



## EMPLOYER ENROLLMENT PACKET



## .....6Y U Veteran Directed Home and Community Based Services (VD-HCBS) Program

6243 IH Ten West, Suite 430, San Antonio, Texas 78201

CDS lines: 210-798-DSSW Fax: 210-7 -

Toll Free Phone: 866-675-7331 Fax: 8 - -

[www.cdsintexas.com](http://www.cdsintexas.com) <http://www.facebook.com/CDSinTexas>



## EMPLOYER INSTRUCTIONS AND CHECKLIST

The employer must complete **all** of the forms in the packet to enroll in the VD-HCBS program. Follow the instructions in this packet to enroll properly. *If the veteran or the veteran's Legally Authorized Representative appoints a designated representative, that person can also sign all of the forms except those for the IRS and TWC. If the employer signs with an "X," a witness must write:*

*"Witnessed By," and sign his/her name next to the "X."* **The witness may not be the employee.**

Use the checklist below to confirm you have completed all required forms. Instructions on how to complete the forms start on the next page.

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REQUIRED FORMS TO RETURN TO CDS IN TEXAS	
<input type="checkbox"/>	<b>Participant Contact Information</b> is filled out and signed
<input type="checkbox"/>	<b>Designation of Representative</b> is filled out and signed, <i>if applicable</i>
<input type="checkbox"/>	<b>IRS Form SS-4</b> is filled out and signed
<input type="checkbox"/>	<b>IRS Form 2678</b> is filled out and signed
<input type="checkbox"/>	<b>TWC Form C-42 Written Authorization</b> is signed
<input type="checkbox"/>	<b>Employer Service Agreement</b> is filled out and signed

FOR YOUR RECORDS	
Information for Employers	Timesheet (make extra copies)
Rate Information for Employers	Payroll Schedule (give copy to employees)

## PARTICIPANT INFORMATION SHEET

### Participant Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing address (if different) \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ Primary Diagnosis: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Fax \_\_\_\_\_ Other \_\_\_\_\_  
No: \_\_\_\_\_ No: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Email address: \_\_\_\_\_

### Family/Guardian/Designated Responsible Party (circle one)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address (if different): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Office Phone: \_\_\_\_\_ Cell / Other: \_\_\_\_\_

Email Address: \_\_\_\_\_

### Other Family contacts

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Office Phone: \_\_\_\_\_ Cell / Other: \_\_\_\_\_

### Emergency Contact

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Office Phone: \_\_\_\_\_ Cell / Other: \_\_\_\_\_

### PERMISSION TO CONTACT ELECTRONICALLY

Texas Regulations regarding Protected Health Information (PHI) require us to get permission from you to email information to you using our current Outlook email server or to **respond to the emails or texts you send to us.**

If you want us to be able to communicate with you electronically, please sign below. Examples of email or text communications include: Acknowledging receipt of new hire documentation, timesheets, requests for reimbursement, and budgets. Responding to or requesting information from your case manager / service coordinator. Responding to emails/texts you send to us. Emailing budgets, quarterly reports or program changes to you.  Yes, use email (or respond to my texts)  No, use US Postal Service

Signed: \_\_\_\_\_ Date: \_\_\_\_\_



**APPOINTMENT OF A DESIGNATED REPRESENTATIVE**

The individual listed below has agreed to be the Designated Representative for the Veteran and is 18 years of age or older.

VETERAN INFORMATION			
<b>First &amp; Last Name:</b>			
<b>Parent/Guardian (if applicable)</b>			
DESIGNATED REPRESENTATIVE INFORMATION			
<b>Name:</b>		<b>SSN:</b>	
<b>Street Address:</b>		<b>First Phone</b>	
<b>City:</b>		<b>Date of Birth:</b>	Month / Day / Year
<b>Email:</b>		<b>State</b>	<b>Zip:</b>
<b>Relationship to Veteran:</b>			

**As the Designated Representative, I understand and agree to the following statements (Please initial each box.)**

I understand that this is a volunteer position for which I will not be paid. My responsibilities will be limited to assisting the veteran in performing the duties of the employer. I understand that as the designated representative, I may not become an employee.	
I certify that I am not listed on the Employee Misconduct Registry nor the State or Federal List of Excluded individuals and Entities, nor have I been convicted of an offense under Chapter 32 of the Penal Code, or an offense barring employment as listed in the Texas Health and Safety Code 250.006 (a) and (b) .	
I accept the responsibility to manage to the requirements of the employer of record to the extent requested by the Veteran and/or the Legally Authorized Representative. If requested, I agree to assist with related health aspects of the Veteran's care in relationship to the VD-HCBS Program.	
I understand that as the DR I may assist or be responsible for all aspects of the VDC Program, including recruitment of employees, training, allocation of funds, scheduling authorized hours, and ensuring timely submission of timesheets and reimbursement requests.	
I will review and sign forms necessary to fulfill documentation requirements of the VDC.	
I understand that person-centered planning is at the core of the Veteran's service plan, and I will respect the Veteran's preferences.	
I understand that the Veteran or the Veteran's Legally Authorized Representative may revoke my Appointment as Designated Representative at any time, and that I may resign at any time I no longer feel I am able to provide this support.	

Date of DPS Check	Time	Obtained By
<b>Convictions:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes, does the conviction(s) prohibit service delivery or is the person serving as the DR in compliance with Health and Safety Code Chapter 250 or other eligibility requirements?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Effective Date:</b>

**Participant/Guardian Signature**

**Date**

**Designated Representative Signature**

**Date**

# 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.

EIN

<b>Type or print clearly.</b>	<b>1</b> Legal name of entity (or individual) for whom the EIN is being requested <p style="text-align: right;">/ <b>HHCSR</b></p>	
	<b>2</b> Trade name of business (if different from name on line 1) <b>N/A</b>	<b>3</b> Executor, administrator, trustee, "care of" name <b>N/A</b>
	<b>4a</b> Mailing address (room, apt., suite no. and street, or P.O. box) <b>6243 IH - 10 West Suite 430</b>	<b>5a</b> Street address (if different) (Do not enter a P.O. box.)
	<b>4b</b> City, state, and ZIP code (if foreign, see instructions) <b>San Antonio, Texas, 78201</b>	<b>5b</b> City, state, and ZIP code (if foreign, see instructions)
	<b>6</b> County and state where principal business is located <b>Bexar</b>	
	<b>7a</b> Name of responsible party	<b>7b</b> SSN, TIN, or EIN
<b>8a</b> Is this application for a limited liability company (LLC) (or a foreign equivalent)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<b>8b</b> If 8a is "Yes," enter the number of LLC members ▶
<b>8c</b> If 8a is "Yes," was the LLC organized in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>9a</b> Type of entity (check only one box). <b>Caution.</b> 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"/> 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/military <input type="checkbox"/> Other nonprofit organization (specify) ▶ _____ <input type="checkbox"/> REMIC <input type="checkbox"/> Indian tribal governments/enterprises <input checked="" type="checkbox"/> Other (specify) ▶ <b>HHCSR using Fiscal Employer Agent</b> Group Exemption Number (GEN) if any ▶		
<b>9b</b> If a corporation, name the state or foreign country (if applicable) where incorporated	State	Foreign country
<b>10</b> 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 checked="" type="checkbox"/> Other (specify) ▶ <b>HHCSR using Fiscal Employer Agent</b> <input type="checkbox"/> Created a trust (specify type) ▶ _____ <input type="checkbox"/> Created a pension plan (specify type) ▶ _____		
<b>11</b> Date business started or acquired (month, day, year). See instructions.	<b>12</b> Closing month of accounting year <b>December</b>	
<b>13</b> Highest number of employees expected in the next 12 months (enter -0- if none). If no employees expected, skip line 14.	<b>14</b> If you expect your employment tax liability to be \$1,000 or less in a full calendar year <b>and</b> want to file Form 944 annually instead of Forms 941 quarterly, check here. (Your employment tax liability generally will be \$1,000 or less if you expect to pay \$4,000 or less in total wages.) If you do not check this box, you must file Form 941 for every quarter. <input type="checkbox"/>	
<b>15</b> First date wages or annuities were paid (month, day, year). <b>Note.</b> If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year) ▶		
<b>16</b> Check <b>one</b> 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"/> Health care & social assistance <input type="checkbox"/> Wholesale-agent/broker <input type="checkbox"/> Real estate <input type="checkbox"/> Manufacturing <input type="checkbox"/> Finance & insurance <input type="checkbox"/> Accommodation & food service <input type="checkbox"/> Wholesale-other <input type="checkbox"/> Retail <input checked="" type="checkbox"/> Other (specify) <b>HHCSR using Fiscal Employer Agent</b>		
<b>17</b> Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided. <b>HHCSR using Fiscal Employer Agent</b>		
<b>18</b> Has the applicant entity shown on line 1 ever applied for and received an EIN? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes," write previous EIN here ▶		

<b>Third Party Designee</b>	Complete this section <b>only</b> 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 <p style="text-align: center;"><b>@ CDS IN TEXAS, INC.</b></p>	Designee's telephone number (include area code) ( <b>210</b> ) <b>798-3779</b>
	Address and ZIP code <b>6243 IH 10 West, Suite 430, San Antonio, Texas 78201</b>	Designee's fax number (include area code) ( <b>210</b> ) <b>798-5200</b>
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)
<b>Name and title (type or print clearly) ▶</b> <b>OWNER</b>		( )
<b>Signature ▶</b>		Applicant's fax number (include area code)
<b>Date ▶</b>		( )

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

(Rev. December 2023) Department of the Treasury — Internal Revenue Service

OMB No. 1545-0748

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

- If you'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

## WRITTEN AUTHORIZATION

To represent employing unit in its relations with the Texas Workforce Commission

### GRANTOR INFORMATION

1. CONTACT NAME: \_\_\_\_\_ 3. TWC ACCT NO: \_\_\_\_\_  
2. PHONE NO: \_\_\_\_\_ 4. FEIN NO: \_\_\_\_\_

\*(5) BY THIS INSTRUMENT, \_\_\_\_\_ (EMPLOYER Name)

(6) an employing unit which is a/an \_\_\_\_\_ INDIVIDUAL  
(Individual, Partnership, or Corporation, etc.)

(7) whose address is \_\_\_\_\_  
(Grantor's current mailing address)

\*(8) appoints \_\_\_\_\_ Disability Services of the Southwest, d/b/a **CDS in Texas, Inc.**  
(Name of Authorized Grantee)

(9) whose TWC ACCOUNT NO. is \_\_\_\_\_ 11-618684-5

and whose address is \_\_\_\_\_ 6243 IH 10 West, Suite 430, San Antonio, TX 78201

its lawful representative to represent it in its relations with the Texas Workforce Commission, and specifically authorizes said representative to transact any and all business as between grantor of said authorization and said Commission to do any and all acts necessary, excluding litigation in court.

**This Written Authorization shall be in full force and effect until such time as a Revocation of Written Authorization, Form C-43, revoking it is filed in the office of said Commission at Austin, Texas. (Revocable by either party, the Grantor or Grantee.)**

\*(10) \_\_\_\_\_, OWNER  
Printed name, signature and title (Owner, Partner, Officer, etc.) of person signing for Grantor.

\*(11) **Date Signed** \_\_\_\_\_

### \*MANDATORY INFORMATION

Form C-42 (061812)

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## EMPLOYER SERVICE AGREEMENT WITH CDS IN TEXAS

This is an agreement between \_\_\_\_\_ hereinafter referred to as the Veteran, the legally authorized representative (if applicable) \_\_\_\_\_, hereinafter referred to as the LAR, and CDS in Texas, a financial management services agency located in the State of Texas, hereinafter referred to as the FMSA, which has contracted with the Bexar Area Agency on Aging, hereinafter referred to as the Agency to provide financial management services to veterans who are participating in the Veteran Directed Home and Community Based Services Program (VD-HCBS).

The parties mutually acknowledge and agree that funds for this program are provided by the Veterans Administration.

### The Veteran and/or the LAR agree:

**Initial**

- 1) To abide by the rules of the VD-HCBS and to follow directions as given by the Agency. \_\_\_\_\_
- 2) To adhere to the budget as developed with the Agency. \_\_\_\_\_
- 3) To complete and return all forms required for participation in the VD-HCBS, including all employer and employee forms provided by Agency or the FMSA. \_\_\_\_\_
- 4) To allow the FMSA to act as the employer's fiscal/employer agent for the purposes of handling payroll and filing, depositing and reporting taxes on behalf of the Employer to the Internal Revenue Service and Texas Workforce Commission. \_\_\_\_\_
- 5) To give prior notice (or immediate notice if prior notice is not an option) of any change in the Veterans condition, such as hospitalization. \_\_\_\_\_
- 6) To notify Agency and FMSA of any change of name, address, telephone number within 24 hours \_\_\_\_\_
- 7) To ensure that attendant services are not used when Veteran is hospitalized. \_\_\_\_\_
- 8) To follow all employer and employment-related laws and regulations of federal, state and local Agencies. The Veteran acknowledges responsibility for such laws even if he/she has chosen a Designated Representative. \_\_\_\_\_
- 9) To assume employer-related responsibilities and liabilities to include at least: \_\_\_\_\_
  - a. Recruiting, selecting, and hiring individual employees or service providers in a sufficient number to meet the needs of the individual.
  - b. Developing and implementing a service back-up plan for each service deemed by the Service Planning Team to be critical to maintaining health and safety
  - c. Avoiding or minimizing the use of overtime without approval of Agency.
  - d. Assuming liability for any negligent acts or omissions by the Employer, his/her employee(s) and service providers, the DR (if applicable), the Individual or others in the work place; and
  - e. Managing the risk of and the incidences of employee work-related injuries or work-related illnesses.
- 10) That neither the Veterans Administration, nor any Area Agency on Agency nor the FMSA have or share any employment related liability. \_\_\_\_\_

- 11) To verify qualifications of an applicant or service provider with the FMSA before offering the applicant or service provider a position or allowing delivery of any services to the Individual through the VD-HCBS Program. \_\_\_\_\_
- 12) To be accountable for the funds spent through the VD-HCBS Program and understand that a VD Employer or DR who submits false or fraudulent time sheets, or approves a time sheet of an unqualified service provider, or approves a time sheet for tasks other than those approved by the Agency will be reported to the appropriate authorities for investigation and possible prosecution as fraud. \_\_\_\_\_
- 13) To terminate the VD-HCBS options if the Employer is unable or unwilling to follow program rules and/or employer-related rules and regulations. \_\_\_\_\_
- 14) To ensure protection of the individual receiving service and preserve evidence in the event of a Department of Family and Protective Services (DFPS) Adult Protective Services (APS) investigation of an allegation of abuse, neglect, or exploitation (ANE) against a VD-HCBS employee, DR, FMSA, or Agency employee or contractor. \_\_\_\_\_

**The Financial Management Services Agency (FMSA) agrees:**

- 1) To provide face-to-face orientation to the employer in the home of the Individual prior to beginning of the VD-HCBS program if requested by Agency.
- 2) To provide ongoing training and assistance as requested or needed by the Employer.
- 3) To review the qualifications of applicants for employment and service providers and notify the Employer of eligibility so that the Employer knows when delivery of services to the Individual by the applicant (employee) can start.
- 4) To deny payment to any employee or service provider that is not qualified to deliver the program service or that delivered a service prior to qualifications being verified by the FMSA.
- 5) To deny payment to any employee or service provider for services delivered while the Individual was not eligible for services through his/her program.
- 6) To adhere to all applicable VD-HCBS rules, policies and procedures related to the Individual's program.
- 7) To act as the registered vendor/fiscal employer-agent for purposes of handling payroll and filing, depositing and reporting taxes, on behalf of the Employer, with required federal and state agencies.
- 8) To adhere to and accept liability for federal, state and local laws and regulations related to employer-agent and employer-representative responsibilities.
- 9) To provide timely notification to the Employer of changes to such laws and regulations that affect employment-related responsibilities of the Employer and/or the FMSA.
- 10) To maintain an ongoing account balance of all transactions.
- 11) To provide accounting summaries and status reports of program funds and service category budgets to the Employer and to the program case manager or service coordinator in accordance with program requirements, but no less than quarterly.

**The Employer and FMSA agree:**

- 1) That if there is a DR, the DR may be the primary contact and decision-maker with the FMSA as determined by the Employer. The Employer must notify the FMSA in writing of designation and changes to the designation using the required Designation of Representative Form.
- 2) That billable activities must not precede the date the Individual is eligible to participate in the program and must not precede the effective date of the individual's approved service plan.

- 3) That services billed must be on the service plan and provided solely to the Individual, and that billed activities must be reasonable, allowable, necessary and included in the Individual's budget prior to the purchase of or delivery of the service or item.
- 4) That funding for services and activities is from public sources, and financial accountability and liability applies to the use of the funds. Both the Employer and the FMSA have an individual and joint responsibility for financial accountability and liability.
- 5) That persons providing services must be employees of the Employer unless:
  - a. exempted from employment by federal, state or local employment laws and regulations; and
  - b. allowed by the Individual's program.
- 6) That payment will not be made to an employee/service provider that:
  - a. does not meet minimum qualification requirements to provide the program service;
  - b. is barred from participation in either Medicaid or Medicare;
  - c. is barred by law due to criminal convictions, registry listings or other circumstances;
  - d. is barred based on the relationship to the Employer, Individual or DR, as excluded by program rules; or
  - e. is otherwise ineligible or not qualified to deliver the service.
7. That any applicable federal, state or local regulations pertaining to the provision of VD-HCBS are incorporated by reference to this Agreement.

**Duration and Modification of Service Agreement**

- 1) This Agreement and referenced rules and regulations constitute the entire Agreement and understanding between the Employer and the FMSA.
- 2) This Agreement will be in effect as of the date this Agreement is signed by the Employer and the FMSA representative, but must not precede the date the Individual is eligible to participate in the program or CDS.
- 3) This Agreement will terminate when:
  - a. the Individual no longer participates in the VD-HCBS program, voluntarily or involuntarily;
  - b. the Individual is no longer eligible for the VD-HCBS program; or
- 4) This service Agreement is null and void when:
  - a. the minor-aged Individual turns 18 years of age, is married or emancipated, and the Employer is not the court-appointed guardian;
  - b. the legal status of either the Employer or the Individual changes; or
  - c. there is any other change in the status of the Employer or Individual that requires a change in the status of the Employer.

**Acknowledgment of Service Agreement:**

Dated this the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

**Employer:** \_\_\_\_\_  
(please print)

**CDS in Texas**  
By: \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

## INSTRUCTIONS FOR REQUIRED FORMS

### PARTICIPANT ENROLLMENT INFORMATION

<b>Purpose</b>	This Enrollment Information form gathers required demographic information needed for enrollment with CDS in Texas
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<b>Instructions</b>	Complete all information requested. Sign and date at bottom of the page
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### DESIGNATION OF REPRESENTATIVE (if applicable)

<b>Purpose</b>	Complete this form if you wish to designate someone to assist you with the responsibilities of being an employer. <b>If appointing a DR, this individual must complete the second half of the form.</b> You both sign and date the form.
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<b>Instructions</b>	Fill out the form; the DR initials each task. Both sign and date. If the participant has a guardian, the guardian must sign.
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### IRS FORM SS-4

<b>Purpose</b>	Completing this form allows CDS in Texas to apply for a Federal Employer Identification Number (FEIN) with the IRS. By doing this, we avoid reporting under your Social Security number when the W-2 is issued.
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- |                     |  |
|---------------------|--|
| <b>Instructions</b> | 1) On line 1, print the employer's full name. <b>It must match the name on the Social Security Card.</b> |
|                     | 2) On Line 6, print the county and state where the employer resides.                                     |
|                     | 3) On Line 7a, print employer's full name again.   |
|                     | 4) On Line 7b, print employer's Social Security Number.  |
|                     | 5) The employer signs and dates form at bottom of page where highlighted in yellow.                      |

### IRS FORM 2678

<b>Purpose</b>	This form appoints CDS in Texas as your agent for the purpose of depositing taxes and filing necessary quarterly reports for the VD-HCBS Program. We are given no access to personal tax information.
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<b>Instructions</b>	Employers signs where "X" is seen and dates form. CDS in Texas will complete the rest.
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### TWC FORM C-42 WRITTEN AUTHORIZATION

<b>Purpose</b>	This form appoints CDS in Texas as your agent for the purpose of paying state unemployment taxes and filing necessary quarterly reports.
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<b>Instructions</b>	The employer signs where highlighted in yellow. CDS in Texas will complete the rest.
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### EMPLOYER SERVICE AGREEMENT

<b>Purpose</b>	This form defines the roles and responsibilities of each party under the VD-HCBS Program.
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<b>Instructions</b>	Read carefully, print the veteran and employer's name, initial where marked and sign and date where highlighted in yellow.
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### Form 1720 - Backup Plan

<b>Purpose</b>	This form assists in preparing for the need if the main employees are not able to perform their duties, the veteran will be cared for.
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<b>Instructions</b>	Read carefully, fill out with method of backup plan, sign and date
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### DIRECT DEPOSIT AUTHORIZATION

<b>Purpose</b>	This form gives CDS in Texas authorization to deposit reimbursements in your bank account
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<b>Instructions</b>	Read the instructions on the form and fill every box. <b>NOTE: For checks we must have a voided check or letter from your bank. For prepaid cards, we need a statement from the card company showing the card is activated and registered. Your name must be printed on the card. You should be able to login to the card company's website and print this form.</b>
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## INFORMATION FOR EMPLOYERS

### FREQUENTLY ASKED QUESTIONS ABOUT CONSUMER DIRECTION

What is consumer direction?	Consumer direction, also known as self-direction, allows the veteran to become the employer of record. You hire, train, and if necessary, fire your employees. This service delivery option gives you more independence and control over who works for you, the hours they work, and how services are delivered.
Who is CDS in Texas?	We are a financial management services agency. We will conduct background checks on new employees for you, process your timesheets, withhold taxes, and track your program funds.
Who is the employer?	You are the employer unless you have a guardian. If you have a court-appointed guardian, then that individual will be the employer.
What are my responsibilities as an employer?	As the employer, you hire, train, supervise, and terminate your employees. You must ensure that you have back-up services if your regular employee cannot work. You submit accurate timesheets for work performed and ensure that the narrative portion of the timesheet is completed.
How do I enroll?	You will complete this enrollment package with a representative of CDS in Texas. We will forward all the documents to Bexar Area Agency on Aging. We will then enroll you; notify you of background results within 2 business days of receiving the new employee information; and set you up for payroll processing. BAAA will work with you on your budget.
How is time worked recorded?	This packet contains a timesheet. You will need to make copies. You can also download the timesheet from our website <a href="http://www.cdsintexas.com">www.cdsintexas.com</a> . See the Payday Schedule in this packet for how and when to submit your timesheet.
How is my employee paid?	The application packet has forms for direct deposit to a bank account or pre-paid card. When your payroll is processed, you will receive an email notification.
When is payday?	This packet contains the payroll schedule. Payday is every other 1st and 15th of the month, excluding weekend and bank holidays.
What if my employee does not receive a paycheck?	Check to see if there is a fax or email confirmation. If there is not, re-send and call our office to let us know about the late timesheet. If there is confirmation of receipt, call our office. We should be able to locate the missing timesheet, and we will process as quickly as possible.
How do I get my payroll records?	We will send you Payroll Detail reports every pay period to an eligible email address that will be submitted to you 2-3 days prior to payday.
What else do I need to know?	If you are in the hospital or other facility or lose eligibility, your employee cannot work.
How do I contact CDS in Texas?	Call your CDS VA Specialist at 210-798-3779 or 877-675-7331, ext. 8319, or email <a href="mailto:VD@cdsintexas.com">VD@cdsintexas.com</a> . Our website is <a href="http://www.cdsintexas.com">www.cdsintexas.com</a> . Follow us on Facebook at <a href="http://www.facebook.com/CDSinTexas">http://www.facebook.com/CDSinTexas</a> . Hours are from 8:00a.m. to 5:00 p.m. Monday - Friday.

Other important things to know	<ul style="list-style-type: none"> <li>You certify your timesheets as true and correct. Never sign blank timesheets. Submitting incorrect timesheets may be considered fraud.</li> </ul>
	<ul style="list-style-type: none"> <li>Any over or under payment of payroll will be corrected as soon as possible but no later than the next payroll.</li> </ul>
	<ul style="list-style-type: none"> <li>Everyone has a responsibility to report abuse, neglect or exploitation (1-800-252-5400).</li> </ul>
	<ul style="list-style-type: none"> <li>Work with your employees until they fully understand what you expect from them.</li> </ul>
	<ul style="list-style-type: none"> <li>Make sure your employees know who to notify if they cannot work a scheduled shift.</li> </ul>
Is there anything else I need to do?	<p><b><u>YES !!</u></b> If any of your information changes -- your name, your address, your banking information, your telephone number, your email address -- use the Change of Information form which is on our website, or call to have a copy sent to you.</p>



**RATE INFORMATION FOR EMPLOYERS**

As an employer, the cost of hiring employees does not only include wages. By law, you are also required to pay payroll taxes. The amounts you pay for each of these is a percentage of payroll and are shown as follows:

Social Security	6.20%
Medicare	1.45%
Federal Unemployment Tax	0.60%
State Unemployment Tax	2.70%
<b>TOTAL Employer Cost Rate*</b>	<b>10.95%</b>

\*Note – These are default rates only. Your rate may vary from the default rates listed above.

This means that for every \$1.00 you pay your employee in wages, you must pay an additional 10.95% or 11 cents, to meet employer payroll taxes.

To determine the total cost for your employees, multiply the employee’s rate of pay by 1.1095.

$$\boxed{\phantom{000}} \times \boxed{\phantom{000}} = \boxed{\phantom{000}}$$

CDS in Texas calculates and pays this amount on your behalf, but it is important for you to understand how this affects your authorized budget. The table below is provided to help you determine your cost to employ someone based on various hourly rate amounts. The “Cost to You” column represents the rate multiplied by the default employer tax rate shown above. You may pay your employee other amounts than those listed in the table.

Hourly Rate	Cost to You	Hourly Rate	Cost to You	Hourly Rate	Cost to You
\$7.25	\$8.05	\$10.00	\$11.10	\$12.75	\$14.15
\$7.50	\$8.33	\$10.25	\$11.37	\$13.00	\$14.42
\$7.75	\$8.60	\$10.50	\$11.65	\$13.25	\$14.70
\$8.00	\$8.88	\$10.75	\$11.93	\$13.50	\$14.98
\$8.25	\$9.15	\$11.00	\$12.20	\$13.75	\$15.26
\$8.50	\$9.43	\$11.25	\$12.48	\$14.00	\$15.53
\$8.75	\$9.71	\$11.50	\$12.76	\$14.25	\$15.81
\$9.00	\$9.99	\$11.75	\$13.04	\$14.50	\$16.09
\$9.25	\$10.27	\$12.00	\$13.31	\$14.75	\$16.37
\$9.50	\$10.55	\$12.25	\$13.59	\$15.00	\$16.64
\$9.75	\$10.82	\$12.50	\$13.87	\$15.25	\$16.92

# CDS in Texas - 2024 Semi Monthly Payroll Schedule

If payday lands on a holiday, payroll will be processed the day before

**NOTE: Payroll is processed semi-monthly (twice in one month). Timesheets are due every 1st or the 16th of the month. Payday will be every 1st and the 15th. (If date falls on a weekend, payroll will be processed the Friday prior.)**

PAY PERIOD	PAYROLL START	END	TIME SHEET DUE	PAY DATE
1	12/16/2023	12/31/2023	01/01/2024	01/12/2024
2	01/01/2024	01/15/2024	01/16/2024	02/01/2024
3	01/16/2024	01/31/2024	02/01/2024	02/15/2024
4	02/01/2024	02/15/2024	02/16/2024	03/01/2024
5	02/16/2024	02/29/2024	03/01/2024	03/15/2024
6	03/01/2024	03/15/2024	03/16/2024	04/01/2024
7	03/16/2024	03/31/2024	04/01/2024	04/15/2024
8	04/01/2024	04/15/2024	04/16/2024	05/01/2024
9	04/16/2024	04/30/2024	05/01/2024	05/15/2024
10	05/01/2024	05/15/2024	05/16/2024	05/31/2024
11	05/16/2024	05/31/2024	06/01/2024	06/14/2024
12	06/01/2024	06/15/2024	06/16/2024	07/01/2024
13	06/16/2024	06/30/2024	07/01/2024	07/15/2024
14	07/01/2024	07/15/2024	07/16/2024	08/01/2024
15	07/16/2024	07/31/2024	08/01/2024	08/15/2024
16	08/01/2024	08/15/2024	08/16/2024	08/30/2024
17	08/16/2024	08/31/2024	09/01/2024	09/13/2024
18	09/01/2024	09/15/2024	09/16/2024	10/01/2024
19	09/16/2024	09/30/2024	10/01/2024	10/15/2024
20	10/01/2024	10/15/2024	10/16/2024	11/01/2024
21	10/16/2024	10/31/2024	11/01/2024	11/15/2024
22	11/01/2024	11/15/2024	11/16/2024	11/29/2024
23	11/16/2024	11/30/2024	12/01/2024	12/13/2024
24	12/01/2024	12/15/2024	12/16/2024	12/31/2024
1	12/16/2024	12/31/2024	01/01/2025	01/15/2025

All timesheets are due by 5 PM every 1ST or the 16TH following the last day of the pay period even if it lands on a holiday

**EMPLOYEES SHOULD NOT TRY TO CASH THEIR CHECKS EARLY.** Our bank receives a list of approved checks on payday. Any checks cashed prior to that date will be returned.

**PLEASE USE THE FAX NUMBER, EMAIL, OR JOTFORM LINK BELOW TO SEND ALL VETERAN TIMESHEETS**

<b>Email Address</b>		<b>Veteran Fax Number</b>
VD@cdsintexas.com		210-640-3913
	<b>JotForm Link</b>	
	<a href="https://dsswtx.jotform.com/kjeffrey/va-timesheet-upload">https://dsswtx.jotform.com/kjeffrey/va-timesheet-upload</a>	

Alternative numbers: If above numbers are not working: 866 301 1182 or 866 4626671 or 877 812 3789

**For all Veteran related questions or inquiries, please contact the Veteran Directed Department  
210-798-3779 Ext. 8319**





# Veteran Directed - Employee Timesheet

\*You may email timesheets to VD@cdsintexas.com or fax to 1-210-640-3913

Type of Service	
PC - Personal Care Services	HM - Homemaker Services
HOS - Hospitalization/Medical Facility	

Veteran Name:	
Employee Name:	
AAA Case Manager:	

Month:
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Pay Period Number:
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**Timesheets are due every 1st and 16th of every month. Late timesheets are subject to be processed for later pay date**

**Time MUST be submitted with AM/PM or Military Time**

Date of the month	Service Type	Time In	Time Out	Time In	Time Out	Comment(s)
1						Military Time
2						8:00 AM = 8:00 or 0800
3						8:00 PM = 20:00 or 2000
4						12PM(Noon) = 12:00
5						1PM = 13:00
6						2 PM = 14:00
7						3 PM = 15:00
8						4PM - 16:00
9						5PM = 17:00
10						6PM = 18:00
11						7PM = 19:00
12						8PM - 20:00
13						9PM = 21:00
14						10PM = 22:00
15						11PM = 23:00
						12PM(Midnight) = 00:00
						12:01AM = 00:01
						12:30AM = 00:30
16						Military Time
17						8:00 AM = 8:00 or 0800
18						8:00 PM = 20:00 or 2000
19						12PM(Noon) = 12:00
20						1PM = 13:00
21						2 PM = 14:00
22						3 PM = 15:00
23						4PM - 16:00
24						5PM = 17:00
25						6PM = 18:00
26						7PM = 19:00
27						8PM - 20:00
28						9PM = 21:00
29						10PM = 22:00
30						11PM = 23:00
31						12PM(Midnight) = 00:00
						12:01AM = 00:01
						12:30AM = 00:30

  

Veteran/DR Signature	Date	Employee Signature	Date

Was the consumer hospitalized or in a medical care facility during this pay period? Please list dates above and leave comment.

Employer and Employee here by certify that the work hours listed above are accurate, that the services provided are in accordance with the current tasks authorized and the services were NOT provided while the consumer was in the hospital, nursing home, or the Veteran-reimbursed healthcare facility. I understand the falsification of this timesheet is considered fraud, and may results in dismissal from the program and criminal prosecution.