EMPLOYER ENROLLMENT PACKET

Central Texas Veteran Directed Care (VDC)

6243 IH Ten West, Suite 430, San Antonio, Texas 78201
CDS lines: 210-798-DSSW Fax: 210-798-5200
Toll Free Phone: 866-675-7331 Fax: 866-301-1182
www.cdsintexas.com http://www.facebook.com/CDSinTexas

AUTHORIZED DESIGNATED REPRESENTATIVE

I. Veteran's Name ____

II. Authorized Designated Representative *(please check only one box in this section)*

☐ I, ________________________ (*Veteran*), am able to self-direct and manage my Veteran Directed Care (VDC) services and supports and do not need an authorized representative at this time. (If selected, skip to signatures section V. of this form.)

☐ I, ________________________ (*Veteran)*, have authorized ______________________________ (*Authorized Representative*) to act as my representative and assist me in directing and managing my Veteran Direct Care (VDC) services and supports on my behalf and be the common law employer of my direct care workers.

☐ My legal guardian/power of attorney, ________________________ (*Legal Guardian/MPOA*), has authorized ________________________ (*Authorized Representative*) to act as my representative and assist me in directing and managing my Veteran Direct Care (VDC) services and supports on my behalf and be the common law employer of my direct care workers.

III. Authorized Designated Representative Information

Name ____

Street Address ____

City/State/Zip ____

Telephone # ____

Email Address ____

Relationship to Veteran ____

IV. Authorized Designated Representative Responsibilities and Attestation

"I, ________________________ (*Authorized Representative*), understand and agree with my role as the Authorized Designated Representative, including being the common law employer of the direct care

workers who provide care to _________________________ (*Veteran*). I understand this means I will be responsible for most of the tasks that any other employer would perform, with payroll and bill payment assistance from the Consumer Directed Services of Texas (CDS) entity.

I understand that my appointment as Authorized Representative may be revoked at any time by the Veteran, myself, or as a result of cases of non-compliance in accordance with the Area on Aging(AAA)/Central Texas Council of Government(CTCOG) Remediation, Training and Termination Process.

By checking each box below, I affirm that I meet all of the requirements to be the Authorized Designated Representative for _________________________ (*Veteran*), who is enrolled in and receiving services from the VDC Program.

- ☐ I am at least 18 years of age (unless state Medicaid participant-directed service waiver has a different requirement).
- ☐ I live within 20 miles of the Veteran’s residence.
- ☐ I understand the kinds of services the Veteran needs and how s/he wants services to be provided.
- ☐ I know the Veteran’s schedule and routine.
- ☐ I know the Veteran’s health care needs and the medicine they take.
- ☐ I am willing and able to do all of the duties that are required to be a Representative.
- ☐ I will be present in the Veteran’s home often enough to be able to properly supervise staff.
- ☐ I understand that I cannot be paid to be as an Authorized Designated Representative.
- ☐ I understand that I cannot be a paid direct care worker for the Veteran if I serve as his/her Authorized Designated Representative.”

By checking each of the boxes below, I affirm that I agree to do the following tasks:

- ☐ Make decisions and perform tasks on the Veteran’s behalf that are:
  - In their best interest,
  - In a manner that truly reflects the Veteran’s wishes and how they would perform them in the absence of his/her disability or chronic condition, and

- Increasing the Veteran’s independence and community integration.

- ☐ Accommodate the Veteran, to the extent necessary, so that the Veteran can participate as fully as possible in all decisions that affect the Veteran.
- ☐ Give due consideration to all information including the recommendations of other interested and involved parties.
- ☐ Develop with the Options Counselor, the Veteran’s spending plan and any amendments to be approved by the Program Coordinator at the VAMC.
- ☐ Decide how much direct care workers will be paid (within limits set by the VA Standard Operation Procedures).
- ☐ Establish direct care workers’ job duties and work schedules.
- ☐ Train direct care workers to provide services and supports based on the Veteran’s needs and preferences.
- ☐ Develop and implement, with the Veteran and their assigned Options Counselor, an emergency back-up plan and designate emergency back-up personnel and natural supports and update them, as needed.
- ☐ Activate their emergency back-up plan and direct care workers and natural supports, as needed.
- ☐ Review/approve, sign and submit direct care workers’ timesheets in an accurate and timely manner to the Consumer Directed Services of Texas (CDS) entity.
- ☐ Develop a job description and recruit, interview and hire direct care workers to provide services to the Veteran.
- ☐ Make sure direct care workers and goods and services vendors provide *only* the amount of service in accordance with the Veteran’s approved case-mix budget and spending plan.
- ☐ Supervise direct care workers.
- ☐ Evaluate the direct care workers’ job performance.
- ☐ Address problems or concerns with direct care workers’ performance.
- ☐ Discharge a direct care worker for cause, when necessary.
- ☐ Identify goods and services vendors and oversee the receipt of approved goods and services in accordance with the Veteran’s spending plan and VMC guidelines.

- ☐ Prepare and submit the *Direct Care Worker Information Change /Termination Form* to the Consumer Directed Services of Texas (CDS) entity when a direct care worker's contact information changes or when terminated from employment for any reason within 24 hours termination.
- ☐ Maintain required VDC Program-related documentation in the home.
- ☐ Maintain compliance with federal and state tax, labor and insurance and VDC Program and Area on Central Texas Council of Government(CTCOG) and Consumer Directed Services of Texas (CDS) entity rules and requirements.

"I understand and willingly accept all of the responsibilities of serving as an Authorized Designated Representative for ________________________ (*Veteran).*"

"I understand that I will receive support from the Veteran's assigned Options Counselor and Consumer Directed Services of Texas (CDS) entity while performing as the Authorized Designated Representative and common law employer of the Veteran's direct care workers. However, the Consumer Directed Services of Texas (CDS) entity cannot hire, train, supervise or discharge the Veteran's direct care workers; I understand I must do this myself.

By signing below, I affirm that I have completed this Agreement. I have read and understood my responsibilities, and agree to perform all responsibilities of an Authorized Designated Representative as defined above."

V. Signatures

____ ______________________

Veteran Employer *Date*

____ ______________________

Authorized Representative-Employer (when appropriate) *Date*

____ ______________________

Central Texas Council of Governments Options Counselor *Date*

FRAUD & ABUSE STATEMENT

Fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself 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 using the Veteran's case mix budget 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 Consumer Directed Service (CDS) entity and/or Area on Aging (AAA) for individual-directed goods and services that were not provided.
- Knowingly and/or purposefully having the Consumer Directed Service (CDS) 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 Consumer Directed Service (CDS) 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 Consumer Directed Service (CDS) 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 Consumer Directed Service (CDS) entity and the Veteran's Options Counselor to remedy the situation.
- Being late in handing in Veteran/representative-employer-related paperwork to the Consumer Directed Service (CDS) 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 reported by the Consumer Directed Service (CDS) entity/ Area on Aging (AAA) and referred to the Veterans Health Administration and reported to the Office of Inspector General Office (OIG) 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 *Date*

____

Authorized Representative (when applicable) *Date*

____

Central Texas Council of Government Options Counselor *Date*

EMPLOYER INSTRUCTIONS AND CHECKLIST

The employer must complete **all** of the forms in the packet to enroll in the VDC program. Follow the instructions in this packet to enroll properly. **All areas highlighted in yellow must be signed.** *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.

REQUIRED FORMS TO RETURN TO CDS IN TEXAS	
❒	**Participant Contact Information** is filled out and signed
❒	**Designation of Representative** is filled out and signed, ***if applicable***
❒	**IRS Form SS-4** is filled out and signed
❒	**IRS Form 2678** is filled out and signed
❒	**TWC Form C-42 Written Authorization** is signed
❒	**Employer Service Agreement** is filled out and signed
❒	**Privacy Practice Notice** is signed
❒	Form 1736 - Documentation of Orientation
❒	Form 1585 - Overview of Employer Responsibilities
❒	Form 1740 - Service Backup Plan
❒	Form 1826-D - Case Information Release

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

INSTRUCTIONS FOR REQUIRED FORMS	
PARTICIPANT ENROLLMENT INFORMATION	
Purpose	This Enrollment Information form gathers required demographic information needed for enrollment with CDS in Texas
Instructions	Complete all information requested. Sign and date at bottom of the page
DESIGNATION OF REPRESENTATIVE (*if applicable)*	
Purpose	Complete this form if you wish to designate someone to assist you with the responsibilities of being an employer. **If appointing a DR, this individual must complete the second half of the form.** You both sign and date the form.
Instructions	Fill out the form; the DR initials each task. Both sign and date. If the participant has a guardian, the guardian must sign.
IRS FORM SS-4	
Purpose	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.
Instructions	1) On line 1, print the employer's full name. **It must match the name on the Social Security Card.**
	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	
Purpose	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.
Instructions	Employers signs where "X" is seen and dates form. CDS in Texas will complete the rest.
TWC FORM C-42 WRITTEN AUTHORIZATION	
Purpose	This form appoints CDS in Texas as your agent for the purpose of paying state unemployment taxes and filing necessary quarterly reports.
Instructions	The employer signs where highlighted in yellow. CDS in Texas will complete the rest.
EMPLOYER SERVICE AGREEMENT	
Purpose	This form defines the roles and responsibilities of each party under the VD-HCBS Program.
Instructions	Read carefully, print the veteran and employer's name, initial where marked and sign and date where highlighted in yellow.
PRIVACY PRACTICES NOTICE	
Purpose	This notice explains how CDS in Texas will handle your protected health information (PHI).
Instructions	Sign and date on lines provided at the bottom of the page where highlighted in yellow.

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. Details can be found in the Employer Service Agreement.
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 from the Central Texas Council of Governments. They will forward all the documents to us. We will then enroll you; notify you of background results within 48 hours of receiving the new employee information; and set you up for payroll processing.
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 www.cdsintexas.com. 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, or the employee can select our pay card. When your payroll is processed, you will receive an email notification.
When is payday?	This packet contains the payroll schedule. Payday is paid semi monthly every 1st and 15th unless stated otherwise on the schedule included.
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 quarterly reports that show how many hours have been worked, any payments made for reimbursable expenses, and how must money has been used from your budget.
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 VA Specialist, Liza Cordoway. You can reach her at 210-798-3779 or 877-675-7331, ext. 1731, or email LCordoway@cdsintexas.com or VD@cdsintexas.com. Our website is www.cdsintexas.com. Follow us on Facebook at http://www.facebook.com/CDSinTexas. Hours are from 8:00a.m. to 5:00 p.m. Monday - Friday.

Other important things to know	• You certify your timesheets as true and correct. Never sign blank timesheets. Submitting incorrect timesheets may be considered fraud.
	• Any over or under payment of payroll will be corrected as soon as possible but no later than the next payroll.
	• Everyone has a responsibility to report abuse, neglect or exploitation (1-800-252-5400).
	• Work with your employees until they fully understand what you expectfrom them.
	• Make sure your employees know how to notify you if they cannot worka scheduled shift.
Is there anything else I need to do?	***YES*** ***!!*** 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.

PARTICIPANT INFORMATION SHEET

Participant Information

Name: ____

Address: ____

City: ____________________ Zip: ____________

Mailing address (if different) ____

City: ____________________ Zip: ____________ Primary Diagnosis: ____________

Home Phone: ____________________ Fax No: ____________ Other No: ____________

Date of Birth: __________ Email address: ____________________________

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

Name: ______________________________ Relationship: ____________

Address (if different): ____

Home Phone: ____________ Office Phone: ____________ Cell/ Other: ____________

Date of Birth: ____________ Email Address: ____________________________

Other Family contacts

Name: ______________________________ Relationship: ____________

Home Phone: ____________ Office Phone: ____________ Cell/ Other: ____________

Emergency Contact

Name: ______________________________ Relationship: ____________

Home Phone: ____________________ Office No: ____________ Other No: ____________

PERMISSION TO CONTACT ELECTRONICALLY

Texas Regulations regarding Protected Health Information (PHI) require us to get permission from you to email information to you using out 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	
First & Last Name:	
Parent/Guardian (if applicable)	

DESIGNATED REPRESENTATIVE INFORMATION					
Name:		**SSN:**			
Street Address:		**First Phone**			
City:		**Date of Birth:**	Month / Day / Year		
Email:		**State**		**Zip:**	
Relationship to Veteran:					

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**
Convictions: ☐ Yes ☐ No	**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?** ☐ Yes ☐ No	**Effective Date:**

Participant/Guardian Signature **Date**

Designated Representative Signature **Date**

Form **SS-4** (Rev. January 2010)
Department of the Treasury
Internal Revenue Service

Application for Employer Identification Number

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

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

OMB No. 1545-0003

EIN

Type or print clearly.

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

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

3 Executor, administrator, trustee, "care of" name
N/A

4a Mailing address (room, apt., suite no. and street, or P.O. box)
6243 IH - 10 West Suite 430

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

4b City, state, and ZIP code (if foreign, see instructions)
San Antonio, Texas, 78201

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

6 County and state where principal business is located
Bexar

7a Name of responsible party

7b SSN, ITIN, or EIN

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

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

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

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

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

Group Exemption Number (GEN) if any ▶

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

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

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

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

12 Closing month of accounting year **December**

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

Agricultural	Household	Other
		1

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

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

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

- ☐ 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) HHCSR using Fiscal Employer Agent

17 Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided.
HHCSR using Fiscal Employer Agent

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: @ CDS IN TEXAS, INC.
Designee's telephone number (include area code): (210) 798-3779
Address and ZIP code: 6243 IH 10 West, Suite 430, San Antonio, Texas 78201
Designee's fax number (include area code): (210) 798-5200

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) ▶ OWNER

Applicant's telephone number (include area code) ( )

Applicant's fax number (include area code) ( )

Signature ▶ Date ▶

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) ☐☐ – ☐☐☐☐☐☐☐

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.)*

Form	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

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

Mail To:
Cashier - Texas Workforce Commission
P.O. Box 149037
Austin, TX 78714-9037
512.463.2731
www.texasworkforce.org

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

Mail To:
Cashier - Texas Workforce Commission
P.O. Box 149037
Austin, TX 78714-9037
512.463.2731
www.texasworkforce.org

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 Area Agency on Aging of Central Texas, hereinafter referred to as the Agency to provide financial management services to veterans who are participating in the Veteran Directed Care Program (VDC).

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 VDC 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 VDC, 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 (DR). _______
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. 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
   d. Managing the risk of and the incidences of employee work-related injuries or work-related illnesses.
   e. Store all employee records and documents for at least 5 years
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 VDC Program. _______
12) To be accountable for the funds spent through the VDC 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 VA will be reported to the appropriate authorities for investigation and possible prosecution as fraud. _______
13) To terminate the VDC 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 VDC 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 VDC 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 VDC 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 VDC 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 VDC program, voluntarily or involuntarily;
   b. the Individual is no longer eligible for the VDC 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: ____________________________________

TEXAS Health and Human Services

Form 1736
June 2014-

Documentation of VDC Employer Orientation by CTADVRC - Veterans Program

Individual's Name	Program Name
Employer Name	Relationship to Individual

Contact Person CTADVRC - Veterans Programs	Telephone Number	Fax Number

Minimum required attendance — **employer** and **CTADVRC representative**; and the **designated representative** (DR), if appointed at time of orientation. The orientation must be conducted **in the individual's residence** and must be completed **before** an individual can begin using CDS services.

Orientation Location

Address		
City	State	ZIP Code

Orientation Session

CTADVRC Representative Name				
Begin Date	Time ☐ a.m. ☐ p.m.	End Date	Time ☐ a.m. ☐ p.m.	Length of Training Session Hours Minutes

Topics Covered (employer to check topics)

- ☐ Employer budget
- ☐ Hiring process/new hire packet
- ☐ Timesheet due dates and payday schedule
- ☐ How to report abuse, neglect and exploitation
- ☐ FMSA's operating hours and complaint procedure
- ☐ *VDC Employer Guide*
- ☐ Employer and Financial Management Services Agency Service Agreement, and program addendum with service definitions, provider qualifications, and training and documentation requirements

Certification — I certify the orientation included, at a minimum, the topics listed above; the topics in the current Chapter 41, Consumer Directed Services Option, of the Texas Administrative Code, Title 40, Part 1; and the topics in the VDC *Employer Guide*.

Employer

Printed Name

Signature

Date

CTADVRC Representative

Printed Name

Signatur

Date

Others in Attendance (DR if appointed at time of orientation)

Printed Name

Signature

Date

Printed Name

Signature

Date

Emergency Backup Service Plan

Name of Veteran	Phone Number	Email Address
Designated Representative (if applicable)	Phone Number	Email Address

An Emergency Backup Services Plan is required for each Veteran enrolled in the VDC Program. The Veteran/Representative-Employer, with assistance from the Veteran's CTCOG Options Counsel, is responsible for developing and updating the Plan, as necessary. The Veteran's Emergency Backup Services Plan must be reviewed and approved by the Veteran's Options Counselor initially and annually thereafter. It is recommended that the Veteran's Plan include multiple resources (i.e., a Natural Support, a Paid Direct Care Worker, Agency-based Services).

Type of Emergency Backup Services Plan ☐ Initial Plan ☐ Revision to the Plan	Date of Service Planning Meeting w/ Options Counselor	Effective Date of Emergency Backup Services Plan

Emergency Backup Services Plan Strategies and Sequence	**Specific Action(s) to Be Taken in Absence of Service Delivery**	**Resource Person or Entity's, Phone Number**
1.		
2.		
3.		
4.		

Plan Approval:

______________________________ ________ ______________________________ ________

Veteran/Representative-Employer Signature Date **CTCOG Options Counselor Signature** Date

Annual Review: **Yes** **No**

Was the Plan implemented? ☐ ☐

If yes, was the Plan effective? ☐ ☐

If the Plan was not effective, please describe why and how it will be improved in future.

____

____

____

____

Options Counselor requested revision on___________(date).

Options Counselor received revised Plan from Veteran/Representative-Employer on_______________(date).

Options Counselor's Initials:____________ Date: ____________

Form 1826-D
October 2004-E

Veteran Directed Care Program

Case Information Release

Section I

Case Name: ______________________ Case Number: ______________________

By signing this authorization form, you are giving the Texas Health and Human Services Commission (HHSC)/CTADVRC Veterans Program permission to release all or part of your case record, which may also include health information. You do not have to sign this release in order to apply for or receive benefits from HHSC/CTADVRC.

Section II

I authorize HHSC/CTADVRC to release my case record to the following person or agency for the purpose(s) stated in Part A below. My information will remain available to the person or agency indicated until the expiration date stated in Part B.

Part A – Release of Information: CDS in Texas

I understand that my case record may contain protected health information. Release my information to the following person/agency:

CTVHCS / AAACT / CTADVRC/ CDSinTexas

Check one of the following:

☒ Release all of my case record

☐ Release only the following information:

Part B – Purpose(s) of Release:

To release funds/ research information required to release funds for goods and services under the Veteran Directed Home and Community Based Services Program

This authorization expires on: N/A

Part C – Signature:

Client or Personal Representatives Signature ______________________ Date ____________

☐ If you are signing for the client, please describe your authority to act for the client on the following line:

____

Note: If the person requesting the release of case information cannot sign his/her name, two witnesses to his/her mark (X) must sign below. Accept one witness signature in circumstances where it is not possible to obtain two witness signatures. Document the reason in the case record.

Witness: ______________________ Date: ____________

Witness: ______________________ Date: ____________

Section III

Notice to Client

- Once you authorize HHSC to release your information, HHSC is not responsible for any re-disclosure of the information by the recipient.
- You can withdraw permission you have given HHSC to use or disclose health information that identifies you, unless HHSC has already taken action based on your permission. You must withdraw your permission in writing.

With a few exceptions, you have the right to request and be informed about the information that the HHSC obtains about you. You are entitled to receive and review the information upon request. You also have the right to ask HHSC to correct information that is determined to be incorrect. (Government Code, Sections 552.021, 552.023, 559.004.) If you would like HHSC to correct information about you that is incorrect, please contact your local eligibility determination office.

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

Email Address	Veteran Fax Number
VD@cdsintexas.com	210-640-3913

JotForm Link
https://dsswtx.jotform.com/kjeffrey/va-timesheet-upload

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 Svcs HM - Homemaker Svcs HOS - Hospital/Medical Facility ES - Escort Svcs RS - Respite Svcs

Veteran Name:

Employee Name:

Month:

Pay Period #

Part 1

Date of month	Service Type	Time In	Time Out	Time In	Time Out	Total Hrs	Comment / Daily Task
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
					Total Pay Period Hours		

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

NOTE: no more than **40 hours** in any one work week, unless you are exempt status. To track, circle date a work week begins (Sun) and date it ends (Sat).

USE 24 HOUR TIME

8:00 AM = 8:00 or 0800
8:00 PM = 20:00 or 2000

Noon = 12:00
1 PM = 13:00
2 PM = 14:00
3 PM = 15:00
4 PM = 16:00
5 PM = 17:00
6 PM = 18:00
7 PM = 19:00
8 PM = 20:00
9 PM = 21:00
10 PM = 22:00
11 PM = 23:00
12 AM = 00:00
12:01 AM = 00:01
12:30 AM = 00:30
1 AM = 01:00

Employer and Employee hereby certify that the work hours listed above and service notes included are accurate, that the services provided are in accordance with the current tasks authorized and the serivces 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 result in dismisal from the program and criminal prosecution.

Veteran/DR Signature **Date**

Employee Signature **Date**

Semi-Monthly

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

CDS in Texas

Employer Name:	

Employee Name:	

Veteran - Directed Home - Service Notes (Required)

Service Date	Written/Narrative Summary of Services Provided

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 Svcs HM - Homemaker Svcs HOS - Hospital/Medical Facility ES - Escort Svcs RS - Respite Svcs

Veteran Name:

Month:

Employee Name:

Pay Period #

NOTE: no more than **40 hours** in any one work week, unless you are exempt status. To track, circle date a work week begins (Sun) and date it ends (Sat).

Part 2

Date of month	Service Type	Time In	Time Out	Time In	Time Out	Total Hrs	Comment / Daily Task
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
					Total Pay Period Hours		

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

USE 24 HOUR TIME
8:00 AM = 8:00 or 0800
8:00 PM = 20:00 or 2000

Noon = 12:00
1 PM = 13:00
2 PM = 14:00
3 PM = 15:00
4 PM = 16:00
5 PM = 17:00
6 PM = 18:00
7 PM = 19:00
8 PM = 20:00
9 PM = 21:00
10 PM = 22:00
11 PM = 23:00
12 AM = 00:00
12:01 AM = 00:01
12:30 AM = 00:30
1 AM = 01:00

Employer and Employee hereby certify that the work hours listed above and service notes included are accurate, that the services provided are in accordance with the current tasks authorized and the serivces 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 result in dismisal from the program and criminal prosecution.

Veteran/DR Signature **Date**

Employee Signature **Date**

Semi-Monthly

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

CDS in Texas

Employer Name:	

Employee Name:	

Veteran - Directed Home - Service Notes (Required)

Service Date	Written/Narrative Summary of Services Provided

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%
TOTAL Employer Cost Rate*	**10.95%**

*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.

	X		=	

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

REIMBURSEMENT REQUEST FORM

This section to be completed by participant/ or guardian/ or representative

Participant Name:________________________________ **Date of Receipt:** ______________

Pay to:________________________________ **Date Submitted:** ______________

Name of person Submitting request:________________________________ **Amount requested: $**______________

Description of purchase: ________________________________

____

____

PLEASE ATTACH RECEIPT.

This section for CDS office use only

Approved by ________________________ **DATE**__________

Processed by: ________________________ **DATE**__________

CHECK # ____________ **AMOUNT $**______________ **DATE**__________

____ **ENTERED IN BUDGET** **PLAN YR**__________-__________

____ **ENTERED IN A/P**

MAILING ADDRESS:

____ **CHECK or DD info** ________________________

NOTES: ________________________ ________________________

____

Billing

Billing Date: ________________ **Bill amount:** ________________

6243 IH-10 West, Suite 430 ♦ San Antonio, Texas 78201
Phone: 210-798-3779 toll free: 866-675-7331 ♦ Fax: 210-733-3119 toll free 877-726-5896

Fill in as appropriate

CDS in Texas

PAYROLL CHANGE / WAGES & BENEFITS / OTHER CHANGES	EFFECTIVE DATE (req'd)

Employee name: ______________________ Hire Date: ______________

Last 4 digits of Social Security # ______________________

REASON FOR CHANGE **(Please check one or more pertinent boxes)**

ADDRESS CHANGE	☐	RESIGNATION	☐
NAME CHANGE	☐	RETIREMENT	☐
NEW HIRE	☐	DISCHARGE	☐
INCREASE - ATTENDANT	☐	LAYOFF	☐
INCREASE - RESPITE	☐	OTHER	☐
PAY DECREASE	☐		

REQUIRED ON ALL DISCHARGES: LAST DAY WORKED: ______________

REASON FOR DISCHARGE: ______________________

ELIGIBLE FOR REHIRE? YES ☐ NO ☐

ADDITIONAL COMMENTS: ______________________

NEW ADDRESS & PHONE NUMBER CHANGE

Street: ______________________

City, State Zip: ______________________

Primary Telephone Secondary Telephone:

CHANGE	EMPLOYEE NAME/ POSITION OR PAY CHANGE	
	From	To
NAME CHANGE:		
PAY - PAS		
PAY - RESPITE		
PAY - Other: ________		

Client Name: ______________________

Employer Signature: ______________________ ______________

(OR DESIGNATED REPRESENTATIVE) DATE