CONSUMER DIRECT CARE NETWORK WISCONSIN

Welcome!

Welcome to self-directed services! We are the Consumer Direct Care Network (CDCN). CDCN encourages people to have more control and choice over the services they receive. We want you to live the life that you want. People who self-direct their services report being happier with the services they receive. They also like the freedom they have as a result.

If you are receiving this package, CDCN was given a referral in your name from either your Managed Care Organization or your County Waiver Agency to enroll you as part of self-directed services. CDCN will act as your Fiscal Agent as part of your self-directed services.

Before services can start and payment can be made to your worker(s) we need you and the employees to complete the paperwork enclosed. You will need to complete and return the Member Enrollment Packet and the Employee (caregiver) Enrollment Packet. You should have received a phone call from your assigned Service Coordinator. If you need assistance in completing these packets or have any other questions, please call or email us. Attached to this information is the card of your assigned Service Coordinator.

We look forward to serving you!

Next Steps:

- You recruit employees.
- You and your prospective employee(s) complete and return an Employee Packet to CDCN.
- CDCN reviews the Employee Packet.
- You and your employee receive an *Okay to Work* notice from CDCN with employee start date.
- Employee receives email from Sandata with Electronic Visit Verification (EVV) IDs.
- Employee submits and you approve their time worked by using Sandata EVV.
- **Employees who live with the member and employees of child members will not use EVV.**
- For non-EVV caregivers, employee submits and you approve their time worked using a paper timesheet or the CDCN web portal.

Do you still have questions? We are happy to help! Below is our contact information.

CDCN Phone Line 877-785-9991
CDCN Fax Line (Forms) 877-785-9992
CDCN Email (Forms/Correspondence) ..... InfoCDWI@ConsumerDirectCare.com
CDCN Web (Forms/Instructions/Training Materials) ..... www.ConsumerDirectWI.com
CDCN Web Portal (Pay Information/Time Approval) ..... https://MyDirectCare.com/

Office Location/Mailing Address
CDCN Wisconsin
744 Ryan Drive, Suite 201
Hudson, WI 54016-7984

This PDF document is optimized for use in Adobe Acrobat. Completion in a browser such as Chrome, Firefox, or Edge is not recommended.

This document is designed for double-sided paper printing.

Reset/clear all fields > Clear Form

CONSUMER DIRECT CARE NETWORK

MEMBER DATA FORM

Member/Employer of Record (EOR) Information

Name on Social Security Card _____ _____ _____
First *Middle* *Last*

Name in Payer Program _____ _____ _____
First *Middle* *Last*

Member Physical Address _____
(Street address only. No PO Box. This is where service will be provided.)

City _____ **State** WI **Zip** _____ **County** _____

Mailing Address _____ _____ _____ _____
Street/PO Box *City* *State* *Zip*

Phone _____ _____ _____ **Email** _____
Home *Cell* *Fax*

ID # _____ **Gender** ☐ Male ☐ Female **Date of Birth** ____/____/_____

Social Security # _____ - ____ - _____ **Would you like to Opt in to allow text messages with CDWI:** ☐ Yes ☐ No

Authorization Start Date or Reactivation Start Date_____ **Approval for photo usage**: ☐ Yes ☐ No

EVV Method ☐ TVV (Telephonic Visit Verification) ☐ FVV (Fixed Visit Verification) ☐ SMC (Sandata Mobile Connect app)

Prior Employer of Record: ☐ Yes ☐ No – Has someone else previously served as the EOR for the Member?

If yes, Previous EOR Name: _____

Prior Fiscal Agent: ☐ Yes ☐ No – Is Member switching services to CDCN from another Fiscal Agent?

If yes, Agent Name: _____

Prior Accounts: ☐ Yes ☐ No – Does Member/EOR have an existing Sole Proprietor or Household Employer business with established accounts?

If yes, provide prior account information via IRS and/or State agency documentation.

Guardianship: ☐ Yes ☐ No – Will a legal guardian sign tax forms on the Member/EOR's behalf?

If yes, Guardian Name*: _____ ____ _____
First *MI* *Last*

**Attach legal guardianship paperwork*

Managing Party Information *(if applicable)*

Name _____ _____ _____
First *Middle* *Last*

Mailing Address _____ _____ _____ _____
Street/PO Box *City* *State* *Zip*

Phone _____ _____ _____ **Email** _____
Home *Cell* *Fax*

Relationship to Member _____

Approving Entity Information

Approving Entity Name _____ **Program** _____

Case Mgr/Care Coordinator Name _____ **Email** _____

Phone _____ _____ _____
Office *Cell* *Fax*

CONSUMER DIRECT CARE NETWORK

FISCAL EMPLOYER AGENT

MEMBER ENROLLMENT CHECKLIST

Member/FEIN Holder Name	Managing Party Name

Welcome to Consumer Direct Care Network (CDCN)!

Please complete all the forms in the list below including this Member Enrollment Checklist. Check off each item upon completion. Provide original signed documents to CDCN Wisconsin.

Member Enrollment Packet - Mandatory Forms:

1. ☐ Member Data Form
2. ☐ Member Enrollment Checklist (this form)
3. ☐ Fiscal Employer Agent Services Agreement
4. ☐ SS-4 Application for Employer Identification Number
5. ☐ Guardianship papers (submit if applicable)
6. ☐ 2678 Employer/Payer Appointment of Agent
7. ☐ UCT-8291 Employer Power of Attorney Assignment (U/I Division)
8. ☐ Employer Handbook (Receipt acknowledgement. Keep for reference.)

I have reviewed and verified the above forms for completeness and all forms are readable.

Signatures:

CDCN Program Coord. Name	Signature	Date
Managing Party Name	Signature	Date

CONSUMER DIRECT CARE NETWORK

FISCAL EMPLOYER AGENT SERVICES AGREEMENT

This Agreement is between Consumer Direct for Wisconsin, LLC doing business as Consumer Direct Care Network Wisconsin (CDCN) and the following person:

☐ Check here if you are the **Member**.

My name is: _____. I will be directing my services under this Agreement.

☐ Check here if you are the Member's **Managing Party** (MP).

My name is: _____. I will be directing the Member's services under this Agreement.

The Member's name is: _____.

A. Introduction

1. In this Agreement:
   - "Member" refers to the Medicaid recipient approved for self-directed services through Wisconsin's Family Care or Children's Long Term Support programs.
   - "You" refers to the person directing the Member's services, either the Member or the Member's MP.
   - "Party" shall mean either You or CDCN individually. "Parties" shall mean You and CDCN together.
   - "Employee" refers to an individual who is hired by You to provide authorized services to the Member.
   - "Approving Entity" is the Managed Care Organization (MCO) or county that authorizes the Member's services. The Approving Entity is: _____.
2. The Member's care plan and budget, authorized by the Approving Entity, outlines the services and supports the Member uses to maintain independence at home and in the community.
3. Through this agreement, You have chosen CDCN to provide Fiscal Employer Agent (FEA) services. CDCN will provide You with payroll and payroll reporting services, as authorized under IRS Procedure Code 70-6. CDCN will file payroll taxes on the Member's behalf using the Member's Federal Employer Identification Number (FEIN).
4. The Member, through their FEIN, is the Employer of Record (EOR) of Employees. Member/MP will hire, manage and dismiss Employees.

B. Member/MP Responsibilities – You agree to:

1. Complete all the forms required by CDCN for FEA services. This includes federal and state tax forms, unemployment forms and CDCN forms. Failure on your part to provide required information or to submit a complete packet may result in an Employee's wages being delayed or paid by You. You may also have to pay penalty charges.
2. Work with CDCN to:
   - Obtain a Federal Employer Identification Number.

- Inform CDCN of Employee standard rate of pay, including notifying CDCN of pay rate changes in a timely basis.
- Monitor CDCN's monthly tracking reports and not use more service hours than what is approved in the Member's authorized budget.

3. Follow all program rules, CDCN policies, and federal and state employment regulations:
   - Recruit, interview, check references, hire, train, schedule, manage, and dismiss Employees. You will direct day-to-day services and resolve conflicts that arise.
   - Employee cannot be a paid guardian.
   - Employees must receive an *Okay to Work* form from CDCN before an they can start work. You are responsible to pay for wages if they start work before receiving the *Okay to Work* form.
   - Do not discriminate against potential or current Employees for race, creed, color, national origin, sex, age, disability, marital status, sexual orientation, or any other status protected by law. This applies to all employment decisions, including recruitment, hiring, schedule/hour changes, lay off, and dismissal. You accept full responsibility for following equal opportunity laws and requirements so that each Employee is treated fairly and consistently. For example, if You decide to do a criminal background check or reference checks on one Employee, it must be done on all Employees.
   - Do not allow Employees to provide services while the Member is hospitalized or receiving any other Medicaid-reimbursed service; including a doctor visit or staying at a long-term care facility.
4. For Employees who serve an adult Member that they do not live with:
   - Make sure the Employee accurately records each shift worked using Electronic Visit Verification (EVV). You can be held liable for fraudulent EVV time approval.
   - Approve Employee work shifts when the Employee clocks out. Use the Sandata Mobile Connect app, telephone, or a fixed device. Clean time will be paid by the payroll deadlines on the Payroll Calendar. Clean time is shift data that is processed through the Sandata system without CDCN having to perform Visit Maintenance. Contact your local CDCN office immediately for any EVV issues that may delay payment.
5. For Employees who live with the Member or who serve a child Member:
   - Review and approve Employee timesheets. Use paper timesheets or the Web Portal. Follow the CDCN payroll schedule. Make sure hours on the timesheet are true and accurate. You can be held liable for fraudulent time approval.
6. Report to CDCN:
   - Changes to the Employee's name, address or employment status within one (1) working day.
   - Changes to the Member's name, Medicaid eligibility, address, telephone number, hospitalization on a timely basis.

7. Report to appropriate authorities:
    - Suspected abuse, neglect, exploitation, or health risk of the Member to the county Adult or Elder Abuse reporting line.
    - Suspected Medicaid fraud. Reporting contact information is available on our website under the Resources/Fraud Prevention tab.
8. Maintain required Employee trainings for all employees.
9. Appoint a temporary PR if You are not capable or available to direct the Member's care.

C. Member/MP Acknowledgments:

1. Limitations of CDCN Payment Obligation:

    CDCN will not pay for tasks and services that are not authorized on the Member's care plan and budget. You must monitor the Member's budget and not use more service hours or budget amounts than what is approved. You agree to reimburse CDCN for payment of any unauthorized wages and expenses.

    You are responsible to pay for:
    - Unauthorized overtime and services.
    - Overlap of services - two Employees working at the same time
        - If allowed, this request must be approved by the Approving Entity prior to CDCN issuing payment.
    - Services provided while the Member is hospitalized or receiving any other Medicaid-reimbursed service.
    - Employee's wages if they start work before receiving the *Okay to Work* form.
2. I acknowledge receiving the CDCN Employer Handbook.

D. Agency Responsibilities – CDCN agrees to:

1. Provide You with:
    - Member and Employee enrollment packets.
    - Employee training materials and notice of expiration dates on required training.
    - Monthly budget tracking reports.
    - Complaint Process for resolving problems.
2. Perform payroll and accountant tasks for You, including:
    - Pay Employee's wages on a bi-weekly schedule.
    - Process federal and state income tax contributions.
    - Process and file all Employer-related taxes in the aggregate using Member's individual FEIN.
    - Follow all IRS and state reporting guidelines, including obtaining all proper federal and state authorizations for the FEA program.

- Submit all claims for services to the Approving Entity on your behalf.

E. Terms and Conditions

Term and Termination: This Agreement starts when it is signed by You and CDCN. Either Party can end the Agreement at any time. CDCN will follow State Policy and Guidelines when determining if service termination is necessary. If CDCN ends the Agreement, You will be notified by email or regular US mail. You agree that ending the Agreement means services from CDCN will stop.

If termination is due to switching to another FEA, it must be done correctly so the tax transition for Employee records is accurate. The switch must occur at the end of a quarter or calendar year and follow necessary transfer procedures.

Indemnification: You are in the best position to oversee your Employees' actions when they are working for You. Due to this, You agree to indemnify CDCN. This means that if your Employees cause property damages or a legal dispute while working for You, You are responsible for paying any damages and legal fees assessed against CDCN. CDCN is also not responsible for Employees' theft of personal belongings. CDCN is not liable for your Employees' actions and damages incurred.

Partial Invalidity: If part of this Agreement is found to be wrong, it does not mean the whole Agreement is not correct. The rest of the Agreement must be followed.

Arbitration: A dispute about this Agreement is handled by an independent arbitrator at the location of the dispute. Parties will split the cost of the arbitrator. Each Party will handle their own legal fees. Parties may agree to another arbitration process.

State Law: If Parties cannot solve a problem through negotiation or talking about the problem, then Wisconsin laws apply. Any legal action related to this Agreement must be held in the county where CDCN is located.

Modification of Agreement: The Agreement can be changed. Changes must be in writing, signed and dated by both parties.

Timely Notification: Both Parties agree to notify each other in a timely manner about the duties in this Agreement.

Assignment: CDCN may sell, assign or transfer this Agreement to another provider without notice. The new owner will have the same rights, benefits, and duties in this Agreement. If this happens, You will receive written notice about the new owner. Medicaid rules do not allow You to assign this Agreement to someone else.

Modification of Tax Forms: You authorize CDCN to make applicable changes to the Employer of Record's tax forms. These changes will be noted on the Data Form.

Workers Compensation Program: You and your Employee must follow CDCN's safety program rules. If not, work-related injuries may be denied coverage under the Workers' Compensation program.

Waiver of Terms and Conditions: Failure to enforce, failure to exercise the benefit of, or waiving the breach of one or more of the Agreement Terms and Conditions does not mean this action will continue in the future. Going forward, both Parties understand the rights and privileges of the Agreement are in full effect.

Relationship of Parties: In this Agreement CDCN is your Fiscal Employer Agent. The only employment arrangement is between You and your Employee. In this arrangement, You are the Employer of Record where You set the working terms with your Employee. CDCN does not control or direct how You and your Employees perform your duties.

Entire Agreement: This Agreement and other written materials describe the complete understanding between You and CDCN. Any verbal agreements do not apply. All agreements must be put in writing.

F. Conclusion:

This Agreement is between You and CDCN. It is not a contract/guarantee of employment for Employees. CDCN does not control or direct how You or the Employees perform duties and responsibilities. You are the direct (managing) employer and Employer of Record of Employees. You are responsible for recruiting, hiring, training and supervising Employees. You are also responsible for monitoring your approved budget and not overspending.

By signing, the Parties agree to follow the Responsibilities, Limitations of CDCN Payment Obligations, and Terms and Conditions stated above.

Member/MP Name	Signature	Date
CDCN Representative Name	Signature	Date

Form **SS-4**
(Rev. December 2023)
Department of the Treasury
Internal Revenue Service

Application for Employer Identification Number

(For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.)
See separate instructions for each line. Keep a copy for your records.
Go to *www.irs.gov/FormSS4* for instructions and the latest information.

OMB No. 1545-0003

EIN

Type or print clearly.

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

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

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

4a Mailing address (room, apt., suite no. and street, or P.O. box)
100 Consumer Direct Way, Suite 30

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

4b City, state, and ZIP code (if foreign, see instructions)
Missoula, MT 59808

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

6 County and state where principal business is located

7a Name of responsible party

7b SSN, ITIN, or EIN

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

8b If 8a is "Yes," enter the number of LLC members 0

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) HCSR
- ☐ Estate (SSN of decedent) _____
- ☐ Plan administrator (TIN) _____
- ☐ Trust (TIN of grantor) _____
- ☐ Military/National Guard ☐ State/local government
- ☐ Farmers' cooperative ☐ Federal government
- ☐ 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) HCSR
- ☐ Banking purpose (specify purpose) _____
- ☐ Changed type of organization (specify new type) _____
- ☐ Purchased going business
- ☐ Created a trust (specify type) _____
- ☐ Created a pension plan (specify type) _____

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

12 Closing month of accounting year **December**

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
0	0	0

14 If you expect your employment tax liability to be $1,000 or less in a full calendar year **and** want to file Form 944 annually instead of Forms 941 quarterly, check here. (Your employment tax liability will generally be $1,000 or less if you expect to pay $5,000 or less, $6,536 or less if you're in a U.S. territory, in total wages.) If you don't check this box, you must file Form 941 for every quarter. ☐

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) . . . . . N/A

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

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

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

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

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
Mikayla Brinda

Designee's telephone number (include area code)
406-532-8502 ext.

Address and ZIP code
100 Consumer Direct Way, Suite 304, Missoula, MT 59808

Designee's fax number (include area code)
406-532-8588

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)
Home Care Service Recipient

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) HCSR

3 **Trade name** (if any)

4 **Address** 100 Consumer Direct Way, Suite 303-WI

Number Street Suite or room number

Missoula | MT | 59808

City State ZIP code

Foreign country name | Foreign province/county | Foreign postal code

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

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

* Generally, you can't appoint an agent to report, deposit, and pay tax reported on Form 940, unless you're a home care service recipient.

☑ Check here if you're a home care service recipient, and you want to appoint the agent to report, deposit, and pay FUTA tax for you. See the instructions.

I am authorizing the IRS to disclose otherwise confidential tax information to the agent relating to the authority granted under this appointment, including disclosures required to process Form 2678. The agent may contract with a third party, such as a reporting agent or certified public accountant, to prepare or file the returns covered by this appointment, or to make any required deposits and payments. Such contract may authorize the IRS to disclose confidential tax information of the employer/payer and agent to such third party. If a third party fails to file the returns or make the deposits and payments, the agent and employer/payer remain liable.

Sign your name here

Print your name here

Print your title here HCSR - Household Employer

Date / /

Best daytime phone

Now give this form to the agent to complete.

EMPLOYER POWER OF ATTORNEY ASSIGNMENT

Department of Workforce Development
Unemployment Insurance Division
P.O. Box 7942
Madison, WI 53707
Fax: (608) 327-6158

Be Aware That:

_____ (Employer Name), _____ (UI Account #), _____ (FEIN #),

having its main office located at _____ (Street Address, City, State & Zip Code),

_____ (Telephone Number with Area Code) appoints **Consumer Direct Care Network WI - Consumer Direct Fiscal Vendor Agent for WI, LLC** (Name of Representing Company),

located at **100 Consumer Direct Way, Suite 304, Missoula, MT 59808** (Street Address, City, State & Zip Code), **406-532-8502 ext. 8** (Telephone Number with Area Code),

as its attorney or representative with full power to represent the employer before the Wisconsin Unemployment Insurance Division. This representation applies to all matters affecting unemployment insurance including, although not limited to, all benefit claims, contributions, refunds, experience rating, hearings and appeals.

The employer further understands the Wisconsin Unemployment Insurance Division maintains three (3) separate and distinct mailing groups* which include:

Group I	UCB-16	Separation Notice
	UCB-23	Wage Verification/Eligibility Report
	UCB-20	Determination
Group II	UCT-14384-1-E	Unemployment Insurance Benefit Charges and Adjustments
Group III	UCB-719	Urgent Request for Wages
	UCB-701	Computation of Unemployment Insurance Benefits
	UCB-708	Notice of Changed Liability for UI Benefits
	UCT-101-E	Quarterly Contribution Report
	UCT-14384-E	Unemployment Insurance Reserve Fund Balance Statement
	UC-7823-E	Quarterly Wage Reports
	UCT-14309-E	Reimbursable Employer Monthly Statement

*** Forms listed above must remain within the respective mailing group**

The employer authorizes group(s) **I, II, III** (List Group Number(s)) to be mailed to the representative's address listed above.

The remaining group(s) _____ (List Group Number(s)) will be mailed to the employer's main office.

By the signatures below, the employer known as _____ (Employer Name),

approves the above directions and voluntarily enters into this assignment on _____ (Date – mm/dd/yyyy),

at which time this assignment is effective and takes place of all previous assignments.

Authorized Signature: _____ (Employer Signature) _____ (Date Signed – mm/dd/yyyy)

Printed Name & Title: _____ (Print Name) _____ (Job Title)

Witnessed By: _____ (Witness Signature) _____ (Date Signed – mm/dd/yyyy)

Printed Name & Title: _____ (Print Name) _____ (Job Title)