughter) is widowed or divorced and not remarried, or living with a spouse who has a mental or physical condition which prohibits the spouse from caring for my grandchild for at least four continuous weeks during the calendar quarter in which services are performed.
6. **Are you under the age of 18 or do you turn 18 this calendar year?**  
 Yes, I am under 18 or am turning 18 this calendar year.  No, I am over 18.  
**If you answered “Yes”, answer the following question. If you answered “No”, skip this section.**  
 Is the job of performing household services (personal assistance) your principal occupation? Do not answer “Yes” if you are a student.  
 Yes, performing household services is my principal occupation.  No, performing household services is not my principle occupation, or I am a student.

Employee Signature: Sign and Date Date:     /    /

**CRIMINAL HISTORY RECORD NAME SEARCH REQUEST**

**PURPOSE OF THIS REQUEST (Check only one):**

- ADOPTION-DOMESTIC                       ADOPTION-INTERNATIONAL  
 VISA (INTERNATIONAL TRAVEL)        OTHER (please specify): Employment

**NAME INFORMATION TO BE SEARCHED:**

<u>LAST NAME</u> <b>Aide completes</b>	<u>FIRST NAME</u> <b>Aide completes</b>	<u>MIDDLE NAME</u> <b>Aide completes</b>	<u>MAIDEN NAME</u> <b>Aide completes</b>
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<u>RACE</u> <b>Aide completes</b>	<u>SEX</u> <b>Aide completes</b>	<u>DATE OF BIRTH</u> <b>Aide completes</b> <b>Aide completes</b> / / (MM/DD/YYYY)	<u>SOCIAL SECURITY NUMBER</u> <b>Aide completes</b>
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**AFFIDAVIT FOR RELEASE OF INFORMATION:**

I hereby give consent and authorize the Virginia State Police to search the files of the Central Criminal Records Exchange for a criminal history record and report the results of such search to the agent or individual authorized in this document to receive same.

**Aide signs in front of Notary\*\*\*\***  
\_\_\_\_\_  
Signature of Person

State of \_\_\_\_\_; County/City of \_\_\_\_\_, to wit: Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.  
My Commission expires \_\_\_\_\_, 20 \_\_\_\_.

**Complete nothing else below this section\*\*\*\*PPL pays for search!**                      \_\_\_\_\_  
Signature of Notary Public

**SIGNATURE OF PERSON MAKING REQUEST:**

As provided in Section 19.2-389, Code of Virginia, I hereby request the criminal history record of the individual named in Section 1 and swear or affirm I have the consent of the individual to obtain their record and will not further disseminate the information received, except as provided by law.

\_\_\_\_\_  
Signature of Person Making Request

State of \_\_\_\_\_; County/City of \_\_\_\_\_, to wit: Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.  
My Commission expires \_\_\_\_\_, 20 \_\_\_\_.

\_\_\_\_\_  
Signature of Notary Public

**NAME AND MAILING ADDRESS OF AGENCY, INDIVIDUAL OR AUTHORIZED AGENT MAKING REQUEST:**

Mail Reply To:



<u>NAME</u> <b>Public Partnerships, LLC</b>	
<u>ATTENTION</u> <b>C/O Criminal History Check</b>	
<u>ADDRESS</u> <b>4991 Lake Brook Drive, Suite 90</b>	
<u>CITY</u> <b>Glen Allen</b>	<u>STATE</u> <b>VA</b> <u>ZIP CODE</u> <b>23060</b>

**FEES FOR SERVICE:**

- |   |   |
|---|---|
| <b>FEES:</b><br><input type="checkbox"/> \$15.00 CRIMINAL HISTORY SEARCH<br><input type="checkbox"/> \$20.00 COMBINATION CRIMINAL HISTORY & SEX OFFENDER SEARCH | <b>* FEES For Volunteers with Non-Profit Organizations:</b><br><input type="checkbox"/> \$8.00 CRIMINAL HISTORY SEARCH<br><input type="checkbox"/> \$16.00 COMBINATION CRIMINAL HISTORY & SEX OFFENDER SEARCH |
|---|---|

\* To be entitled to reduced price, services must be on volunteer basis for a non-profit organization with a tax exempt number. Attach documentation to form which supports volunteering status and include organization's name, address, and your tax exempt identification number.

**METHOD OF PAYMENT: (Note: Personal Checks Not Accepted)**

- Business or Certified Check or Money Order (payable to Virginia State Police)  
 Charge Card     MasterCard     **OR**     Visa   
 Account Number:                      -                      -                      -  
 Expiration Date:                      /  
 Signature of Cardholder: \_\_\_\_\_  
 Virginia State Police Charge Account Number:

**Mail Request To:**

Virginia State Police  
 Central Criminal Records Exchange  
 P.O. Box 85076  
 Richmond, Virginia 23261-5076

**FOR STATE POLICE USE ONLY – DO NOT WRITE BELOW THIS LINE**

Response based on comparison of name information submitted in request against a master name index maintained in the Central Criminal Records Exchange only.

No Conviction Data – Does Not Preclude the Existence of an Arrest Record No Criminal Record – Name Search Only No Sex Offender Registration Record	Purpose code: <b>C</b> <b>N</b> <b>O</b>
No Criminal Record – Fingerprint Search Criminal Record Attached	
Date _____ By CCRE/ _____	

# Virginia Department of Social Services/Child Protective Services Central Registry Release of Information Form

**Part I: INSTRUCTIONS - Read all instructions before completing form: Incomplete forms will be returned.**

1. Type or print legibly in ink. Indicate N/A if a question is not applicable
2. Submit a separate form for each individual whose name is to be searched. MUST USE THIS FORM BEGINNING 11/01/09
3. Provide proof of identity and sign Part III in the presence of a Notary Public.
4. **Enclose a \$7.00** money order, company /business check or cashiers check payable to: **Virginia Department of Social Services** (unless waived) **DO NOT SEND CASH or PERSONAL CHECKS.** This fee is nonrefundable. \$25 will be charged for checks returned for insufficient funds.
5. Search results disseminated beyond the requesting agency/individual named below are not considered official.
6. Mail completed form to: **VA Dept. of Social Services, 801 East Main St, 6th floor, OBI Search Unit, Richmond VA 23219-2901**

**MAIL SEARCH RESULTS TO: Agency, Individual or Authorized Agent Requesting Search**

<b>Name</b> Public Partnerships, LLC <hr/> <b>Address:</b> 4991 Lake Brook Drive, Suite 90 <hr/> <b>City</b> Glen Allen <b>State</b> Va <b>Zip Code</b> 23060 <hr/> <b>Contact Person</b> Christopher L Calloway Sr <b>Contact's Phone Number</b>	<b>Payment Code/ Fips Code</b> (If assigned by Central Registry Unit) <hr/> <b>Mandatory for all coded agencies</b>
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**Purpose of Search, Check one:**  Adam Walsh Law  Adoptive Parent  Babysitter/Family Day Care  CASA  
 Children's Residential Facility  Custody Evaluation  Day Care Center  Foster Parent  Institutional Employee  
 Other Employment  School Personnel  Volunteer  Other Employment

**Part II: TO BE COMPLETED IN FULL, BY INDIVIDUAL WHOSE NAME IS BEING SEARCHED**

**Identifying Information for Person Being Searched:**

Last Name <span style="color: blue;">Employee must fill out this whole section</span>	First Name	Full Middle Name – no initials (if name is initial only state Initial Only)		
Maiden Name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Race	Date of Birth MM/DD/YY	Social Security Number
Driver's License Number	Other names Used by the Individual (Nicknames, previous married names, etc.)			
Current Address Street	Current Address City	Current Address State	Current Address Zip Code	
Prior Address Street	Prior Address City	Prior Address State	Prior Address Zip Code	Date of Residency
Prior Address Street	Prior Address City	Prior Address State	Prior Address Zip Code	Date of Residency
Prior Address Street	Prior Address City	Prior Address State	Prior Address Zip Code	Date of Residency

**CURRENT SPOUSE INFORMATION**  CHECK HERE IF NOT CURRENTLY MARRIED

Last Name	First Name	Full Middle Name	Maiden Name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Race	Birth Date MM/DD/YY
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**ALL PREVIOUS SPOUSES**  CHECK HERE IF NOT PREVIOUSLY MARRIED

Last Name	First Name	Full Middle Name	Maiden Name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Race	Birth Date MM/DD/YY
Last Name	First Name	Full Middle Name	Maiden Name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Race	Birth Date MM/DD/YY

**Full Names of All Children:** (Include Adult Children, Step, Foster, Children Not Living with you. Attach additional paper if needed)

Check here if you do not have children

Last Name	First Name	Full Middle Name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Race	Birth Date MM/DD/YY
Last Name	First Name	Full Middle Name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Race	Birth Date MM/DD/YY
Last Name	First Name	Full Middle Name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Race	Birth Date MM/DD/YY
Last Name	First Name	Full Middle Name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Race	Birth Date MM/DD/YY
Last Name	First Name	Full Middle Name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Race	Birth Date MM/DD/YY



# Choose Direct Deposit or Debit Card - This is the DD form - Must Send

## Voided NON-STARTER Check with this form\*\*\*

MAIL WITH VOIDED CHECK TO: VA DMAS Programs, Public Partnerships, LLC, 4991 Lake Brook Drive, Suite G90, Glen Allen, VA 23060

Public Partnerships, LLC - Virginia DMAS Programs

FORM -EFT1

### DIRECT DEPOSIT APPLICATION (for use with checking, savings, and personal debit card direct deposit requests only)

Section 1

#### CREATE OR CHANGE PPL EFT ACCOUNT CLOSE EXISTING PPL EFT ACCOUNT

Check the appropriate box below based on your request.

- New Direct Deposit Set-up       Change Account Number       Cancellation Request  
 Change Account Type       Change Financial Institution

Aide

Section 2

#### PAYEE INFORMATION Aide 1 or 2 and 3-8 - most have SSN, not EIN

Disclosure of your Social Security Number (SSN) is voluntary pursuant to 42 USC 405c2C. PPL will use to file required information returns to IRS.

1 Federal Employer Identification No. (EIN)   -         ← EIN

OR

2 Social Security Number (SSN)    -   -     ← SSN

3 Payee Name  4. Telephone Number

5 Payee Address

6 City  7 State  8 Zip

Section 3

#### AUTHORIZATION FOR SET-UP, CHANGE OR CANCELLATION Aide 9-11

I authorize PPL to stop making electronic transfers to my account without advance notice. I certify that I'm authorized to contract for entity receiving deposits per this agreement, & that all information provided is accurate.

9 Signature (Required)  10 Title  Self 11 Date

I authorize PPL to process payments owed to me for services authorized by a VA DMAS Program in the Commonwealth of Virginia. Per my request, PPL will deposit my payment directly to my bank account indicated below using Automated Clearing House (ACH) transaction. I recognize that if I fail to provide complete and accurate information on this form, processing may be delayed or made impossible, or my electronic payments may be erroneously made. I certify I have read and agree to comply with PPL rules governing payments and electronic transfers. I authorize PPL to withdraw from the designated account all amounts deposited electronically in error. If the designated account is closed or has an insufficient balance to allow withdrawal, then I authorize PPL to withhold any payment owed to me by PPL until the erroneous deposited amounts are repaid. If I decide to change or revoke this authorization, I recognize that I must forward such notice to PPL.

Section 4

#### ACCOUNT DETAIL INFORMATION Must fill out 12-19

12 Financial Institution Name (My Bank's Name)

13 Bank Address

14 Bank Routing Number  -          15 Account Type  Checking  Savings  Your Debit Card

16 My Account Number

17 Bank City  18 Bank State  19 Bank Zip

Section 5

CANCELLATION  
Cancellation Reason

PPL Use ONLY  
Staff Entry: \_\_\_\_\_  
Date: \_\_\_\_\_

I do not have access to the PPL Web Portal, please send a Pay Stub.



# IF aide would like Debit Card vs. Direct Deposit, fill out this form

## Sections 1-3.

MAIL TO: VA DMAS Programs, Public Partnerships, LLC, 4991 Lake Brook Drive, Suite G90, Glen Allen, VA 23060

<p><b>Public Partnerships, LLC - Virginia DMAS Programs</b></p> <h2 style="margin: 0;">PPL DEBIT CARD APPLICATION</h2> <p><b>(for use with the PPL Debit Card requests only)</b></p>	<p>FORM - PPL DEBIT CARD</p> 
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Section 1

**MONEY NETWORK® SERVICE** - I select to use either of the following options:

**Check Box to Begin Using the PPL Debit Card**

**Money Network® Check.** The Money Network Check ("Check") is a paycheck that I can easily complete on or after each payday morning wherever I am, eliminating the need to wait for my paycheck to be mailed, or pay for it to be cashed. The Check can be deposited into my personal bank account or cashed free at Money Network check-cashing partners. There is no fee for using Money Network Checks.

**PPL Debit Card (Money Network® Payroll Debit Card).** The Money Network Payroll Debit Card ("Card") provides a dependable, safe, optional, and convenient way to receive and access my pay on and after each payday morning with the following features: 1.) Eliminates the need to wait for my paycheck to be mailed, or pay for it to be cashed; 2.) Immediate, worldwide access wherever the logos displayed on your Card are accepted for ATM cash withdrawals, bank-branch withdrawals, and store purchases (including "cash back"); 3.) Money transfers to a personal or joint checking account; and 4.) free balance inquiries by phone. I am automatically eligible for the Card and there is no application or approval process. There is no monthly service charge for the Card as long as I am employed by Employer. Many Card transactions are free, but there are fees for other transactions, and Money Network Checks can be used to access funds free of charge. All of the transaction fees are listed in the Welcome Packet.

Section 2

**PAYEE INFORMATION**  
Disclosure of your Social Security Number (SSN) is voluntary pursuant to 42 USC 405c2C. PPL will use to file required information returns to IRS.

**Social Security Number (SSN)**         -   -          ← SSN

**Payee Name** **Telephone Number**

**Payee Address ( Must be Physical Address - where you live - No P.O. Box accepted)**

**City** **State** **Zip**

Section 3

**AUTHORIZATION FOR SET-UP. CHANGE OR CANCELLATION**

I authorize PPL to stop making electronic transfers to my account without advance notice. I certify that I'm authorized to contract for entity receiving deposits per this agreement, & that all information provided is accurate.

**Signature (Required)** **Title** **Date**

I authorize PPL to process payments owed to me for services authorized by a VA DMAS Program in the Commonwealth of Virginia. Per my request, PPL will deposit my payment directly to my PPL Debit Card using Automated Clearing House (ACH) transaction. I recognize that if I fail to provide complete and accurate information on this form, processing may be delayed or made impossible, or my electronic payments may be erroneously made. I certify I have read and agree to comply with PPL rules governing payments and electronic transfers. I authorize PPL to withdraw from the designated account all amounts deposited electronically in error. If the designated account is closed or has an insufficient balance to allow withdrawal, then I authorize PPL to withhold any payment owed to me by PPL until the erroneous deposited amounts are repaid. If I decide to change or revoke this authorization, I recognize that I must forward such notice to PPL.

Section 4

**CANCELLATION**

**Cancellation Reason**

**I do not have access to the PPL Web Portal, please send a Pay Stub.**

**PPL Use ONLY**

Staff Entry:

Date: