Attendant
Employment Documents

The following is an example of what needs to be completed on the Attendant Hire Packet. Everything that is highlighted in

Yellow

Is for the completion / signature of the attendant.

Everything that is highlighted in

Turquoise

Is for the completion / signature of the EOR.

Everything that is highlighted in

Pink

Is for a notary to complete.

Information in red ink will be the fields that have been pre-populated by PPL.

Notations made in green ink are informational.

PCG | Public Partnerships

Supporting Choice. Managing Costs.™

AGREEMENT BETWEEN EMPLOYER AND ATTENDANT ("Employee")

Name of Consumer: Last First Consumer ID: 123456789123

Name of Employer of Record: Last, First

Name of Attendant: Last, First Attendant ID: E012345

Attendant Address: Street, City, Zip

Attendant Phone: BEST PHONE NUMBER FOR YOUR ATTENDANT – CELL?

Attendant E-mail Address: BEST E-MAIL FOR YOUR ATTENDANT

☞ **NOTE**: **The Attendant and Employer of Record (EOR) must fill out this form completely. Please contact PPL Customer Service if any pre-filled information is incorrect.**

SECTION 1: TO BE COMPLETED BY ATTENDANT:

Are you the spouse of the Consumer?	□ Yes	□ No
Are you the parent of the Consumer?	□ Yes	□ No
Are you at least 18 years of age?	□ Yes	□ No

This agreement is made as of MM/DD/YYYY (DATE) between the Employer of Record (EOR) and the Attendant to establish the responsibilities of the parties to each other. As the Attendant, I recognize my employment is contingent upon the Consumer's enrollment in the Virginia Consumer-Directed Services Program. When the Consumer is no longer enrolled in the Consumer-Directed Services Program, I may no longer be employed by that Consumer and wages no longer will be payable under the Virginia Consumer-Directed Services Program.

SECTION 2: TO BE COMPLETED BY the EMPLOYER OF RECORD:

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

The Attendant will be compensated for services at the hourly rate of ~~$8.86 ROS ~or~ $11.47~~ **$9.04 ROS ~or~ $11.70 NOVA** NOVA. The hourly rate is subject to adjustment as determined by the Virginia Department of Medical Assistance Services (DMAS) in accordance with rates established by the Virginia General Assembly.

If the Attendant is unable to work at a scheduled time, she/he shall notify the Employer at least 24 hours in advance, to allow the Employer time to find an alternative. If the Attendant knowingly will be late for work, she/he will call the Employer. In case of emergency that

unexpectedly will delay or deter the Attendant from work, the Attendant will notify the Employer at the earliest possible opportunity.

If the Employer needs to change a scheduled time, the Employer agrees to notify the Attendant at least 24 hours in advance.

SECTION 3: TO BE READ AND UNDERSTOOD BY ATTENDANT and EMPLOYER OF RECORD:

In order to fulfill the terms of my employment as the Attendant, I understand and agree to the following:

Basic Qualifications:

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

Background Checks and Communications:

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

Reporting Abuse and Neglect:

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

Reporting of Incidents in Service Implementation:

12. I agree to immediately report to my Consumer's Services Facilitator any error in service/support implementation; all incidents or events involving personal injury, illness, or medical emergency; or any other incident or event that would be described as unusual.

Requirements:

13. I agree to be approved as an Attendant prior to providing and being paid for any services under this DMAS program and/or the Commonwealth Coordinated Care (CCC) program, and to complete and submit all required paperwork correctly.
14. I agree to take part in any meetings requested by and/or regarding the Consumer.
15. I agree to review any/all updates to the program, time schedules or procedures made available to me by my Employer.
16. I understand that in consideration of the above stated agreement, I shall be compensated through this program for only those services approved by my Employer and authorized in the Consumer-Directed Services Program.
17. I understand and acknowledge that wages are from federal and state funds. Any untruthful submission of services provided in an attempt to obtain improper payment is subject to investigation as Medicaid Fraud. Medicaid Fraud is a felony and can lead to substantial penalties and/or imprisonment.
18. I understand Federal Income Tax, and Medicare, Social Security and Virginia Income Tax (as applicable), will be withheld from my wages per IRS Form W-4 and Virginia Form VA-4. I also understand that garnishments, support orders, liens, and processing fees could be withheld from my pay.
19. I agree to maintain confidential all information and discussions regarding the Consumer and to respect the Consumer's privacy. This includes but is not limited to the use of social media.
20. I will not use the Consumer's property, including the telephone and computer, for my personal use.
21. The ATTENDANT AND EMPLOYER understand the following requirements:
    a. EDCD Waiver Program – The Attendant may not be the parent of a minor child or the spouse of the individual who is receiving waiver services, or a family caregiver who is directing the care of the individual receiving waiver services.
    b. IFDDS, ID, and CMH Waiver Programs or the EPSDT program – The Attendant may not be the parent of minor children, or the spouse, or a paid caregiver of the individual who is receiving waiver services.
    c. The Attendant understands that he/she may not be paid for services furnished if he/she is another family member/caregiver living under the same roof unless there is objective written documentation by the Services Facilitator explaining why no other attendants are available to provide the care.

Attendant Initials _____

d. Attendant care services may not be provided to other people in the Consumer's household unless they also are eligible for Medicaid authorized Consumer-Directed Services.
e. Simultaneous sharing of the Attendant (i.e., caring and billing for two Consumers by one Attendant at the same time) is not allowed.
f. If the attendant has not provided care in over 12 months of not working for the EOR, the attendant will need to complete new paperwork with PPL. This will include new background checks.

Timesheets and Payment:

22. Timesheets must be accurately completed and signed by the Employer and the Attendant. Hours recorded on the timesheet cannot exceed the authorized number of hours.
23. Timesheets are due at PPL by 5:00 p.m. Eastern Time two (2) business days after the end of the pay period. Timesheets received by PPL more than two (2) business days after the end of the pay period will be paid within the next payroll cycle.
24. Timesheets submitted electronically are due before 5:00 p.m. Eastern Time on the Tuesday following the end of the pay period.
25. Incorrect timesheets will be returned and no paycheck will be issued until the timesheet is corrected and resubmitted, at which point the paycheck will be issued in the next regular payroll cycle.
26. Incorrect or missing paperwork will delay payment and a paycheck will not be issued.
27. The Consumer may be required to pay the Attendant a patient pay. If so, both parties understand that this dollar amount will not be included in the payment made by PPL. PPL will, however, withhold applicable taxes on this amount. The Consumer is responsible for reimbursing the Attendant for the patient pay portion.
28. All DMAS-approved wages are paid by PPL through Electronic Funds Transfer (EFT).

Employment Understanding:

29. We understand and acknowledge that PCG Public Partnerships, LLC is NOT the Employer, and that DMAS, the Medicare Medicaid Plans (MMPs) or any other entity involved with the Consumer-Directed Services Program, also is NOT the Employer.
30. We understand that the Consumer or his/her appointed representative (Employer of Record) is the Employer.
31. The Attendant is a Domestic Worker and not offered Workers' Compensation insurance. (Under Code of Virginia Section 65.2-100 Section 2f, domestic service employees are not eligible for Worker's Compensation insurance.)
32. The EOR agrees to provide training and to direct the Attendant in providing services that are within the Consumer's Service Plan.
33. We understand that timesheets and paychecks will be processed by PPL. PPL is a Financial Management Service (FMS) Organization only, and it is not able to pay for any services that are not authorized by DMAS, the MMP or the service authorization contractor; nor for any services provided during periods of Medicaid or waiver ineligibility; nor for any request that exceeds the Consumer's Service Authorization.

34. We understand that the Attendant will not be paid under the Consumer-Directed Services Program for any work performed over the amount authorized by DMAS or the MMP or performed for a Consumer who is not approved for the Long-Term Care waiver for Consumer-Directed Services. In this case, the Attendant will need to seek payment directly from the Employer. This includes when a Consumer is hospitalized, or in a nursing or other medical facility.
35. We understand payments are authorized by the Commonwealth of Virginia DMAS or the MMP and that the Attendant will not be compensated by DMAS or the MMP for hours or work performed in excess of the authorized amount. Authorized hours are approved for the Consumer prior to the Attendant's employment.
36. This agreement does not guarantee employment or payment of wages for any time period.

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

By signing below, we attest that we have read this agreement in its entirety. We understand each of us must sign and return this entire Agreement as a condition of employment in this program, and that the Attendant cannot begin working until this entire agreement is completed and returned to PPL. In addition, the Attendant acknowledges having completed and returned all forms in the Attendant Enrollment Forms Packet, and the EOR acknowledges having completed and returned all forms in the Employer of Record Enrollment Forms Packet, before the Attendant may perform work within the program for which he or she can be paid. We further attest, by signing below, that we understand what is being requested of us, and we agree to abide by these terms and conditions. We further understand and agree that violation of any of the terms and/or conditions of this agreement may result in termination of this agreement and employment, including payment for services provided to any individual in this program who is receiving Medicaid.

Attendant/Employee Signature Date

Employer of Record Signature Date

☞ **IMPORTANT:** *Before this Agreement can be submitted to PPL*: **All blanks MUST be filled in. Both the Attendant and the Employer MUST sign and date** this Agreement. **The Attendant MUST sign his/her initials at the bottom of each page** of this Agreement, **on the lines indicated**.

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

START HERE. **Read instructions carefully before completing this form. The instructions must be available during completion of this form.**
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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

Last Name (*Family Name*)	First Name (*Given Name*)	Middle Initial	Other Names Used (*if any*)
Aide	Jane		

Address (*Street Number and Name*)	Apt. Number	City or Town	State	Zip Code
2222 Grace St		Richmond	VA	11111

Date of Birth (*mm/dd/yyyy*)	U.S. Social Security Number	E-mail Address	Telephone Number
07/03/95	- -		

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

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

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

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

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

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

Foreign Passport Number: _____

Country of Issuance: _____

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

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date (*mm/dd/yyyy*):

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

I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator:		Date (*mm/dd/yyyy*):
Last Name (*Family Name*)	First Name (*Given Name*)	

Address (*Street Number and Name*)	City or Town	State	Zip Code

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

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

Employee Last Name, First Name and Middle Initial from Section 1:

List A OR Identity and Employment Authorization	List B Identity	List C AND Employment Authorization
Document Title:	Document Title: VA Drivers License	Document Title: Soc. Sec. Card
Issuing Authority:	Issuing Authority: State of VA	Issuing Authority: Social Security Administration
Document Number:	Document Number: T1023456	Document Number: 111-11-1111
Expiration Date *(if any)(mm/dd/yyyy)*:	Expiration Date *(if any)(mm/dd/yyyy)*: 12/31/2020	Expiration Date *(if any)(mm/dd/yyyy)*: N/A
Document Title:		
Issuing Authority:		
Document Number:		
Expiration Date *(if any)(mm/dd/yyyy)*:		
Document Title:		
Issuing Authority:		
Document Number:		
Expiration Date *(if any)(mm/dd/yyyy)*:		

3- Do

The above information is factious ~ used as an example to show you how PPL would like the form completed. It is highlighted in turquoise for the EOR to complete, however remember it is the information of the attendant. You should not make copies of the attendant's identification.

D Barcode Not Write in This Space

Certification

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

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

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
		Managing Employer

Last Name *(Family Name)* First Name *(Given Name)*	Employer's Business or Organization Name
	EOR's NAME

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	Zip Code
CONSUMER/EOR ST ADDRESS	CITY		ZIP CODE

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

A. New Name *(if applicable)* Last Name *(Family Name)* First Name *(Given Name)* Middle Initial	**B.** Date of Rehire *(if applicable) (mm/dd/yyyy)*:

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

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

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

Signature of Employer or Authorized Representative:	Date *(mm/dd/yyyy)*:	Print Name of Employer or Authorized Representative:

Form W-4 (2014)

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

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2014 expires February 17, 2015. See Pub. 505, Tax Withholding and Estimated Tax.

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

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

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

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

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

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

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity iincome, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

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

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2014. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

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

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A** _____
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less. . . .	**B** _____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C** _____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D**
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . .	**E**
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit . . . (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F**
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $65,000 ($95,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to six eligible children or **less** "2" if you have seven or more eligible children. • If your total income will be between $65,000 and $84,000 ($95,000 and $119,000 if married), enter "1" for each eligible child . . .	**G** _____
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▫	**H** _____

For accuracy, **complete all worksheets that apply.**

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

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

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▫ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074
2014

1 Your first name and middle initial: Attendant First Name	Last name: Attendant Last Name	**2** Your social security number
Home address (number and street or rural route): Attendant's Street Address	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code: Attendant's City, State, Zip	**4** If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▫ ☐	
5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)		**5**
6 Additional amount, if any, you want withheld from each paycheck		**6** $
7 I claim exemption from withholding for 2014, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ▫		**7**

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

Employee's signature
(This form is not valid unless you sign it.) ▫ **Date** ▫

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

FORM VA-4

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF TAXATION

PERSONAL EXEMPTION WORKSHEET

(See back for instructions)

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

Detach here and give the certificate to your employer. Keep the top portion for your records

FORM VA-4 EMPLOYEE'S VIRGINIA INCOME TAX WITHHOLDING EXEMPTION CERTIFICATE

Your Social Security Number	Name **Attendant Name**	
Street Address **Attendant Street Address**		
City **Attendant's City**	State **VA**	Zip Code **Attendant's Zip**

COMPLETE THE APPLICABLE LINES BELOW

1. If subject to withholding, enter the number of exemptions claimed on:
   - (a) Subtotal of Personal Exemptions - line 4 of the Personal Exemption Worksheet..... _____
   - (b) Subtotal of Exemptions for Age and Blindness line 7 of the Personal Exemption Worksheet..... _____
   - (c) Total Exemptions - line 8 of the Personal Exemption Worksheet..... _____
2. Enter the amount of additional withholding requested (see instructions)..... _____
3. I certify that I am not subject to Virginia withholding. I meet the conditions set forth in the instructions ..... (check here) ☐
4. I certify that I am not subject to Virginia withholding. I meet the conditions set forth Under the Service member Civil Relief Act, as amended by the Military Spouses Residency Relief Act ..... (check here) ☐

2601064 Rev. 08/11

Signature _____ Date _____

EMPLOYER: Keep exemption certificates with your records. If you believe the employee has claimed too many exemptions, notify the Department of Taxation, P.O. Box 1115, Richmond, Virginia 23218-1115, telephone (804) 367-8037. Note: Employers may establish a system to electronically receive Forms VA-4 from employees, provided the system meets Internal Revenue Service requirements as specified in § 31.3402(f)(5)-1(c) of the Treasury Regulations (26 CFR).

PCG | Public Partnerships

Supporting Choice. Managing Costs.™

Application for Tax Exemptions Form

State Worked: Virginia Program: Virginia Consumer-Directed Services Program

Consumer Name: Consumer's Name Employer Name (EOR): EOR's Name

Employee Name: Attendant's Name Employee Date of Birth: 07 / 03 / 1995

Please fill out this form completely (instructions are found in your **Attendant Welcome Packet**). PCG Public Partnerships, LLC (PPL) will determine the tax exemptions that apply based on the information you provide.

☞ **IMPORTANT**: **Answer all of the following questions based on your relationship to the Employer of Record (EOR):**

1. ***Are you a non-resident alien temporarily in the United States on an F-1, J-1, M-1, or Q-1 visa admitted to the US for the purpose of providing domestic services?***
   ____Yes, that description fits my status. ____No, that description does not fit my status.

2. ***Are you the child of the employer (includes adopted children)?***
   ____Yes, my employer is my parent (mother or father). ____No, my employer is not my parent.

3. ***Are you the spouse of the employer?***
   ____Yes, my employer is my spouse (husband or wife). _____No, my employer is not my spouse.

4. ***Are you the parent of the employer (includes adopted children)?***
   ____Yes, my employer is my child (son or daughter). ____No, my employer is not my child.

5. ***If you answered "Yes" to Question 4, check any of the following that apply. If you answered "No," proceed to Question 6.***
   ____Yes, I also provide care for my grandchild or step-grandchild in my child's home.
   ____Yes, my grandchild or step-grandchild is under age 18, or has a physical or mental condition that requires personal care of an adult for at least four consecutive weeks during the calendar quarter in which services are performed.
   ____Yes, my child (son or daughter) is widowed or divorced and not remarried, or living with a spouse who has a mental or physical condition that prohibits the spouse from caring for my grandchild for at least four consecutive weeks during the calendar quarter in which services are performed.

6. ***Are you under the age of 18 or do you turn 18 during this calendar year?***
   ____Yes, I am under 18 or am turning 18 during this calendar year. ____No, I am over 18.

   If you answered "Yes" to Question 6, answer the following question. If you answered "No", skip this section.

   Is the job of performing household services (respite or nursing) your principal occupation? Note: Do not answer "Yes" if you are a student.

   ____Yes, performing household services is my principal occupation. ____No, performing household services is not my principal occupation, or I am a student.

☞ **IMPORTANT: You must notify PCG Public Partnerships, LLC if your status changes regarding any of the questions on this form.**

Employee Signature: _____ Date: _____/_____/_____

SP-167 (Revised 12-01-2012)

CRIMINAL HISTORY RECORD NAME SEARCH REQUEST

PURPOSE OF THIS REQUEST (Check only one):

☐ DOMESTIC ADOPTION ☐ INTERNATIONAL ADOPTION _____ COUNTRY

☐ VISA (INTERNATIONAL TRAVEL) ☒ OTHER (please specify) Employment Screening

NAME INFORMATION TO BE SEARCHED:

LAST NAME	FIRST NAME	MIDDLE NAME	MAIDEN NAME
Attendant Last Name	Attendant First Name		

RACE	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER
White or Caucasian	Female	07 / 03 / 1995 (MM/DD/YYYY)	

AFFIDAVIT FOR RELEASE OF INFORMATION:

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

_____ Signature

State of _____ County City of _____; to wit: Subscribed and sworn to before me _____ (MM/DD/YYYY)

_____ My commission expires: _____ My registration # is: _____

Signature of Notary Public

SIGNATURE OF PERSON MAKING REQUEST:

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

_____ Signature of Individual Making

Request State of _____ ☐ County ☐ City of _____; to wit: Subscribed and sworn to before me on: _____ (MM/DD/YYYY)

_____ My commission expires: _____ My registration # is: _____

Signature of Notary Public

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

Mail Reply To:

NAME
PCG Public Partnerships, LLC.

ATTENTION
Criminal Background Department

ADDRESS
4991 Lake Brook Drive Suite G90

CITY Glen Allen STATE VA ZIP CODE 23060

PPL is the party requesting this background check, & they are responsible for the cost associated with it. Please leave these areas blank.

FEES FOR SERVICE:

☐ $15.00 CRIMINAL HISTORY SEARCH
☐ $20.00 COMBINATION CRIMINAL HISTORY & SEX OFFENDER SEARCH

* FEES For Volunteers with Non-Profit Organizations:
☐ $8.00 CRIMINAL HISTORY SEARCH
☐ $16.00 COMBINATION CRIMINAL HISTORY & SEX OFFENDER SEARCH

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

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

☐ Business or Certified check or Money order (payable to Virginia State Police)

CHARGE CARD: ☐ MasterCard OR ☐ Visa

Account Number: - - - Expiration: /

Signature of Cardholder: _____

Mail Request To:

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

ATTN: NEW FORM

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

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

☐ No Conviction Data – Does Not Preclude the Existence of an Arrest Record
☐ No Criminal Record – Name Search Only ☐ No Criminal Record – Fingerprint Search
☐ No Sex Offender Registration Record ☐ Criminal Record Attached

Purpose code: ☐ C N O ☐ ☐

Date: _____ By CCRE/ _____

VA Department of Social Services
Office of Background Investigations – Search Unit
801 East Main Street, 6th Floor, Richmond, VA 23219-2901

Central Registry Release of Information Form

PurposeofSearch.Checkone: ☐ Adam Walsh Law ☐ Adoptive Parent ☐ Babysitter/Family Day Care
☐ CASA ☐ Children's Residential Facility ☐ Custody Evaluation ☐ Day Care Center ☐ Foster Parent
☐ Institutional Employee ☐ Other Employment ☐ School Personnel ☐ Volunteer ☒ Other

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

Name	Public Partnerships, LLC				**Payment/FIPS Code (Use only if assigned by OBI-CRU)**
Address	4991 Lake Brook Drive, Suite G90				
City	Glen Allen	**State**	VA	**Zip** 23060	**Mandatory if agency code has been assigned**
Contact Name		**Tel.#**		**Ext.**	
Contact E-Mail					

PART I: DETAILS OF INDIVIDUAL WHOSE NAME MUST BE SEARCHED

Last Name	First Name	Full Birth Middle Name – no initials (if middle name is an initial, indicate "Initial Only")
Attendant Last Name	Attendant First Name	

Maiden Name	Sex	Date of Birth **(MM/DD/YYYY)**	Race
	☐ Male ☒ Female	07/03/95	White or Caucasian

Social Security Number	Driver's License Number or ID #	Other names used (nicknames, previous married names, etc.)

Current Address (Include Street # and Apt #)	City	State	Zip
Attendant's Street Address	City	VA	Zip

Applicant's Prior Addresses

Include Street # and Apt #	City	State	Zip	Start Date **(MM/YY)**	End Date **(MM/YY)**

Marital Status __ Single __ Married __ Divorced __ Widowed
If married, list current spouse. If previously married, list all previous spouses. If you have never been married, write 'N/A'.

Last Name	First Name	Middle Name	Maiden Name	Race	Sex	Date of Birth **(MM/DD/YYYY)**
					☐ Male ☐ Female	
					☐ Male ☐ Female	
					☐ Male ☐ Female	

List all of your children. If you have none, write **'N/A'.** Include all adult children, step and foster children not living with you.

Last Name	First Name	Full Middle Name	Relationship	Sex	Date of Birth **(MM/DD/YYYY)**
				☐ Male ☐ Female	
				☐ Male ☐ Female	
				☐ Male ☐ Female	

VA Department of Social Services **Central Registry Release of Information Form**
Office of Background Investigations – Search Unit
801 East Main Street, 6th Floor, Richmond, VA 23219-2901

PART II: CERTIFICATION AND CONSENT FOR RELEASE OF INFORMATION

I hereby certify that the information contained on this form is true, correct and complete to the best of my knowledge. Pursuant to Section 2.2-3806 of the *Code of Virginia*, I authorize the release of personal information regarding me which has been maintained by either the Virginia Department of Social Services or any local department of social services which is related to any disposition of founded child abuse/neglect in which I am identified as responsible for such abuse/neglect. I have provided proof of my identity to the Notary Public prior to signing this in his/her presence.

_____ _____

Signature of person whose name is being searched.
(Sign in presence of Notary)

Parent or Guardian signature required for minor children under the age of 18

PART III: CERTIFICATE OF ACKNOWLEDGEMENT OF INDIVIDUAL

City/County of _____

Commonwealth/State of _____

Acknowledged before me this _____ day of _____, year _____

_____ _____

Notary Public Signature **Notary Number**

My Commission Expires: _____

PART IV: CENTRAL REGISTRY FINDINGS – COMPLETED BY CENTRAL REGISTRY STAFF ONLY

1. We are unable to determine at this time if the individual for whom a search has been requested is listed in the Central Registry. Please answer the following questions and return to the Central Registry Unit in order for us to make a determination:

_____
_____
_____
_____
_____

Worker: _____ Date: _____

2. _____ Based on information provided by the Local Department of Social Services, we have determined that _____ is listed in the Child Abuse/Neglect Central Registry with a founded disposition of child abuse/neglect. For more detailed information, contact the

_____ Dept. of Social Services in reference to referral _____ phone# _____

_____ Dept. of Social Services in reference to referral _____ phone# _____

3. _____ As of this date, based on the information provided, the individual whose name was being searched is **NOT** identified in the Central Registry of Child Abuse/Neglect.

Signature of worker completing search: _____ Date: _____

OBI Staff Only

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

Section 1

CREATE OR CHANGE PPL EFT ACCOUNT CLOSE EXISTING PPL EFT ACCOUNT

Check the appropriate box below based on your request.

☐ New Direct Deposit Set-up ☐ Change Account Number ☐ Cancellation Request

☐ Change Account Type ☐ Change Financial Institution

Section 2

PAYEE INFORMATION

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

1 Federal Employer Identification No. (EIN) ☐☐-☐☐☐☐☐☐☐☐☐ ⇦ EIN

OR

2 Social Security Number (SSN) XXX-XX-4825 ⇦ SSN

Attendant Name

3 Payee Name | 4. Telephone Number

Attendant's Street Address

5 Payee Address

Attendant's City | VA | Zip

6 City | 7 State | 8 Zip

Section 3

AUTHORIZATION FOR SET-UP, CHANGE OR CANCELLATION

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

9 Signature (Required) | 10 Title | 11 Date

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

Section 4

ACCOUNT DETAIL INFORMATION

12 Financial Institution Name (My Bank's Name)

13 Bank Address

14 Bank Routing Number ☐☐☐☐-☐☐☐☐☐

15 Account Type ☐ Checking ☐ Savings ☐ Your Debit Card

Must Attach a Voided Check. This cannot be a Starter Check

16 My Account Number

Section 5

CANCELLATION

Cancellation Reason

PPL Use ONLY

Staff Entry:

Date:

MAIL COMPLETED FORM TO: Virginia Programs, PCG Public Partnerships, LLC, 4991 Lake Brook Drive, Suite G90, Glen Allen, VA 23060

PCG Public Partnerships, LLC (PPL) - Virginia DMAS Programs

MONEY NETWORK® ACCOUNT FORM

(For creating or canceling a Money Network Account)

Section 1

The Money Network® Account gives you a fast, safe and convenient way to receive your pay electronically, withdraw or transfer your funds, and make purchases. This direct-deposit account comes with the **Money Network® Debit Card** and **Money Network® Checks.** The **Money Network® Debit Card** ("Card"): 1.) Eliminates waiting for your paycheck in the mail, or paying for it to be cashed; 2.) Allows immediate access to ATM cash withdrawals, bank-branch withdrawals, and store purchases (including "cash back") wherever Money Network Cards are accepted; 3.) Enables money transfers to a personal or joint checking account; and 4.) Permits free balance inquiries by phone. Once you are enrolled in the VA DMAS Program, you are automatically eligible to have the Card. There is no monthly service charge for the Card as long as you are employed for an Employer in a VA DMAS Program. Many Card transactions are free of charge. All of the transaction fees are listed in the Money Network Services Welcome Packet that will be sent to you. You can use **Money Network® Checks** to pay bills, transfer money from your Money Network Account into your personal bank accounts, or cash at Money Network check-cashing partners. There are no fees for using Money Network Checks. Details are found in the Money Network Services Welcome Packet that will be sent to you.

Section 2

PAYEE INFORMATION

Disclosing your Social Security Number (SSN) is voluntary pursuant to 42 USC 405c2C. PPL needs your SSN to file with the IRS.

Social Security Number (SSN) X X X - X X - 4 8 2 5 ⇦ SSN

Attendant's Name | **Telephone Number**

Payee Name (Name of Attendant)

Attendant's Street Address

Payee Address (Must be the physical address where you live - P.O. Box is not accepted)

Attendant's City | VA | Zip

City **State** **Zip**

Section 3

ACCOUNT AUTHORIZATION

I authorize PPL to process payments owed to me for services authorized by a VA DMAS Program in the Commonwealth of Virginia. Per my request, PPL will deposit my payment directly to my Money NetworkAccount. I recognize that if I fail to provide complete and accurate information on this form, processing may be delayed or made impossible, or my electronic payments may be erroneously made. I certify I have read and agree to comply with PPL rules governing payments and electronic transfers. I authorize PPL to withdraw from the designated account all amounts deposited electronically in error. If the designated account is closed or has an insufficient balance to allow withdrawal, then I authorize PPL to withhold any payment owed to me by PPL until the erroneous deposited amounts are repaid. If I decide to change or revoke this authorization, I recognize that I must forward such notice to PPL. **I further authorize PPL** to stop making electronic transfers to my account without advance notice. I certify that I am authorized to receive deposits per this agreement, and that all information provided is accurate.

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

s

☐ I wish to cancel an existing Money Network Account

State reason for cancellation.

PPL Use ONLY
Staff Entry:
Date:

☐ **I do not have access to the PPL Web Portal. Please mail my pay stubs to me.**

Thing to remember about new attendant packets.....

- ✓ The criminal history background check MUST be notarized along with the central registry name check. PPL will take care of all charges associated with this.

- ✓ It is advisable that you keep a copy of your attendant's information.

- ✓ Remember PPL must have the ORIGINAL attendant paperwork. They cannot accept copies. You cannot fax your attendant's information to PPL.

- ✓ The Direct Deposit From MUST have a voided check attached. This cannot be a deposit slip or a starter check. If your attendant does not have a check available, their bank can provide a form (must be on the bank's letterhead) stating your attendant's name, account number and routing number. Your attendant also has the option of having their pay placed on a debit card that PPL will provide, or if they currently have one they would like to use.