

VDC Veteran & ADNA Agreement

This agreement made this _____ day of _____, 20__ , by and between _____ (Veteran), and _____ (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	Signature of Veteran	Date
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Name of ADNA Care Advisor	Signature of ADNA Care Advisor	Date
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Name of ADNA Supervisor	Signature of ADNA Supervisor	Date
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Name of Surrogate	Signature of Surrogate	Date
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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.

EIN _____

Type or print clearly.	1 Legal name of entity (or individual) for whom the EIN is being requested	
	2 Trade name of business (if different from name on line 1)	3 Executor, administrator, trustee, "care of" name
	4a Mailing address (room, apt., suite no. and street, or P.O. box)	5a Street address (if different) (Don't enter a P.O. box.)
	4b City, state, and ZIP code (if foreign, see instructions)	5b City, state, and ZIP code (if foreign, see instructions)
	6 County and state where principal business is located	
	7a Name of responsible party	7b SSN, ITIN, or EIN

8a Is this application for a limited liability company (LLC) (or a foreign equivalent)? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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

<input type="checkbox"/> Sole proprietor (SSN) _____	<input type="checkbox"/> Estate (SSN of decedent) _____
<input type="checkbox"/> Partnership	<input type="checkbox"/> Plan administrator (TIN) _____
<input type="checkbox"/> Corporation (enter form number to be filed) _____	<input type="checkbox"/> Trust (TIN of grantor) _____
<input type="checkbox"/> Personal service corporation	<input type="checkbox"/> Military/National Guard <input type="checkbox"/> State/local government
<input type="checkbox"/> Church or church-controlled organization	<input type="checkbox"/> Farmers' cooperative <input type="checkbox"/> Federal government
<input type="checkbox"/> Other nonprofit organization (specify) _____	<input type="checkbox"/> REMIC <input type="checkbox"/> Indian tribal governments/enterprises
<input type="checkbox"/> Other (specify) _____	Group Exemption Number (GEN) if any _____

9b If a corporation, name the state or foreign country (if applicable) where incorporated	State	Foreign country
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10 Reason for applying (check only one box)

<input type="checkbox"/> Started new business (specify type) _____	<input type="checkbox"/> Banking purpose (specify purpose) _____
<input type="checkbox"/> Hired employees (Check the box and see line 13.)	<input type="checkbox"/> Changed type of organization (specify new type) _____
<input type="checkbox"/> Compliance with IRS withholding regulations	<input type="checkbox"/> Purchased going business
<input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Created a trust (specify type) _____
	<input type="checkbox"/> Created a pension plan (specify type) _____

11 Date business started or acquired (month, day, year). See instructions.	12 Closing month of accounting year
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13 Highest number of employees expected in the next 12 months (enter -0- if none). If no employees expected, skip line 14.	14 If you expect your employment tax liability to be \$1,000 or less in a full calendar year and want to file Form 944 annually instead of Forms 941 quarterly, check here. (Your employment tax liability will generally be \$1,000 or less if you expect to pay \$5,000 or less, \$6,536 or less if you're in a U.S. territory, in total wages.) If you don't check this box, you must file Form 941 for every quarter <input type="checkbox"/>			
<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%; border-right: 1px solid black; text-align:center;">Agricultural</td> <td style="width:33%; border-right: 1px solid black; text-align:center;">Household</td> <td style="width:33%; text-align:center;">Other</td> </tr> </table>	Agricultural	Household	Other	
Agricultural	Household	Other		

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.

<input type="checkbox"/> Construction	<input type="checkbox"/> Rental & leasing	<input type="checkbox"/> Transportation & warehousing	<input type="checkbox"/> Accommodation & food service	<input type="checkbox"/> Wholesale—agent/broker	<input type="checkbox"/> Wholesale—other	<input type="checkbox"/> Retail
<input type="checkbox"/> Real estate	<input type="checkbox"/> Manufacturing	<input type="checkbox"/> Finance & insurance	<input type="checkbox"/> Other (specify) _____			

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

18 Has the applicant entity shown on line 1 ever applied for and received an EIN? Yes No
 If "Yes," write previous EIN here _____

Third Party Designee	Complete this section only if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.	
	Designee's name	Designee's telephone number (include area code)
	Address and ZIP code	Designee's fax number (include area code)

Under penalties of perjury, I declare that I have examined this application, and to the best of my knowledge and belief, it is true, correct, and complete.	Applicant's telephone number (include area code)
Name and title (type or print clearly)	Applicant's fax number (include area code)
Signature _____	Date _____



Form TA-1 Application for Original Registration

Massachusetts
Department of
Revenue

Check As Many As Apply

- 1. A 1. Employer under the Income Tax Withholding Law (payroll tax)
- 2. Withholding for Pension Plans, Annuities and Retirement Distributions
- B 1. Sales/Use Tax on Goods Vendor
- 2. Sales/Use Tax on Telecommunications Services Vendor
- 3. Meals Tax on Food and All Beverages
- 4. Purchasing in MA for Out-of-State Resale Only
- C Room Occupancy Excise
- D Governmental or Charitable Exempt Purchaser
- E Chapter 180 Organization Selling Alcoholic Beverages
- F Use Tax Purchaser
- G Boston Sightseeing Tour Surcharge
- H Boston Vehicular Rental Transaction Surcharge
- I Parking Facilities Surcharge in Boston, Springfield and/or Worcester
- J Cigar and Smoking Tobacco Excise

Note: If you are selling cigarettes at retail, see instructions.

2. Federal Identification number

3. Social Security number

4. No. of locations

Principal Place of Business

5. Owner, partnership or legal corporate name

Name (cont'd.)

6. Number and street

7. City or town

8. State

9. Zip

10. (Area code) Telephone number

General Information. If a corporation, trust, association, fiduciary, or partnership — you must complete Schedule TA-3.

11. Indicate type of organization:
 Corporation Trust or association Sole proprietor Fiduciary Partnership Other (specify): _____

12. Indicate type of business:
 Retail trade Wholesale trade Manufacturing Construction Governmental Finance Real estate Service
 Other (specify): _____

13. Describe nature of business: _____

14. Business activity code 15. Check applicable box: Profit Non-profit

16. If subsidiary corporation

Name of parent corporation	Federal Identification number
▶ <input type="text"/>	<input type="text"/>
Name of owner	Social Security number
▶ <input type="text"/>	<input type="text"/>

17. If sole proprietor (sole owner)

18. Reason for applying:
 Started new business Purchased existing business — enter name, address, and Federal Identification number of previous owner

Federal Identification number

Organizational change — Federal Identification number and close date of previous organization **must** be entered, or application will be returned. Other (attach explanation)

Federal Identification number

Close date: Mo Day Yr

Background Information

19. Are any Massachusetts tax returns due or any Massachusetts taxes owed by your firm? Yes No. If yes, please explain: _____

20. Have you ever been issued a Certificate of Registration that was later revoked? Yes No. If yes, please explain: _____

Exempt Organizations

21. If you are applying for exempt purchaser status, be sure to include a copy of your IRS letter of exemption under Section 501(c)(3) of the Internal Revenue Code. Subordinate organizations covered under an IRS group exemption letter should include a copy of the group exemption ruling **and** a copy of the organization's directory page listing the organization as an approved subordinate. Both of the questions below must be answered.

A. Are you exempt from paying U.S. income taxes? Yes No. B. Are you exempt from paying local property taxes? Yes No.

Location of business

Federal Identification number

22. Trade name
Trade name (cont'd.)

23. Number and street (PO box is not acceptable)

24. City or town

25. State 26. Zip

27. (Area code) Telephone number

- 28. Send certificate to: Principal place of business Location of business.
29. Send tax forms to: Principal place of business Location of business Other.
If "Other," complete Schedule TA-4.

Convention Center Financing District

- 30. Check here if your business location is within a Convention Center Financing District:
31. Check here if your business location is within a hotel, motel or other lodging establishment in Boston or Cambridge:

Filing Frequencies

Table with columns for months (Jan-Dec) and tax brackets (\$0-\$100, \$101-\$1,200, \$1,201-\$25,000, over \$25,000). Rows include Withholding, Sales/Use on Goods, Sales/Use on Telecom. Services, Meals, Room Occupancy, and Use Tax Purchaser.

Tax Type Information

Withholding

34. Date you were first required to withhold taxes at this location.

35. Number of employees in Massachusetts:

APPROX # OF EMPLOYEES TO BE PAID EACH PAYROLL

Sales/Use Tax on Goods

APPROX DATE OF FIRST PAYROLL

36. Date you were first required to collect sales/use tax at this location.

Sales/Use Tax on Telecommunications Services

37. Date you were first required to collect sales/use tax on telecommunications services at this location.

Meals Tax on Food and All Beverages

- 38. Check if you serve: Food Beer Wine Alc. bev.
39. Check if food/beverage vending machine:

40. Date you were first required to collect meals tax.

41. Name and address on liquor license at this location.

42. Seating capacity:

Room Occupancy

43. Date you were first required to collect room occupancy tax.

44. Locality code

45. Number of rooms:

Use Tax Purchaser

46. Date you were first required to pay use tax.

Convention Center Financing Surcharges

- 47. Date you were first required to collect: a. Boston Sightseeing Tour Surcharge.
b. Boston Vehicular Rental Transaction Surcharge.
c. Parking Facilities Surcharge in Boston, Springfield and/or Worcester.

Cigar and Smoking Tobacco Excise

48. Date you were first required to collect cigar and smoking tobacco excise.

Mail to: Massachusetts Department of Revenue, Data Integration Bureau, PO Box 7022, Boston, MA 02204.

I hereby certify that the statements made herein have been examined by me and are, to the best of my knowledge and belief, true and correct. Signed under the pains and penalties of perjury.

Your signature Title Date

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)
	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	CAF No. _____
	PTIN _____
	Telephone No. _____
	Fax No. _____
Check if to be sent copies of notices and communications <input type="checkbox"/>	Check if new: Address <input type="checkbox"/> Telephone No. <input type="checkbox"/> Fax No. <input type="checkbox"/>

Name and address	CAF No. _____
	PTIN _____
	Telephone No. _____
	Fax No. _____
Check if to be sent copies of notices and communications <input type="checkbox"/>	Check if new: Address <input type="checkbox"/> Telephone No. <input type="checkbox"/> Fax No. <input type="checkbox"/>

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

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 ▶

5 Retention/revocation of prior tax information authorizations. If the line 4 box is checked, skip this line. If the line 4 box isn't checked, the IRS will automatically revoke all prior tax information authorizations on file unless you check the line 5 box and **attach a copy** of the tax information authorization(s) that you want to retain ▶
 To revoke a prior tax information authorization(s) without submitting a new authorization, see the line 5 instructions.

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.

Signature	Date
Print Name	Title (if applicable)

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

(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)

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

3 Trade name (if any)

4 Address

Number	Street	Suite or room number
City	State	ZIP code
Foreign country name	Foreign province/county	Foreign postal code

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

	For ALL employees/ payees/payments	For SOME employees/ payees/payments
Form 940, Employer's Annual Federal Unemployment (FUTA) Tax Return* (all 940 series)	<input type="checkbox"/>	<input type="checkbox"/>
Form 941, Employer's QUARTERLY Federal Tax Return (all 941 series)	<input type="checkbox"/>	<input type="checkbox"/>
Form 943, Employer's Annual Federal Tax Return for Agricultural Employees (all 943 series)	<input type="checkbox"/>	<input type="checkbox"/>
Form 944, Employer's ANNUAL Federal Tax Return (all 944 series)	<input type="checkbox"/>	<input type="checkbox"/>
Form 945, Annual Return of Withheld Federal Income Tax	<input type="checkbox"/>	<input type="checkbox"/>
Form CT-1, Employer's Annual Railroad Retirement Tax Return	<input type="checkbox"/>	<input type="checkbox"/>
Form CT-2, Employee Representative's Quarterly Railroad Tax Return	<input type="checkbox"/>	<input type="checkbox"/>

* Generally, you 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

Print your name here

Print your title here

Date

Best daytime phone

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)

-

7 Agent's name (not trade name)

8 Trade name (if any)

9 Address

Number Street Suite or room number

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

Print your name here

Print your title here

Date

/ /

Best daytime phone

Massachusetts Department of Revenue
Form M-2848
Power of Attorney and Declaration of Representative

Part 1. Power of Attorney

Name of taxpayer(s) or principal reporting corporation	Social Security number(s)
Mailing address	Federal Identification number
City/Town	State Zip
Phone number	Email address

Representative Information

Hereby appoint(s) the following individual(s) as attorney(s)-in-fact to represent the taxpayer(s) before any office of the Massachusetts Department of Revenue for the following tax type(s) and filing period(s) [specify the tax type(s) and year(s) or filing period(s) (date of death if estate tax)]:

Name of individual and firm	Address	Email address/phone number

Fill in oval if you wish to allow a DOR representative to communicate with any individual from firms listed above.

Tax Type(s) & Filing Period(s) at Issue

Tax type(s)	Filing period(s)

The representative is authorized, subject to any limitations set forth below or to revocation, to receive confidential information and to perform any and all acts that the principal(s) can perform with respect to the above specified tax matters, such as the authority to sign any agreements, consents or other documents. The authority does not include the power to receive refund checks.

List below any specific additions or deletions to the acts otherwise authorized in this power of attorney:

Originals of notices and other written communications go to the taxpayer(s). Send copies of all notices and all other written communications addressed to the taxpayer(s) in proceedings involving the above tax matters to:

- 1** Appointee first named above, or
2 Another appointee designated above. Name _____

This power of attorney revokes all earlier powers of attorney on file with the Department of Revenue for the same tax matters and years or periods covered by this power of attorney, except the following (specify to whom granted, date and address including Zip code or attach copies of earlier powers):

Signature of taxpayer(s) or authorized individual of principal reporting entity. See instructions. If signed by a corporate officer, partner, or fiduciary on behalf of the taxpayer, I certify that I have the authority to execute this power of attorney on behalf of the taxpayer and/or principal reporting entity.

Signature (see instructions)	Title (if applicable)	Date
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If signing for a taxpayer who is not an individual or a principal reporting corporation, type or print your name


Signature (see instructions)	Title (if applicable)	Date
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Part 2. Declaration of Representative. All representatives must complete this section.

I declare that I am not currently under suspension or disbarment from practice within the Commonwealth or in any jurisdiction, that I am aware of regulations governing the practice of attorneys, certified public accountants, public accountants, enrolled agents and others, and that I am one of the following:

- 1 a member in good standing of the bar of the highest court of the jurisdiction shown below;
- 2 duly qualified to practice as a certified public accountant or public accountant in the jurisdiction shown below;
- 3 enrolled as an agent under the requirements of Treasury Department Circular No. 230;
- 4 a bona fide officer of the taxpayer organization or principal reporting corporation;
- 5 a full-time employee of the taxpayer;
- 6 a member of the taxpayer's immediate family (spouse, parent, child or sibling);
- 7 a fiduciary for the taxpayer;
- 8 other (describe relationship) _____

and that I am authorized to represent the taxpayer identified in Part 1 for the tax matters specified there.

Designation (insert appropriate number from above list)	Jurisdiction (state, etc.) or enrollment card number	Signature (see instructions)	Print name	Date
				



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 a MassHealth 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 MassHealth 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 MassHealth for actual work done by PCA or 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 Unlimited, 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 _____ Relationship _____

Name _____ 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 _____ Relationship _____

Name _____ 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 _____ 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 of Consumer/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 facturaciones 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 facturaciones para reembolso para la facturación y reembolso de otros programas. Tipos de PHI que podemos compartir podrían ser su número de identificación de MassHealth, 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 MassHealth 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 MassHealth por el trabajo realizado por el PCA 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 _____ Relación _____

Nombre _____ 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 _____ Relación _____

Nombre _____ 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: _____ 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/Delegado
Representante Legal o Personal

Nombre impreso

Fecha