Participant / Employer Packet

Date of Completion: _____

Estimated Start Date: _____

Enrollment Forms

(These forms must be returned to enroll you as an employer.)

FORM	PURPOSE
Enrollment Checklist	This form lists the forms that are required to enroll. Use this checklist as a guide to ensure all forms are completed.
Participant Information Form	Basic contact information is recorded on this form.
Personal Representative Form	This form is used to designate a Personal Representative, someone to assist with employer tasks, if you want one.
Participant Agreement	By signing this form you give permission to your FEA to provide fiscal services. It also defines the roles and responsibilities of each party.
Form SS-4 Application for Employer Identification Number (FEIN)	This form registers you with the IRS as a household employer. It is also used to get a Federal Employer Identification Number (FEIN) that is needed for filing taxes.
Form 2678 Employer/Payer Appointment of Agent	Completing this form appoints your FEA to perform employer tax responsibilities. It allows your FEA to withhold taxes from your employees' paychecks and deposit those taxes with the IRS.
Gen-58 Power of Attorney	This form gives your FEA permission to be your agent in NC and file taxes on your behalf.
CAP/Choice Bill of Rights	Your rights and responsibilities are explained on this form under the CAP/Choice program.

Other Information in the Packet:

- Electronic Time Submittal Instructions
- Payroll Calendar
- Preventing Medicaid Fraud Handout
- Signs and Symptoms of Abuse, Neglect & Exploitation

Enrollment Checklist

First Last
Print Participant Name

First Last
Legal Guardian (if applicable)

First Last
Employer Name

Use this checklist as a guide to ensure all forms are completed. Initial next to each item when the form is complete, then return this checklist along with all other packet items together.

	Participant Initials	**FEA use only**
Participant Information Form		
Participant Agreement		
Personal Representative Form		
IRS Form SS-4		
IRS Form 2678		
IRS Form 8821		
GEN-58 Power of Attorney		
Consumer Bill of Rights		

My signature indicates that the following forms have been explained to me.

Participant/Legal Guardian/Employer Signature Date

Participant/Employer Agreement

Print Participant's Name _____ **Print Legal Guardian's Name** (if applicable) _____

Please review each topic for your understanding and discussion. Your initials by each topic show your (Participant or Legal Guardian) agreement and understanding to the information in the Agreement.

_____ **CONSENT:** By signing this form, I agree to have my FEA provide financial management services in relation to self-direction services.

_____ **CONSENT:** I understand that my FEA will:

1. Provide a Participant Enrollment Packet and process all Federal and state participant forms.
2. Provide a New Employee Packet and process all Federal and state employee forms, and assist the Participant with completion of employee forms, if needed.
3. Provide training materials (Medicaid Fraud Prevention; Signs and Symptoms of Abuse, Neglect and Exploitation; Employee Training - HIPAA, Lifting Safety, Universal Precautions).
4. Confirm employees eligibility including conducting a background and registry check.
5. Keep a record of all participant and employee forms.
6. Collect time worked for participant employees electronically, and if not available, on a paper time sheet.
7. Process payroll for participant employees including paying taxes and benefits(workers compensation and unemployment).
8. Provide a Monthly Payroll Report and Spending Summary that is available online or can be mailed or faxed, if requested.
9. Report concerns about Medicaid Fraud to the appropriate authorities.
10. Report concerns of abuse, neglect and exploitation to the appropriate authorities.
11. Communicate with the Care Advisor about services, and if necessary a representative at NC Medicaid.
12. Assist the participant with time entry and payroll problems or questions, if needed.
13. Resolve complaints related to service dissatisfaction in a timely matter.
14. Provide transfer documents to a receiving Fiscal Management Service, if needed.

_____ **CONSENT:** I will, as my role as the Participant and/or Employer:

1. Agree to be the employer of record for employees hired (interview, hire, schedule,manage and terminate, if necessary).
2. Understand that an employee:
   a. Cannot be a participant's representative or legal guardian.
   b. Must meet the following requirements:
      - Be 18 years or older
      - Be a U.S. Citizen or legal alien authorized to work in the U.S.
      - Submit to a criminal background and registry check and not have any barring offenses
      - Be able to communicate clearly with me
      - Must submit an employment application and meet the hiring requirements as listed in the competency validation assessment
      - Have an active CPR certification within the hiring period when providing services to a beneficiary under the age of 21
   c. My employee(s) cannot begin work until I receive an Employee Approval/Good to Go from my FEA
3. Complete and submit New Employee Packet(s) including the Participant-Employee Agreement that identifies the employee's wage and train my employee(s) about MedicaidFraud, Abuse, Neglect and Exploitation, HIPAA, Lifting Safety and Infectious Disease.
4. Follow the Budget and Care Plan developed with my Care Advisor.

5. Verify that the time an employee works is accurate as authorized on my Plan of Care and scheduled. I understand that:
    a. Services can begin once my employee(s) has received a Criminal History, Registry Check and Office of the Inspector General clearances, their age has been verified and their eligibility has been clearly established authorizing them to work in the USA. I **MUST** receive an Employee Approval/Good to Go from my FEA before the employee(s) can begin working.
    b. I am financially responsible for payment of an employee if:
        - I do not qualify for or lose my Medicaid
        - I allow my employees to work unauthorized overtime
        - I allow my employee(s) to work more time than is approved on my Care Plan
        - I allow my employee(s) to do tasks that are not approved on my Care Plan
    c. I need to approve and submit time worked online, email, or fax accurately and timely. Approving a time sheet when an employee has not worked, or approving a time sheet that does not agree with the Care Plan, is **Medicaid fraud**.
    d. Work time cannot be submitted for payment before the date worked.
6. Call my FEA if questions exist about time entry, budget or employee paperwork.
7. Notify my FEA **immediately** if:
    a. There is a change in address or phone number
    b. I am hospitalized, admitted to a skilled nursing facility or acute rehabilitation.
    c. An employee quits or is dismissed
    d. There is a change with personal representative (as soon as possible but not to exceed five (5) days)
8. I**mmediately** report:
    a. Concerns about Medicaid fraud to the NC Division of Medical Assistance **1-877-362-8471** and my FEA or my Care Advisor
    b. Abuse, neglect and exploitation to the appropriate authority (police or 911), the Department of Social Services in the county in which I live
    c. If I need additional help I can call the NC DHHS CARELINE at 1-800-662-7030, and my Care Advisor or my FEA
    d. Employee injury to my FEA Employee Injury Line **877-901-5824**
9. Call my FEA when problems occur or if there is a complaint.
10. Understand that services may be stopped if NC Medicaid confirms:
    a. My Care Advisor has concerns about my health and safety
    b. I do not follow my Care Plan
    c. I abuse Medicaid funds
    d. There is a conflict of interest between me and other people involved in my care
    e. A loss of Medicaid or failure to pay my Medicaid deductible, if applicable

_____**DELAY IN MEDICAID ELIGIBILITY:** I understand that a delay in Medicaid or service eligibility may occur. While I am authorized for services, eligibility may not show on the Medicaid payment system throughout your forms. If this happens, my FEA will pay my employee for two pay periods. If the delay continues, payment may be stopped. I will be notified before this occurs.

_____**TRAINING MATERIALS:** I have received and will read the following training materials and review with my employee(s):

1. *Signs and Symptoms Abuse, Neglect and Exploitation*
2. *Medicaid Fraud Prevention*
3. *Employee Training including HIPAA/Confidentiality, Lifting Safety and Universal Precautions*
4. *Employer Resource Guide -The guide describes policies, procedures and requirements for employees and for participants self-directing their care. I will read the guide and use it as a reference.*

_____**MEDICAL EMERGENCY:** I know that my FEA is not an emergency medical provider. I will call emergency services (such as 911) during a medical emergency.

_____**PRIVACY:** I have received a copy of my FEA's Notice of Privacy Practices. The rules follow federal privacy regulations (HIPAA). If I have concerns that my protected health information has not been kept confidential, I will report to this to my FEA immediately.

1. I will ensure copies of my employee background checks are either destroyed, kept confidential, safe and secure at all times.

This Agreement describes the roles and responsibilities of my FEA, the Participant and/or Employer, and/or the Legal Guardian. My signature indicates full understanding of the agreement. Further, I accept all responsibility for any personal injury, medical or related liability, including Medicaid Fraud, for services provided under this program.

Participant/Employer or Legal Guardian Signature	*Date*
FEA Signature	*Date*

Appointment of Representative Form

In the CAP/Choice program I am the employer of record and I am responsible for managing my services. I understand that I can choose a Personal Representative to assist me with employer related tasks.

I_____, choose to appoint the individual named below as my Personal Representative. I know that a Personal Representative:

- is not paid for their services
- cannot be my employee
- can be a trusted friend, neighbor, relative or other supporter
- demonstrates knowledge and understanding of the participant's needs and preferences
- agrees to a predetermined level of contact with the participant
- will comply with program requirements
- is at least 18 years of age
- is approved by the participant to represent

The Representative can assist me with:

- being the point of contact for program tasks
- recruiting, interviewing and hiring new employees
- training employees
- scheduling employees
- monitoring work time
- managing the employee day to day

The representative CANNOT:

- sign legal documents on my behalf

My Personal Representative will make sure that my service needs are met, my preferences are respected and good decisions will be made regarding my care.

Personal Representative Name: _____

Personal Representative Signature: _____ **Date**: _____

☐ **I am choosing <u>not</u> to elect a Personal Representative at this time.**

_____ _____

Participant Signature **Date**

Employer's Previous Business Information

This form must be completed by the individual assuming the role of the Employer. Please provide a response to every question below. If any of the questions *cannot* be answered, check "N/A" or write "Do not know" next to the question.

Please do not provide answers to the below questions based on a Partnership, Corporation, Limited Liability Company (LLC), Trust, Estate, Nonprofit or any other entity not considered a Sole Proprietor. Acumen Fiscal Agent, LLC can only accept an EIN and business information for a Sole Proprietor business. **If you have ever owned a Sole Proprietor (currently or in the past), you must let us know. Failure to do so will also drastically increase the time it takes to enroll and receive services under this program.**

Employer Full Name (as shown on Social Security Card)	**Employer Social Security Number (SSN)**
Other Names or Alias Used (please list all)**:**	

		YES	NO	N/A
1.	Have you ever received an Employer Identification Number (EIN) for any Sole Proprietor business you currently or have previously owned? If yes: Please provide the previously assigned Federal EIN: _____ What was the nature of the business: _____ Is the business still active (including any requirements for filing income tax, payroll tax, or information returns): YES_____NO_____	☐	☐	☐
2.	Have you ever previously been enrolled with another Fiscal/Employer Agent (F/EA), sometimes known as a Financial Management Service Agency? If yes: Please provide the name of the F/EA: _____ Please provide dates of when you were with the F/EA: _____	☐	☐	☐
3.	Was a business account ever established on your behalf for state unemployment insurance (SUTA) by your state's Department of Labor/Employment? If yes: Please provide the account number, if known: _____	☐	☐	☐
4.	Was a business account for state income tax (SIT) withheld on behalf of your employees ever established on your behalf with the state's Department of Revenue? If yes: Please provide the account number, if known: _____	☐	☐	☐

If you answered yes to question #2, please contact the prior F/EA to obtain the documents received from the Internal Revenue Service (IRS) and state taxing authorities when you were granted your EIN and state tax accounts. Documents should include a Letter 147C or CP575 issued by the IRS, and confirmation of the state tax accounts being created.

_____ _____

Employer Signature *Date*

ACUMEN FISCAL AGENT LLC
5416 E BASELINE RD STE 200
MESA, AZ 85206
ENROLLMENT@ACUMEN2.NET

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.)*

	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.

X **Sign your name here**

Print your name here

Print your title here HCSR EMPLOYER

Date / /

Best daytime phone

Now give this form to the agent to complete.

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.

Employer's Name Here

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

2 Trade name of business (if different from name on line 1)	**3** Executor, administrator, trustee, "care of" name
4a Mailing address (room, apt., suite no. and street, or P.O. box) 5416 E BASELINE RD STE 200	**5a** Street address (if different) (Don't enter a P.O. box.)
4b City, state, and ZIP code (if foreign, see instructions) MESA, AZ 85206-4704	**5b** City, state, and ZIP code (if foreign, see instructions)

Employer's Street Address Here

Employer's City, St, Zip Here

Employer's County & State Here

6 County and state where principal business is located

Employer's Name Here

7a Name of responsible party	**7b** SSN, ITIN, or EIN

Employer's SSN Here

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) HCSR EMPLOYER
- ☐ 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 EMPLOYER
- ☐ 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

14 Reserved for future use

13 Highest number of employees expected in the next 12 months (enter -0- if none).

Agricultural	Household	Other
	0	

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) HCSR EMPLOYER

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

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 JARED ENDERS, SUNNY HUDSON	Designee's telephone number (include area code) (623) 792-6100
Address and ZIP code 5416 E BASELINE RD STE 200, MESA, AZ 85206-4704	Designee's fax number (include area code) (480) 371-2241

Telephone number required

Employer's Name Here

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) HCSR EMPLOYER

Applicant's telephone number (include area code)

Employer Sign Here

Signature

Date

Applicant's fax number (include area code)

Employer's Date Here

Do I Need an EIN?

File Form SS-4 if the applicant entity doesn't already have an EIN but is required to show an EIN on any return, statement, or other document.[1] See also the separate instructions for each line on Form SS-4.

IF the applicant...	AND...	THEN...
started a new business	doesn't currently have (nor expect to have) employees	complete lines 1, 2, 4a–8a, 8b–c (if applicable), 9a, 9b (if applicable), 10–13, and 16–18.
hired (or will hire) employees, including household employees	doesn't already have an EIN	complete lines 1, 2, 4a–6, 7a–b, 8a, 8b–c (if applicable), 9a, 9b (if applicable), and 10–18.
opened a bank account	needs an EIN for banking purposes only	complete lines 1–5b, 7a–b, 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10, and 18.
changed type of organization	either the legal character of the organization or its ownership changed (for example, you incorporate a sole proprietorship or form a partnership)[2]	complete lines 1–18 (as applicable).
purchased a going business[3]	doesn't already have an EIN	complete lines 1–18 (as applicable).
created a trust	the trust is other than a grantor trust or an IRA trust[4]	complete lines 1–18 (as applicable).
created a pension plan as a plan administrator[5]	needs an EIN for reporting purposes	complete lines 1, 3, 4a–5b, 7a–b, 9a, 10, and 18.
is a foreign person needing an EIN to comply with IRS withholding regulations	needs an EIN to complete a Form W-8 (other than Form W-8ECI), avoid withholding on portfolio assets, or claim tax treaty benefits[6]	complete lines 1–5b, 7a–b (SSN or ITIN as applicable), 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10, and 18.
is administering an estate	needs an EIN to report estate income on Form 1041	complete lines 1–7b, 9a, 10–12, 13–17 (if applicable), and 18.
is a withholding agent for taxes on nonwage income paid to an alien (that is, individual, corporation, or partnership, etc.)	is an agent, broker, fiduciary, manager, tenant, or spouse who is required to file Form 1042, Annual Withholding Tax Return for U.S. Source Income of Foreign Persons	complete lines 1, 2, 3 (if applicable), 4a–5b, 7a–b, 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10, and 18.
is a state or local agency	serves as a tax reporting agent for public assistance recipients under Rev. Proc. 80-4, 1980-1 C.B. 581[7]	complete lines 1, 2, 4a–5b, 7a–b, 9a, 10, and 18.
is a single-member LLC (or similar single-member entity)	needs an EIN to file Form 8832, Entity Classification Election, for filing employment tax returns and excise tax returns, or for state reporting purposes[8], or is a foreign-owned U.S. disregarded entity and needs an EIN to file Form 5472, Information Return of a 25% Foreign-Owned U.S. Corporation or a Foreign Corporation Engaged in a U.S. Trade or Business	complete lines 1–18 (as applicable).
is an S corporation	needs an EIN to file Form 2553, Election by a Small Business Corporation[9]	complete lines 1–18 (as applicable).

[1] For example, a sole proprietorship or self-employed farmer who establishes a qualified retirement plan, or is required to file excise, employment, alcohol, tobacco, or firearms returns, must have an EIN. A partnership, corporation, REMIC (real estate mortgage investment conduit), nonprofit organization (church, club, etc.), or farmers' cooperative must use an EIN for any tax-related purpose even if the entity doesn't have employees.

[2] However, don't apply for a new EIN if the existing entity only (a) changed its business name, (b) elected on Form 8832 to change the way it is taxed (or is covered by the default rules), or (c) terminated its partnership status because at least 50% of the total interests in partnership capital and profits were sold or exchanged within a 12-month period. The EIN of the terminated partnership should continue to be used. See Regulations section 301.6109-1(d)(2)(iii).

[3] Don't use the EIN of the prior business unless you became the "owner" of a corporation by acquiring its stock.

[4] However, grantor trusts that don't file using Optional Method 1 and IRA trusts that are required to file Form 990-T, Exempt Organization Business Income Tax Return, must have an EIN. For more information on grantor trusts, see the Instructions for Form 1041.

[5] A plan administrator is the person or group of persons specified as the administrator by the instrument under which the plan is operated.

[6] Entities applying to be a Qualified Intermediary (QI) need a QI-EIN even if they already have an EIN. See Rev. Proc. 2000-12.

[7] See also *Household employer agent* in the instructions. **Note:** State or local agencies may need an EIN for other reasons, for example, hired employees.

[8] See *Disregarded entities* in the instructions for details on completing Form SS-4 for an LLC.

[9] An existing corporation that is electing or revoking S corporation status should use its previously assigned EIN.

NCDOR
Web-Fill
1-24

GEN-58
Power of Attorney and Declaration of Representative

DOR Use Only

Part 1. Power of Attorney *(Please type or print.)*

ID Type *(Specify one)*
SSN *(Social Security Number)* or
FEIN *(Fed Employer ID Number)*

1 Taxpayer Information

Individual's First Name	M.I.	Individual's Last Name	ID Type	Primary Identification Number

Spouse's First Name	M.I.	Spouse's Last Name	ID Type	Spouse Identification Number

Entity Legal Name	ID Type	Business Identification Number
	SSN	

Mailing Address	Daytime Phone Number *(Include area code)*

City	State	Zip Code

Email Address

hereby appoint(s) the following representative(s) as attorney(s)-in-fact:

2 Representative(s) (Representative(s) must sign and date this form on page 2, Part 2.)

First Name	Last Name	Phone Number
JARED	ENDERS	(623) 792-6100

Mailing Address: 5416 E BASELINE RD STE 200

City	State	Zip Code
MESA	AZ	85206

Email Address: **TAX-NC@ACUMEN2.NET**

First Name	Last Name	Phone Number
SUNNY	HUDSON	(623) 792-6100

Mailing Address: 5416 E BASELINE RD STE 200

City	State	Zip Code
MESA	AZ	85206

Email Address: **TAX-NC@ACUMEN2.NET**

First Name	Last Name	Phone Number
DANIEL	HICKS	(623) 792-6100

Mailing Address: 5416 E BASELINE RD STE 200

City	State	Zip Code
MESA	AZ	85206

Email Address: **TAX-NC@ACUMEN2.NET**

to represent the taxpayer(s) before the North Carolina Department of Revenue for the following matters:

3 Tax Matters
You may list any tax years or periods that have already ended as of the date you sign the power of attorney. You may include future tax years or periods that end no later than 3 years after the date the power of attorney is received by the Department of Revenue.

Type of Tax	Begin Tax Period	End Tax Period
WITHHOLDING	01-01-24	12-31-26

4 Acts Authorized. - The representative(s) are authorized to receive and inspect confidential tax information, which may include federal tax information, and to perform any and all acts that I (we) can perform with respect to the tax matters described on line 3, for example, the authority to sign any agreements, consents, or other documents. For purposes of this section, federal tax information is defined as federal tax returns and return information received from the Internal Revenue Service.

Do you have any specific additions/deletions? ○ Yes ◉ No

If yes, you must list them below.

5 Signature of Taxpayer(s). - If you request joint representation for you and a spouse related to a joint return, both spouses must sign the form. If you request representation for just you, your spouse is not required to sign. If signed by a corporate officer, partner, guardian, tax matters partner/person, executor, representative, receiver, administrator, or trustee on behalf of the taxpayer, I certify that I have the authority to execute this form on behalf of the taxpayer.
▶ **IF NOT SIGNED AND DATED, THIS POWER OF ATTORNEY WILL BE RETURNED.**

Signature	Date	DOMESTIC EMPLOYER Title (if applicable)
Print Name		
Signature (If applicable)	Date	Title (if applicable)
Print Name		

Part 2. Declaration of Representative (To be completed by representative)

Under penalties of perjury, I declare that:

- I am authorized to represent the taxpayer(s) identified in Part 1 for the tax matter(s) specified there; and
- I am one of the following:
  - **a** Attorney - a member in good standing of the bar of the highest court of the jurisdiction shown below.
  - **b** Certified Public Accountant - duly qualified to practice as a certified public accountant in the jurisdiction shown below.
  - **c** Enrolled Agent - Enrolled as an agent under the requirements of Treasury Department Circular No. 230.
  - **d** Officer - a bona fide officer of the taxpayer's organization.
  - **e** Full-Time Employee - a full-time employee of the taxpayer.
  - **f** Family Member - a member of the taxpayer's immediate family (i.e., spouse, parent, child, brother, or sister).
  - **g** Other (explain) - PAYROLL SERVICE PROVIDER

▶ **IF THIS DECLARATION OF REPRESENTATIVE IS NOT SIGNED AND DATED, THE POWER OF ATTORNEY WILL BE RETURNED.**

Designation - Insert above letter (a-g)	Jurisdiction (e.g. state) or Enrollment Card No.	Signature	Date
b	AZ		
g			
g			

Mail to: North Carolina Department of Revenue, P. O. Box 25000, Raleigh, NC 27640-0005
Fax: 919-715-1786

NC Dept. of Commerce
Division of Employment Security
Post Office Box 26504, Raleigh, NC 27611-6504 (* All fields are required unless specified optional *)

POWER OF ATTORNEY AND DECLARATION OF REPRESENTATIVE

Part 1. Employer's Information. Must sign and date this form on page 2

EMPLOYER'S NAME AND ADDRESS *(Exactly as shown on the Division of Employment Security Records)*	STATE UNEMPLOYMENT TAX ACCOUNT NUMBER
	FEDERAL EMPLOYER IDENTIFICATION NUMBER -

Part 2. Representative

REPRESENTATIVE NAME	PHONE NUMBER
ACUMEN FISCAL AGENT	(623) 792-6100
ADDRESS	CITY, STATE, ZIPCODE
5416 E BASELINE RD STE 200	MESA,AZ,85206
EMAIL ADDRESS	FAX NUMBER
TAX-NC@ACUMEN2.NET	(480) 371-2241

The above representative is appointed to represent the above-referenced employer in any of the matters pertaining to contributions (tax) and benefits (claims) as listed below. An agent appointed pursuant to this Power of Attorney and Declaration may:

1. Complete and submit documents for filing employer's tax and wage reports;
2. Complete and submit documents regarding an employer's tax rate, contributions, and direct reimbursements;
3. Respond to benefit claims documents, including responding to requests for information about a claimant's separation or status;
4. Engage in discussion with a representative of the Division of Employment Security regarding the actions listed above;and
5. Accept or receive correspondence sent by DES regarding claims for benefits or an employer's contributions.

The undersigned employer acknowledges that the agent appointed pursuant to this Power of Attorney and Declaration of Representative is not authorized to: (a) Represent the employer in hearings (b) Enter appeals except as authorized by N.C. Gen. Stat. § 96-17(b), and 04 N.C. Admin. Code 24A.0110(a) and (b).

The undersigned employer further acknowledges that its mailing address for tax matters will remain unchanged, unless the employer submits a change of address in accordance with 04 N.C. Admin. Code 24A.0102.

Part 3. Agent Account Number

Your representative may request an Agent account number with this Division to perform above services on behalf of your business. If your representative has an Agent account number, please provide this number below. If not, visit the Division's website at www.des.nc.gov/employers and click on 'Third-Party Administrators and Agents' for more information.

(optional) Agent account number: 16082

Part 4. Declaration of Representative

This Power of Attorney and Declaration of Representative shall become effective on _____ and shall remain in effect until revoked by the employer, the representative, or the Division of Employment Security. On the effective date, this Power of Attorney and Declaration of Representative revokes any earlier power of attorney on file with the Division of Employment Security.

(SEAL)

AUTHORIZING SIGNATURE

(Individual signing must be the proprietor, a general partner or duly elected corporate official exactly as shown on the Division of Employment Security records).

TYPED OR PRINTED NAME

DOMESTIC EMPLOYER

TITLE

SIGNED AND SWORN to before me on this _____ day of _____.

E-NOTARY PUBLIC SEAL

REPRESENTATIVE SIGNATURE

TYPED OR PRINTED NAME

TITLE

NC Dept. of Commerce
Division of Employment Security
Post Office Box 26504, Raleigh, NC 27611-6504 (* All fields are required unless specified optional *)

AGENT AUTHORIZATON FORM

Part 1. Employer's Information. Must sign and date this form on page 2

EMPLOYER'S NAME AND ADDRESS *(Exactly as shown on the Division of Employment Security Records)*	STATE UNEMPLOYMENT TAX ACCOUNT NUMBER
	FEDERAL EMPLOYER IDENTIFICATION NUMBER -

Part 2. Agent's Information

AGENT'S NAME	AGENT'S ACCOUNT NUMBER
ACUMEN FISCAL AGENT	16082
ADDRESS	CITY, STATE, ZIPCODE
5416 E BASELINE RD STE 200	MESA,AZ,85206
EMAIL ADDRESS	FAX NUMBER
TAX-NC@ACUMEN2.NET	(480) 371-2241
AGENT'S REPRESENTATIVE NAME	PHONE NUMBER
DANIEL HICKS	(623) 792-6100

The above representative is approved by the above-referenced employer to access and/or obtain information regarding the account's unemployment insurance and tax matters as selected below:

Select	Roles	Access Begin Date	Access End Date *(Optional)*
☐	All Roles		
☒	Wage Reports		
☒	Payments		
☒	Account Maintenance		
☐	Unemployment Insurance Claims		
☒	Tax Rate Information		

Part 3. Declaration of Representative

This Agent Authorization form shall become effective by the “Access Begin Date” and shall remain in effect until the “Access End Date” as shown above or until revoked by the employer, the Agent, or the Division of Employment Security. On the effective date, this Agent Authorization form revokes any earlier authorizations on file with the Division of Employment Security.

AUTHORIZING SIGNATURE

(Individual signing must be the proprietor, a general partner or duly elected corporate official exactly as shown on the Division of Employment Security records).

DOMESTIC EMPLOYER

TYPED OR PRINTED NAME

TITLE

Consumer Rights and Responsibilities

As a Participant of the Consumer-Directed Care Program you have the following rights:

- To be safe
- Treated with courtesy, consideration and respect
- Trust your instincts
- Take and negotiate risks
- Agree or disagree with others
- Be informed of choices and consequences
- Be free from mental, physical, financial and sexual abuse
- Have communication appropriate to your communication needs
- Arrange consumer-directed services in a safe and professional manner
- Voice your complaints verbally and/or in writing
- Direct your own care or designate in writing a Representative who is willing and capable of assuming this responsibility
- Be aware of changes in your services and that your signature or your representative's consent is needed before changes are made
- Know about all fees for the services you receive and how your budgeted money is spent
- To tell your Care Advisor about any problems or concerns you have without fear of punishment for expressing concerns
- You may voice complaints verbally and/or in writing
- Expect that all service providers that come into your home will respect your personal privacy and property
- Expect that information you provide to Consumer-Directed Care Program staff will be respected, held in confidence, and that this information will only be shared with you or your representative's written consent
- To request assistance from your Care Advisor as needed
- To be referred to other community agencies as appropriate
- To be informed of any financial responsibility that must be met prior to Medicaid paying for services (*deductible*)
- To be notified of any appeal rights you may have upon your termination from the Consumer-Directed Care Program

As a Participant of the Consumer-Directed Care Program you have the following RESPONSIBILITY:

- To treat the people providing your services with respect and courtesy
- To notify your Care Advisor and your FEA as soon as possible if there are any of the following changes:
    - Change in your address
    - Change in your phone service or internet access
    - Change in your support system
    - Change in your physician
    - Any admission to the hospital, nursing or rehabilitation facility or visit to the emergency room or any other critical incident within 24 hours of the occurrence

    - Changes to your Medicaid status
    - Change with your Personal Assistant
    - Any change, substitution or problem with your Plan of Care
    - Any new medical equipment received

- To keep track of the balance of your monthly budget so you do not overspend
- To submit all required paperwork on time
- To comply with all tax and labor laws
- To have accessible for your hired workers and other support staff, an Emergency and Disaster Plan that clearly outlines who will provide care to you when your primary caregiver or personal assistant is not able to provide you with your care needs due to illness, emergency and /or holiday
    - Your Emergency and Disaster Plan should also provide additional information about your care needs and supervision requirements to protect your health, safety and well-being
- To pay your financial manager the amount of your monthly deductible, if applicable
- To pay your hired worker wages while you are in your deductible period
- To provide a safe working environment for those who will provide your care
- To engage in a cooperative working relationship with your Personal Assistant, Care Advisor and Financial Manager

The Consumer Bill of Rights and Responsibilities has been explained to me and I understand and accept these rights.

Participant's Signature *Date*	*FEA Representative* *Date*

What is Medicaid Fraud?

Medicaid fraud involves knowingly misrepresenting the truth about services provided.

Fraud includes:

* Abuse of Medicaid dollars resulting in increased costs.
* Waste which is overusing resources and receiving inaccurate payments for services.

The following are typical schemes used to defraud the Medicaid program:

Billing for Services Not Provided

A caregiver records time worked for services not performed, such as recording time worked preparing and cooking a meal for a participant when the caregiver did not.

Doubling Billing

A participant approves time worked for two caregivers at the same time or approves time worked for a caregiver when the participant was in the hospital.

Billing for Phantom Visits

A participant falsely bills the Medicaid program for caregiver visits that never take place.

Billing for More Hours Than Worked

Inflating the amount of time a caregiver spends with the participant, for example submitting a time sheet that records the caregiver having worked five hours in a day when the caregiver actually worked three.

Unapproved Tasks

Asking a caregiver to perform tasks, like walking a dog, that is not an approved Medicaid task and submitting the time spent on a time sheet.

Non-Eligible Employee

Submitting a time sheet using the name of an employee who is approved to work but a different person actually did the work and receives payment.

Committing Fraud is a Crime. Consequences: Those committing Medicaid fraud can be charged with a felony or misdemeanor and If convicted, they will be required to pay back all money received falsely, and possibly serve time in prison. If you recognize that you have made a mistake on a time sheet, call right away so it can be corrected: **877.901.5827**

If you are concerned that fraud is occurring, call the NC Division of Medical Assistance at **1.800.662.7030** and inform your FEA at **877.901.5827**

SIGNS OF ABUSE, NEGLECT, AND EXPLOITATION

The law protects the health and safety of "vulnerable adults" and children from abuse, neglect, and exploitation. It is important for participants and employees to know signs and symptoms of abuse, neglect and exploitation for health and safety reasons. A vulnerable adult is someone over the age of 65 with a long-term disability. If you have concerns that a "vulnerable adult" or child is being harmed, please report it right away.

Acumen Fiscal Agent

www.outreachhealthnorthcarolina.com
outreach.NC@outreachfiscalagent.com
1-877-901-5827

What is Abuse, Neglect, & Exploitation?

- **ABUSE** is the willful infliction of injury, unreasonable confinement, intimidation, or punishment which results in physical harm, pain or mental anguish. It also includes the deprivation of food, water, shelter, etc. (Includes emotional, physical and sexual abuse).
- **NEGLECT** is the refusal or failure to fulfill any part of a person's obligations to another person, such as the provision of food, clothing, medicine, comfort, or personal safety.
- **FINANCIAL OR MATERIAL ABUSE** or exploitation is the illegal or improper use of a person's funds, property, or assets.
- **SELF-NEGLECT** is an adult's inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including providing for one's own food, clothing, shelter, and medical care. Choice of lifestyle or living arrangement is not, in itself, evidence of self-neglect.

WHAT IS ABANDONMENT?

"Abandonment" is when a person or agency with a duty to care for a vulnerable adult or child acts (or fails to act) in a way that leaves the vulnerable adult unable to get needed food, clothing, shelter, or health care.

INDICATORS OF ABUSE, NEGLECT, OR EXPLOITATION

The following descriptions are not necessarily proof of abuse, neglect, or exploitation. But maybe clues that a problem exists, and that a report needs to be made to law enforcement or Adult Protective Services or Child Protective Services.

To report concerns of Abuse, Neglect and Exploitation, contact the Department of Social Services in the county in which you live. If the vulnerable adult is in immediate danger, please call 911

BEHAVIORAL SIGNS

- Fear
- Anxiety
- Agitation
- Acting out
- Anger
- Isolation/withdrawal
- Depression
- Contradictory statements
- Implausible stories
- Hesitation to talk openly
- Confusion or disorientation

PHYSICAL SIGNS

- Forced isolation
- Skin discoloration
- Sunken eyes or cheeks
- Pain from touching
- Soiled clothing or bed
- Inappropriate administration of medication
- Injury that has not been cared for properly
- Injury that is inconsistent with explanation for its cause
- Cuts, puncture wounds, burns, bruises, welts
- Frequent use of hospital or health care/doctor shopping
- Lack of necessities such as food, water, or utilities
- Dehydration or malnutrition without illness-related cause
- Lack of personal effects, pleasant living environment, personal items

FINANCIAL ABUSE

- Unexplained sudden transfer of assets,
- Providing unnecessary services,
- A complaint of financial exploitation,
- Unexplained missing funds or valuables
- Providing substandard care
- Unpaid bills despite having enough money
- Sudden changes in bank account or banking practice
- Adding additional names on a bank signature card
- Unapproved withdrawal of funds using an ATM card
- Sudden changes in a will or other financial documents
- Forged signature for financial transactions or for the titles of property
- Sudden appearance of previously uninvolved relatives claiming their rights to a person's affairs and possessions
- Unexplained withdrawal of a lot of money by person accompanying the victim

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

You have the right to:

Your Rights

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	· You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. · We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	· You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. · We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	· You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. · We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	· You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. · If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	· You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. · We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	· You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	· If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. · We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	· You can complain if you feel we have violated your rights by contacting us using the information on page 1. · You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** · We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	· Share information with your family, close friends, or others involved in your care · Share information in a disaster relief situation · Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	· Marketing purposes · Sale of your information · Most sharing of psychotherapy notes
In the case of fundraising:	· We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	· We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	· We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	· We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	· We can share health information about you for certain situations such as: · Preventing disease · Helping with product recalls · Reporting adverse reactions to medications · Reporting suspected abuse, neglect, or domestic violence · Preventing or reducing a serious threat to anyone's health or safety
Do research	· We can use or share your information for health research.
Comply with the law	· We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	· We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	· We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	· We can use or share health information about you: · For workers' compensation claims · For law enforcement purposes or with a law enforcement official · With health oversight agencies for activities authorized by law · For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	· We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Original Effective Date: 11/06/03 Rev. 09/21/13; Rev. 09/01/2017

This Notice of Privacy Practices applies to the following organizations.