SAMPLE

CONS #

VDC Veteran & ADNA Agreement

This agreement made this __DAY__ day of _____MONTH_____, 20__, by and between _____VETERAN_____ (Veteran), and _____ADNA_____ (ADNA) provides as follows:

- Veteran has been determined to be eligible for the Veteran Directed Care (VDC) program administered by the ADNA as set forth in this Agreement.

- Veteran has voluntarily chosen to participate in the VDC Program, which provides for the Veteran to utilize Veterans Administration funds to select, train and employ support worker(s) in accordance with the terms of this Agreement.

- ADNA reserves the right to:

  - Terminate the agreement if the Veteran fails to comply with any of the requirements of this Agreement and the VDC Program guidelines;

  - Require the Veteran to change from the VDC Program to a traditional Veteran's or other home and community-based program utilizing agency employees;

  - Terminate VDC program services if the Surrogate becomes unavailable, or ADNA requires Veteran to replace the Surrogate and another Surrogate cannot be identified within 30 days of the notification for the need for such replacement;

  - Require the Veteran to obtain a Surrogate if ADNA determines that the Veteran is not able to manage the VDC independently. ADNA will terminate the VDC Program option if the Veteran does not obtain a Surrogate within 30 days from the date the Veteran was assessed and determined to need a Surrogate;

  - Require the Veteran to replace a Surrogate if the Surrogate is not performing the VDC Program tasks in accordance with this Agreement.

- During the contract period, ADNA agrees to authorize, with approval from the VA Medical Center (VAMC) VDC Coordinator, the number of hours per week for the benefit of Veteran to hire support worker(s) who shall perform home care services for the benefit of the Veteran. Any cost incurred by the Veteran for hours worked in excess of those authorized by ADNA is the sole responsibility of the Veteran. Veteran shall be solely responsible for the hiring, training, retention and firing of such support worker(s).

- ADNA obligation to authorize and provide the expenditure of funds under this Agreement is subject to the availability of funding made available to ADNA.

- As a condition for receiving The VDC program services, Veteran shall:

- fully and accurately complete and deliver to ADAN all documentation as directed by ADNA;
- complete and sign all employment forms required by ADNA;
- complete and sign any activity forms and submit them to Fiscal Intermediary (FI) in accordance with the instructions provided and the timeframe specified by ADNA;
- ensure that information submitted on any activity form and/or timesheet for each pay period correctly identifies who provided VDC program services and the correct hours and dates that the VDC program services were provided;
- hire, fire, and train support worker(s) for no more than the authorized hours and at the rates of pay as set forth in this Agreement;
- cooperate with ADNA during assessments, evaluations/re-evaluations, monthly telephone and quarterly home visits ;
- notify ADNA of date of termination of the Veteran's support worker(s) and/or any changes in worker(s);
- notify ADNA of the Veteran change of address;
- notify ADNA when there is a change in the Veteran's medical condition or living situation that may require an adjustment in the number of day/evening hours per week or type of service to be provided including hospitalization or out of home admission/placement;
- work with ADNA to resolve any issues or complaints;
- comply with all applicable state and federal labor laws, including, but not limited to, federal and state child labor laws.
- Veteran hereby acknowledges that the support workers he or she hires to perform home care services are not employees, agents, representatives and/or servants of ADNA.

- Veteran holds harmless ADNA and their agents, representatives, servants, directors, employees, attorneys, officers and anyone else claiming by or through ADNA against any and all claims, charges, promises, agreements, controversies, demands, liabilities, obligations, suits, judgments, actions, causes of action, rights, damages, costs, losses, debts, and expenses (including attorneys' fees and costs), of any nature whatsoever, in law and in equity, ("potential claim") resulting from the acts, omissions, breach, default or other conduct of the Veteran, his or her employees, agents, and others acting on his or her behalf, in connection with the performance of any work by or for the Veteran arising out of this Agreement and the Veteran hereby agrees to indemnify
- ADNA and defend and bear all cost to defend any and all such potential claims against ADNA

- ADNA agrees to provide case management services to Veteran, including monthly telephone contact, quarterly home visits, and ongoing case management for any issues that arise, provided Veteran is not in breach of this Agreement.

- This Agreement shall not be amended or modified unless such amendment or modification is in writing and signed by both parties. If any part of this Agreement shall in any form or matter deemed to be invalid, illegal or unenforceable, the remaining portions of this Agreement not so affected shall continue to operate and be of full force and effect.

Name of Veteran

Name of Veteran	Signature of Veteran	Date

Name of ADNA Care Advisor

Name of ADNA Care Advisor	Signature of ADNA Care Advisor	Date

Name of ADNA Supervisor

Name of ADNA Supervisor	Signature of ADNA Supervisor	Date

Name of Surrogate

Name of Surrogate	Signature of Surrogate	Date

Form **SS-4**
(Rev. December 2023)
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.
Go to *www.irs.gov/FormSS4* for instructions and the latest information.

OMB No. 1545-0003

EIN

Type or print clearly.

1 Legal name of entity (or individual) for whom the EIN is being requested
EMPLOYER'S NAME HCSR

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

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

4a Mailing address (room, apt., suite no. and street, or P.O. box)
PO BOX 936

5a Street address (if different) (Don't enter a P.O. box.)
EMPLOYER'S PHYSICAL ADDRESS

4b City, state, and ZIP code (if foreign, see instructions)
RANDOLPH, MA 02368

5b City, state, and ZIP code (if foreign, see instructions)
EMPLOYER'S CITY, STATE AND ZIP CODE

6 County and state where principal business is located
EMPLOYER'S STATE AND COUNTY

7a Name of responsible party
EMPLOYER'S NAME

7b SSN, ITIN, or EIN
EMPLOYER'S SSN 000-00-0000

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 t
☐ Personal service corporation
☐ Church or church-controlled orga
☐ Other nonprofit organization (specify) _____
☑ Other (specify) HCSR

SAMPLE

☐ State/local government
☐ Federal government
☐ Indian tribal governments/enterprises

☐ REMIC
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) HCSR
☐ 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

14 Reserved for future use

13 Highest number of employees expected in the next 12 months (enter -0- if none).

Agricultural	Household	Other
0	0	0

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

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

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

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

18 Has the applicant entity shown on line 1 ever applied for and received an EIN? ☐ Yes ☒ No
If "Yes," write previous EIN here UNLESS EMPLOYER HAS EIN HE/SHE MUST CHECK THIS BOX

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
INTAKE SUPERVISOR

Designee's telephone number (include area code)
877-479-7577

Address and ZIP code
600 TECHNOLOGY CENTER DRIVE, STOUGHTON, MA 02702

Designee's fax number (include area code)
617-934-1191

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

Name and title (type or print clearly) EMPLOYER'S NAME: HOUSEHOLD EMPLOYER

Applicant's telephone number (include area code)
EMPLOYER PHONE #

Signature EMPLOYER'S SIGNATURE OR SIGNATURE & SOCIAL SECURITY NUMBER OF PARENT OR LEGAL GUARDIAN, IF MINOR CHILD

Date TODAY'S DATE

Applicant's fax number (include area code)
EMPLOYER FAX #

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

Cat. No. 16055N Form **SS-4** (Rev. 12-2023)

EMPLOYER'S DATE OF BIRTH 000-000-0000 CONSUMER NUMBER 000000

Do I Need an EIN?

File Form SS-4 if the applicant entity doesn't already have an EIN but is required to show an EIN on any return, statement, or other document.[1] See also the separate instructions for each line on Form SS-4.

IF the applicant...	AND...	THEN...
started a new business	doesn't currently have (nor expect to have) employees	complete lines 1, 2, 4a–8a, 8b–c (if applicable), 9a, 9b (if applicable), 10–13, and 16–18.
hired (or will hire) employees, including household employees	doesn't already have an EIN	complete lines 1, 2, 4a–6, 7a–b, 8a, 8b–c (if applicable), 9a, 9b (if applicable), and 10–18.
opened a bank account	needs an EIN for banking purposes only	complete lines 1–5b, 7a–b, 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10, and 18.
changed type of organization	either the legal character of the organization or its ownership changed (for example, you incorporate a sole proprietorship or form a partnership)[2]	complete lines 1–18 (as applicable).
purchased a going business[3]	doesn't already have an EIN	complete lines 1–18 (as applicable).
created a trust	the trust is other than a grantor trust or an IRA trust[4]	complete lines 1–18 (as applicable).
created a pension plan as a plan administrator[5]	needs an EIN for reporting purposes	complete lines 1, 3, 4a–5b, 7a–b, 9a, 10, and 18.
is a foreign person needing an EIN to comply with IRS withholding regulations	needs an EIN to complete a Form W-8 (other than Form W-8ECI), avoid withholding on portfolio assets, or claim tax treaty benefits[6]	complete lines 1–5b, 7a–b (SSN or ITIN as applicable), 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10, and 18.
is administering an estate	needs an EIN to report estate income on Form 1041	complete lines 1–7b, 9a, 10–12, 13–17 (if applicable), and 18.
is a withholding agent for taxes on nonwage income paid to an alien (that is, individual, corporation, or partnership, etc.)	is an agent, broker, fiduciary, manager, tenant, or spouse who is required to file Form 1042, Annual Withholding Tax Return for U.S. Source Income of Foreign Persons	complete lines 1, 2, 3 (if applicable), 4a–5b, 7a–b, 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10, and 18.
is a state or local agency	serves as a tax reporting agent for public assistance recipients under Rev. Proc. 80-4, 1980-1 C.B. 581[7]	complete lines 1, 2, 4a–5b, 7a–b, 9a, 10, and 18.
is a single-member LLC (or similar single-member entity)	needs an EIN to file Form 8832, Entity Classification Election, for filing employment tax returns and excise tax returns, or for state reporting purposes[8], or is a foreign-owned U.S. disregarded entity and needs an EIN to file Form 5472, Information Return of a 25% Foreign-Owned U.S. Corporation or a Foreign Corporation Engaged in a U.S. Trade or Business	complete lines 1–18 (as applicable).
is an S corporation	needs an EIN to file Form 2553, Election by a Small Business Corporation[9]	complete lines 1–18 (as applicable).

[1] For example, a sole proprietorship or self-employed farmer who establishes a qualified retirement plan, or is required to file excise, employment, alcohol, tobacco, or firearms returns, must have an EIN. A partnership, corporation, REMIC (real estate mortgage investment conduit), nonprofit organization (church, club, etc.), or farmers' cooperative must use an EIN for any tax-related purpose even if the entity doesn't have employees.

[2] However, don't apply for a new EIN if the existing entity only (a) changed its business name, (b) elected on Form 8832 to change the way it is taxed (or is covered by the default rules), or (c) terminated its partnership status because at least 50% of the total interests in partnership capital and profits were sold or exchanged within a 12-month period. The EIN of the terminated partnership should continue to be used. See Regulations section 301.6109-1(d)(2)(iii).

[3] Don't use the EIN of the prior business unless you became the "owner" of a corporation by acquiring its stock.

[4] However, grantor trusts that don't file using Optional Method 1 and IRA trusts that are required to file Form 990-T, Exempt Organization Business Income Tax Return, must have an EIN. For more information on grantor trusts, see the Instructions for Form 1041.

[5] A plan administrator is the person or group of persons specified as the administrator by the instrument under which the plan is operated.

[6] Entities applying to be a Qualified Intermediary (QI) need a QI-EIN even if they already have an EIN. See Rev. Proc. 2000-12.

[7] See also *Household employer agent* in the instructions. **Note:** State or local agencies may need an EIN for other reasons, for example, hired employees.

[8] See *Disregarded entities* in the instructions for details on completing Form SS-4 for an LLC.

[9] An existing corporation that is electing or revoking S corporation status should use its previously assigned EIN.

Form BAR Rev. 01/24

SAMPLE

State of Rhode Island
of Taxation\Employer Tax
apitol Hill, Providence RI 02908
https://tax.ri.gov - Taxation
s://uitax.ri.gov - Employer Tax

PPLICATION and REGISTRATION

For Office Use Only

Permit #_____
Liability Date: _____

Section A: Name, Mailing Address and Tax Identification Number

Type of Entity: ○ Corporation ○ General Partnership ◉ Sole Proprietor ○ LP/LLP
○ LLC - Corporation ○ LLC - Partnership ○ LLC - Single Member

Is the Entity a: ☐ IRS Code 501 (c)(3) ☐ Non-profit Organization ☐ Religious Organization

Name (Employer, Business, Corporation, or Owner): **EMPLOYER NAME**	RI Employer Reg. # (if assigned): **RI EMPLOYER**	Business Telephone: **PHONE #**	
Business Name if different from above:	FEIN or if Sole Prop. SSN # (required): **FEIN OR SSN**	Sales Tax Permit #:(if assigned) **SALES TAX PERMIT #**	
Mailing Address - include street, apt./office #, city/town, state and zip (this should NOT be a 3rd party address): **c/o Tempus Unlimited, Inc., 600 Technology Center Drive, Stoughton, MA 02072**		State + Date of Incorporation: **RI**	
Actual **Rhode Island work location** (include street, apt/office #, city/town and zip) ***CANNOT accept a PO Box #.*** If more than 1 location, please complete Section F-2 of this form ☐ ***Check if this is an employee's home address***		Is any other license or permit required:	
Address: **RI ADDRESS IF APPLICABLE**	City/Town:	State: **RI**	Zip:
If you do not have a RI location, enter out-of-state business location address: **600 TECHNOLOGY CENTER DRIVE**	City/Town: **STOUGHTON**	State: **MA**	Zip: **02072**
Employer Email: **RIDOR@Tempusunlimited.org**	Name and Sales Permit # of former owner, if applicable.		

Section B: Contact Information for Person(s) in Charge of Record Keeping

Person in charge of ***Sales Tax Records***:
Name: Tempus Unlimited, Inc. Email: RIDOR@Tempusunlimited.org Phone: _____

Person in charge of ***Payroll Records***:
Name: Tempus Unlimited, Inc. Email: RIDOR@Tempusunlimited.org Phone: _____

Person in charge of ***Unemployment Records***:
Name: Tempus Unlimited, Inc. Email: RIDOR@Tempusunlimited.org Phone: _____

Section C: Name, Social Security Number, Home Address, and Title of *Owner*, each *Partner*, or *each Corporate Officer*

Name: _____ Title: Owner
Address: _____
SSN: _____ Phone: _____ Email: _____

Name: _____ Title: _____
Address: _____
SSN: _____ Phone: _____ Email: _____

Name: _____ Title: _____
Address: _____
SSN: _____ Phone: _____ Email: _____

Section D: Account Information

Sales permit is renewable at fiscal year ending June 30th

			If yes, in addition to Sections A,B,C and D, complete sections listed below:
Do you have employees **working** in RI?	☐ Yes	☐ No	E F G and Taxpayer Status Affidavit
If yes, are they hired to work ONLY in RI?	☐ Yes	☐ No	E F G and Taxpayer Status Affidavit
Do you have RI Withholding?	☐ Yes	☐ No	E F G and Taxpayer Status Affidavi
Do you lease employees in RI?	☐ Yes	☐ No	E F G and Taxpayer Status Affidavit
Are you an Employee Leasing Organization?	☐ Yes	☐ No	E F G and Taxpayer Status Affidavit
Do you make sales at retail?	☐ Yes	☐ No	F G and Taxpayer Status Affidavit
Do you have multiple locations?	☐ Yes	☐ No	F G and Taxpayer Status Affidavit
If yes, would you like to consolidate returns?	☐ Yes	☐ No	If yes, enter the number of locations below next to the item(s) you will be selling and complete Section F-2. Each location requires a separate permit.

Will you be selling:

			# of Locations	Provide any required, additional info listed below
Beverages or Food	☐ Yes	☐ No	_____	
Gasoline	☐ Yes	☐ No	_____	Filing station license # _____(Required)
Liquor	☐ Yes	☐ No	_____	
Motor Vehicles	☐ Yes	☐ No	_____	If yes, MV Dealer license #_____(Required)
Motor Vehicles leasing	☐ Yes	☐ No	_____	If yes, MV Dealer license #_____(Required)
Prepaid wireless phone cards	☐ Yes	☐ No	_____	
Rental of room(s)/home(s)	☐ Yes	☐ No	_____	Type of Rental: ☐ Residential Dwelling ☐Room Rental
Other	☐ Yes	☐ No	_____	Product: _____
Cigarettes/Tobacco/Other Tobacco*	☐ Yes	☐ No	_____	* A $25.00 fee is due for each location, as well as each cigarette vending machine. Each location and cigarette vending machine requires a separate license and fee.

# of locations selling cigarettes + # of cigarette vending machines x $25 = Total Cigarette Fee Due and Enclosed
_____+_____ x $25 = $0.00

			# of Locations
Are you an Artist, Writer or Composer?	☐ Yes	☐ No	_____
Are you a Class A Package and Liquor Store?	☐ Yes	☐ No	_____
Are you an Eating or Drinking Establishment?	☐ Yes	☐ No	_____
Are you a Convenience Store, Mini-Market or Supermarket that provides chairs, tables, or counter(s) in an area of your store where prepared food and/or beverages may be consumed?	☐ Yes	☐ No	_____

Date business will commence in this state? _____ If Seasonal operation, enter months open: _____

Is this application for a temporary event? ☐ Yes ☐ No If yes, date(s) of temporary event? _____

Section E: Payroll Information

Your Unemployment Account will be set up within 90 days of your liability date, or actual first date of wages paid.

Amount of RI withholding taxes you expect to withhold from employees each month:		Payment Frequency will be
$600 or more	☐	Weekly
$50 or more but less than $600	☐	Monthly
Less than $50	☐	Quarterly

Number of employees working in RI: _____

Actual first date of wages paid in RI: _____

Note: Form RI-941, used to report RI withholding, is filed quarterly regardless of the amount of RI withholding per month or payment frequency.

If any part of the business or its assets were acquired, please enter the date of acquisition, name, address and, if known, the RI Employment Registration number of the former owner.

Date of Acquisition:	RI Employer Registration #:	FEIN #:
Name of former owner:		
Acquired Business Name:		
Address, City/Town, State and Zip:		
Number of Employees acquired from that business, if any:		

If you are a sole owner or partnership that is incorporating, state the name and address of the former business:

Date of Ownership Change:	RI Employer Registration #:	FEIN #:
Business Name:	Business Address:	

Section F: Industry Description

F-1: Completion of this section is mandatory under Section 28-42-38.1(b) of the RI Employment Security Law, Chapters 42-44. Detailed information about your business is essential so that we may accurately assign the correct North America Industrial Classification Code (NAICS code) to your company. In the space provided, describe your key business activities, products, or services, at this location (provide percentage breakout if necessary). If your business is based out of state but has an employee(s) working from home in Rhode Island, please describe the nature of the work that the employee(s) performs in RI. **Failure to comply with an accurate description may result in the delayed allocation of an UI account number.** For inquiries on the business description only, call (401) 462-8760.

Business description (Required): *Example 1.) We are an auto body shop and we also sell used cars. We expect 70% of our revenue to come from auto body and 30% from car sales. 2.) A national bank located in Chicago employing call center help working from home.*

Household employer

F-2: Establishment Locations:

If you operate your business at more than one location in Rhode Island, please list the street address, city and zip code for each RI location and the approximate employment for each location. If the business activities of any establishment differ from the above, please tell us the main business activity of the differing location. In addition, please check the box of each tax type in the columns below that applies to each location.

RI Location Address Street Address, City/Town, Zip Code	# of Employees	Activity	Beverages or Food	Cigarette/ Tobacco/ Other Tobacco	Prepaid Wireless Phone Cards	Rental of Room(s)/ Home(s)	Sales Tax
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐

F-3 NAICS Code *Required*: Click the link below to assign the NAICS code that best fits your business activity in Rhode Island. Enter key words or phrases from the business description above within the '2022 NAICS Search' box.

https://www.census.gov/naics/ NAICS Code: 624120 (6 digits required)

For inquiries on the NAICS code, call the Division of Taxation's Registration Section at (401) 574-8938.

Section G: Certification and Signature (must be signed)

The undersigned certifies that the information given on this form is true and correct to the best of their knowledge and belief.

Signature: _____ Date: _____

Print Name: _____ Title: _____

Telephone: _____ Email: _____

BUSINESS APPLICATION and REGISTRATION

State of Rhode Island
Division of Taxation
One Capitol Hill
Providence, RI 02908

Taxpayer Status Affidavit / Identity Verification

All persons applying or renewing any license, registration, permit or other authority (herein after called "licensee") to conduct a business or occupation in the state of Rhode Island are required to file all applicable tax returns and pay all taxes owed to the state prior to receiving a license as mandated by state law (R.I. Gen. Laws § 5-76) except as noted below.

In order to verify that the state is not owed taxes, licensees are required to provide their Social Security Number, or Federal Tax Identification Number as appropriate. These numbers will be checked by the Division of Taxation to verify tax status prior to the issuance of a license. This declaration must be made prior to the issuance of a license.

Licensee Declaration

I hereby declare, under penalty of perjury;

- ☐ I have filed all required state tax returns and have paid all taxes owed.
- ☐ I have entered a written installment agreement to pay delinquent taxes that is satisfactory to the Tax Administrator.
- ☐ I am currently pursuing administrative review of taxes owed to the state.
- ☐ I am in federal bankruptcy. (Case # _____)
- ☐ I am in state receivership. (Case # _____)
- ☐ I have been discharged from Bankruptcy. (Case # _____)

Type of Permit(s)/License(s) for which you are applying

Name: _____ Social Security Number: _____

Signature: _____ Phone:_____

Date: _____

This completed Status Affidavit must be submitted with a Business Application Registration (Form BAR) or any other License/Permit application filed with the Division of Taxation.

Form **8821**

(Rev. January 2021)

Department of the Treasury
Internal Revenue Service

Tax Information Authorization

▶ Go to *www.irs.gov/Form8821* for instructions and the latest information.
▶ Don't sign this form unless all applicable lines have been completed.
▶ Don't use Form 8821 to request copies of your tax returns or to authorize someone to represent you. See instructions.

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 6.

Taxpayer name and address	Taxpayer identification number(s)	
Employer Name **Employer Address**	**TAX ID NUMBER**	
	Daytime telephone number	Plan number (if applicable)

2 Designee(s). If you wish to name more than two designees, attach a list to this form. **Check here if a list of additional designees is attached ▶** ☐

Name and address	
TEMPUS UNLIMITED, INC. **600 TECHNOLOGY CENTER DRIVE** **STOUGHTON, MA. 02072**	CAF No. **0312-75867R** PTIN Telephone No. **877-479-7577** Fax No. **617-934-1191**
Check if to be sent copies of notices and communications ☑	Check if new: Address ☐ Telephone No. ☐ Fax No. ☐
Name and address	CAF No. **0312-75867R** PTIN Telephone No. **877-479-7577** Fax No. **617-934-1191**
Check if to be sent copies of notices and communications ☐	Check if new: Address ☐ Telephone No. ☐ Fax No. ☐

3 Tax information. Each designee 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.

☑ By checking here, I authorize access to my IRS records via an Intermediate Service Provider.

(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 TAX WITHHOLDING AND EMPLOYMENT TAX	**940,940R,940EZ,941,941R,941X,941 (C), 843, W-2,W-2(C), W-3,W-3 (C),SS-4.**	**QUARTERS 1,2,3,4 2024 - 2026**	**TAX LIABILITY**
	147-C		**VERIFICATION LETTER**

4 Specific use not recorded on the 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 line 5 . . . . . ▶ ☑

Authorization for SS-4 and 147C

5 Retention/revocation of pr ed, skip this line. If the line 4 box isn't checked, the IRS will a file unless you check the line 5 box and **attach a copy** of th . . . . . ▶ ☐
To revoke a prior tax informa e the line 5 instructions.

SAMPLE

6 Taxpayer signature. If signed by a corporate officer, partner, guardian, partnership representative (or designated individual, if applicable), executor, receiver, administrator, trustee, or individual other than the taxpayer, I certify that I have the legal authority to execute this form with respect to the tax matters and tax periods shown on line 3 above.

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

▶ DON'T SIGN THIS FORM IF IT IS BLANK OR INCOMPLETE.

EMPLOYER OR LEGAL GUARDIAN SIGNATURE	**DATE**
Signature	Date
PRINT EMPLOYER OR LEGAL GUARDIAN NAME	**HCSR**
Print Name	Title (if applicable)

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

SAMPLE

Consumer #

(Rev. December 2024) Department of the Treasury — Internal Revenue Service

OMB No. 1545-0029

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're 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 isn't effective until we approve your request. See the instructions for more information.

- If you're 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're 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)

EMPLOYER NAME

3 Trade name (if any)

4 Address

EMPLOYER NUMBER, STEET, SUITE

Number Street Suite or room number

EMPLOYER CITY | STATE | ZIP CODE

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, Employer's Annual Federal Unemployment (FUTA) Tax Return* (all 940 series)	✔	☐
Form 941, Employer's QUARTERLY Federal Tax Return (all 941 series)	✔	☐
Form 943, Employer's Annual Federal Tax Return for Agricultural Employees (all 943 series)	☐	☐
Form 944, Employer's ANNUAL Federal Tax Return (all 944 series)	☐	☐
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 can't appoint an agent to report, deposit, and pay tax reported on Form 940, unless you're a home care service recipient.

☐ Check here if you're 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 EMPLOYER OR LEGAL GUARDIAN SIGNATURE

Print your name here EMPLOYER NAME

Print your title here HCSR

Date DATE

Best daytime phone EMPLOYER PH#

Now give this form to the agent to complete.

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

6 Agent's employer identification number (EIN) 0 4 – 3 7 7 0 1 7 8

7 Agent's name (not trade name) Tempus Unlimited, Inc.

8 Trade name (if any)

9 Address 600 Technology Center Drive

Number Street Suite or room number

Stoughton MA 02072

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, they are true, correct, and complete.

Sign your name here INTAKE COORDINATOR SIGNATURE

Print your name here INTAKE COORDINATOR NAME

Print your title here Intake Coordinator

Date DATE

Best daytime phone 1-877-479-7577

State of Rhode Island Division of Taxation

Form RI-2848

Power of Attorney

14103999990101

Taxpayer name		Social security or federal identification number
EMPLOYER NAME		000-00-0000
Address	City, town or post office	State ZIP code
EMPLOYER ADDRESS	CITY	STATE ZIP CODE
Taxpayer name		Social security or federal identification number
Address	City, town or post office	State ZIP code

hereby appoints:

Power of Attorney name		Telephone number
DAVID GOLDBERG		(781) 297-5400
Address	City, town or post office	State ZIP code
600 TECHNOLOGY CENTER DRIVE	STOUGHTON	MA 02072
Power of Attorney name		Telephone number
Address	City, town or post office	State ZIP code

as attorney(s)-in-fact to represent the taxpayer(s) before the office of the State of Rhode Island, Division of Taxation, for the following state matters (specify the type(s) of tax and year(s) or period(s) (date of death if this is for estate tax)):

TAX TYPE: INCOME TAX WITHHOLDING FILING PERIODS: ALL

The attorney (s)-in-fact (or either of them) are authorized, subject to revocation, to receive confidential information and to perform on behalf of the taxpayer (s) the following acts for the above tax matters:

Check off any of the following which are NOT granted.

- [x] **To receive, but not to endorse and collect, checks i**
- [x] **To execute waivers (including offers of waivers) of r ers of notice of disallowance of a claim for credit or refund.**
- [x] **To execute consents extending the statutory period agreements.**
- [x] **To represent taxpayer (s) at preliminary reviews and administrative hearings. (must be an attorney, person authorized by law to practice accountancy, or partner or corporate officer of taxpayer as provided by the Administrative Hearing Procedures.)**
- [ ] **Other acts (specify) _____**

SAMPLE

Notices and other written communications in proceedings involving the above matters shall be sent to the above named attorney (s) so long as this power of attorney remains in effect.

Copies to be sent to the taxpayer (s).

This power of attorney revokes all earlier powers of attorney and tax information authorizations on file with the Division of Taxation office for the same matters and years or periods covered by this form, except the following (Specify to whom granted, date granted, and address including ZIP code; or refer to attached copies of earlier powers and authorizations):

If signed by corporate officer, partner, or fiduciary on behalf of the taxpayer,
I certify that I have authority to execute this power of attorney on behalf of the taxpayer.

Taxpayer signature	Print name	Title (if applicable)	Date
EMPLOYER SIGNATURE	PRINT EMPLOYER NAME	EMPLOYER	DATE
Taxpayer signature	Print name	Title (if applicable)	Date
		EMPLOYER	

Mailing address: RI Division of Taxation, One Capitol Hill, Providence, RI 02908-5806

Revised
02/2021

State of Rhode Island Division of Taxation

Form RI-2848

Power of Attorney

14103999990102

This declaration must be completed by the attorney, certified public accountant, licensed public accountant, or enrolled agent.

I declare that I am not currently under suspension or disbarment from practice before the Division of Taxation and that:

- [ ] **I am a member in good standing of the bar of the highest court of the jurisdiction indicated below; or**
- [x] **I am duly qualified to practice as a certified public accountant in the jurisdiction indicated below; or**
- [ ] **I am a licensed public accountant in the jurisdiction indicated below.**
- [ ] **I am actively enrolled to practice before the Internal Revenue Service.**

Designation (Attorney, CPA, LPA or enrolled agent)	Jurisdiction (State, etc)	Signature	Date
DAVID GOLDBERG	MA		

If the power of attorney is granted to a person other than an attorney, certified public accountant, or licensed public accountant, or enrolled agent, it must be witnessed or notarized below.

The person (s) signing as or for the taxpayer (s): (Check and complete ONE.)

- [ ] **is/are known to and signed in the presence of the two disinterested witnesses whose signatures appear here:**

Signature of witness **Date**

Signature of witness **Date**

- [ ] **appeared this day before a notary public and acknowledged this power of attorney as a voluntary act and deed**

Signature of notary **Date**

NOTARIAL SEAL

SAMPLE

RHODE ISLAND VDC PROGRAM

VETERAN DIRECTED CARE PROGRAM
FRAUD & ABUSE STATEMENT

ADNA NAME
Name of ADNA

Fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. In other words, 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 a direct care worker'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 Aging and Disability Network Provider (ADNA) to bill the VA for services that were not provided;
- Knowingly and/or purposefully using the Veteran's 365-day global case mix budget authorization funds for any other purpose than what has been approved in the Veteran's Service Plan.
- Knowingly and/or purposefully allowing a direct care worker to document services or hours that were not provided.
- Knowingly and/or purposefully submitting invoices to the Vendor Fiscal Employer Agent (VF/EA) Financial Management Services (FMS) entity and/or ADNA for individual-directed goods and services that were not provided.
- Knowingly and/or purposefully having the VF/EA FMS entity pay a direct care worker or individual-directed goods and services vendor for goods and/or services actually provided by someone else. (This is also tax fraud).
- Knowingly and/or purposefully making a "side deal" with a direct care worker to split their pay check with the Veteran or his/her representative. (This is also tax fraud).
- Knowingly or purposefully withholding information from authorities during an investigation.
- Knowingly and/or purposely having the VF/EA FMS entity pay for an approved individual-directed good included in the participant's Veteran's Spending Plan,

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 VDC 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 VDC program.

Examples of Abuse include:

- Making errors when filling out the direct care worker's timesheet and not immediately reporting the error to the VF/EA FMS entity to remedy the situation.
- Documenting the tasks performed by the direct care worker while in the Veteran's home inaccurately in any *Biweekly Progress Notes* and not immediately reporting the error to the VF/EA FMS entity and the Veteran's Options Counselor to remedy the situation.
- Being late in handing in Veteran/representative-employer-related paperwork to the VF/EA FMS entity or the Veteran's Options Counselor.

Fraud and Abuse is both a state and federal offense. All reports or allegations of fraud and abuse within the VDC Program will be referred to the Veterans Health Administration for possible criminal investigation. Veterans or Authorized Representatives suspected of Fraud or Abuse also face termination from the VDC Program.

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

Signatures

VETERAN SIGNATURE DATE

Veteran *Date*

AUTHORIZED REP SIGNATURE (WHEN APPLICABLE) DATE

Authorized Representative (when applicable) *Date*

OPTIONS COUNSELOR SIGNATURE DATE

Options Counselor *Date*

SAMPLE

TEMPUS UNLIMITED, INC.
Opportunities for Independence

Consent to the Use and Disclosure of Protected Health Information

I hereby give my consent for Tempus Unlimited, Inc. to use and disclose protected health information (PHI) on my behalf to enable billing and reimbursement for services provided by the Tempus Unlimited Fiscal Intermediary program. I understand that Tempus Unlimited, Inc. staff may have access to the following types of PHI and may use this information to either approve or deny timesheets and/or to submit billing for reimbursement or for other program billing and reimbursement. Types of PHI that we may share could be an ID, other payer Insurance IDs, admit and discharge paperwork for inpatient stays, and information of your stay at a long-term care facility. We only use this information to provide documentation to Veteran Affairs and other payers for reimbursement for FI services. We also use this information to ensure that timesheets are not submitted fraudulently and that we are billing Veteran Affairs for actual work done by worker that you have authorized. We also use this information for staff training and for conducting quality assurance (monitoring the need, appropriateness, and quality of services provided).

I have been given a Notice of Privacy Practices that fully explains the uses and disclosures that Tempus, Inc. will make with my protected health information (PHI). I understand and have been given the right to review the *Notice of Privacy Practices* before signing this consent. Tempus Unlimited, Inc. has given sufficient time for me to review the *Notice of Privacy Practices* and has answered any questions I may have had to my satisfaction.

I understand that I do not have to consent to the use or disclosure of my protected health information for payment, and health care operations, but that if I do not consent, Tempus Unlimited, Inc. may refuse to provide me Fiscal Intermediary services unless applicable state or federal law requires Tempus Unlimited, Inc. to provide such services. If Tempus Unlimited Inc. does agree to my requested restrictions, it is bound by this agreement.

The following person(s) have my consent regarding my protected health information. **You have my permission** to release information to them or **I am adding the access** of the following persons:

Name Name of Person Relationship Relationship

Name Name of Person Relationship Relationship

I understand that I have the right to object to the use and/or disclosure of my protected health information to family members. **You do not have my permission** to release information to them or **I am revoking the access** of the following persons:

Name Name of Person Relationship Relationship

Name Name of Person Relationship Relationship

Password: I would like to have a password added to my account. Information will not be disclosed over the phone unless the following password is used:

Password Your password (if applicable) Effective Date: Effective Date

Permission to leave detailed voicemails on my home or cell phone voicemail:

◯ Yes, you have my permission ◯ No, you do not have my permission

I understand that I may revoke this consent in writing but that the revocation will not be effective to the extent that Tempus Unlimited, Inc. has already taken action based on my earlier consent. **This consent will be in effect, if not revoked, until one month after the termination date of your Program**.

Signature	Printed Name	Date
Signature of Veteran/Surrogate Legal or Personal Representative	**Printed Name**	**Date**

Consentimiento para el Uso y la Divulgación de Información Protegida de Salud

Por este medio le doy mi consentimiento a Tempus Unlimited, Inc. para utilizar y divulgar información protegida de salud (PHI) sobre mí para llevar a cabo fracturaciones y reembolso de los servicios proporcionados por el programa de Intermediario Fiscal de Tempus Unlimited, Inc. Entiendo que Tempus Unlimited, Inc. y sus empleados pueden utilizar esta información para aprobar o negar hojas de tiempo y/o someter fracturaciones para reembolso para la facturación y reembolso de otros programas. Tipos de PHI que podemos compartir podrían ser su número de identificación de Veteran Affairs, otras identificaciones del seguro del pagador, documentación de admisión y alta para estadías de pacientes hospitalizados e información de su estadía en un centro de atención a largo plazo. Sólo utilizamos esta información para proporcionar documentación a Veteran Affairs y a otros pagadores para el reembolso de los servicios del intermediario fiscal (FI por sus siglas en inglés). También utilizamos esta información para asegurarnos de que las hojas de tiempo trabajados no se envíen de manera fraudulenta y que estemos facturando a o el trabajador a quien usted haya autorizado. También utilizamos esta información para la capacitación del personal y para realizar controles de calidad (monitoreando la necesidad, idoneidad y calidad de los servicios prestados).

Me han dado un Aviso de prácticas de privacidad que explica plenamente los usos y las divulgaciones que Tempus Unlimited, Inc. hará con mi información de salud. Entiendo y se me ha dado el derecho de revisar el *Aviso de Prácticas de Privacidad* antes de firmar este consentimiento. Tempus Unlimited, Inc. ha dado suficiente tiempo para poder revisar el *Aviso de Prácticas de Privacidad* y ha contestado cualquier pregunta la cual pude haber tenido a mi satisfacción.

Entiendo que no tengo que dar el consentimiento al uso o divulgación de mi información de salud para pago y operaciones de atención médica, pero si no consiento, Tempus Unlimited, Inc. tiene el derecho de denegar proveerme servicios de cuidado de salud a menos que la ley aplicable del estado o federal le requiera a Tempus Unlimited, Inc. facilitar esos servicios. Si Tempus Unlimited, Inc. está de acuerdo con mis restricciones pedidas, es obligado por el presente acuerdo.

La(s) siguiente(s) persona(s) tiene(n) mi consentimiento con respecto a mi información de salud. **Usted tiene mi permiso** para divulgarles información o **le estoy añadiendo acceso** a la(s) siguiente(s) persona(s):

Nombre Nombre Relación Relación

Nombre Nombre Relación Relación

Entiendo que tengo el derecho a objetar al uso y/o divulgación de mi información de salud a familiares. **Usted no tiene mi permiso** para divulgarles información a ellos o **le estoy revocando el acceso** de las siguientes personas:

Nombre Nombre Relación Relación

Nombre Nombre Relación Relación

Contraseña: Me gustaría añadirle una contraseña a mi cuenta. Información no será discutida por teléfono a menos que la siguiente contraseña sea usada:

Contraseña: Contraseña Fecha de vigencia: Fecha de vigencia

Permiso para dejar mensajes de voz detallados en mi grabadora de mensajes en mi hogar o teléfono celular:

◯ Si, usted tiene mi permiso ◯ No, usted no tiene mi permiso

Entiendo que puedo revocar este consentimiento por escrito pero que la revocación no estará en efecto hasta el punto que Tempus Unlimited, Inc. ya haya tomado acción basada en mi consentimiento anterior. **Este consentimiento estará en efecto, de no ser revocado, hasta un mes luego de la fecha de terminación de su programa.**

Firma del Consumidor/DelegadoRepresentante Legal o Personal	Nombre Impreso	Fecha
Firma del Veteran/Delegado Representante Legal o Personal	**Nombre impreso**	**Fecha**