CDS in Texas

Veteran Participant Name:_____

EMPLOYER ENROLLMENT PACKET

Central Texas Veteran Directed Home and Community Based Services (VD-HCBS) Program

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

PARTICIPANT CONTACT INFORMATION

Participant Name: _____

Address: _____ _____

City: _____ Zip: _____ Primary Diagnosis: _____

Home Phone: _____ Fax No: _____ Cell Phone: _____

Email address: _____

Family Member/Guardian/Designated Representative (circle one)

Name: _____ Relationship: _____

Address (if different): _____

Home Phone: _____ Office Phone: _____ Cell / Other: _____

Email Address: _____

Emergency Contact

Name: _____ Relationship: _____

Home Phone: _____ Office Phone: _____ Cell / Other: _____

PERMISSION TO CONTACT ELECTRONICALLY

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

If you want us to be able to communicate with you electronically, please sign below. Examples of email or text communications include: Acknowledging receipt of new employee documentation, timesheets, requests for reimbursement, and budgets. Responding to or requesting information from your case manager / service coordinator. Responding to emails/texts you send to us. Emailing budgets, quarterly reports or program changes to you.

___ Yes, use email (or respond to my texts) ___ No, use US Postal Service

Signed: _____ Date: _____

CDS in Texas

APPOINTMENT OF A DESIGNATED REPRESENTATIVE

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

VETERAN INFORMATION					
First & Last Name:					
Parent/Guardian (if applicable)					
DESIGNATED REPRESENTATIVE INFORMATION					
Name:		**SSN:**			
Street Address:		**First Phone**			
City:		**Second Phone**			
Email:		**State**		**Zip:**	
Relationship to Veteran:					

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

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

Participant /Guardian Signature **Date**

Designated Representative Signature **Date**

CDS in Texas

INFORMATION FOR EMPLOYERS

FREQUENTLY ASKED QUESTIONS ABOUT CONSUMER DIRECTION

What is consumer direction?	Consumer direction, also known as self-direction, allows the veteran to become the employer of record. You hire, train, and if necessary, fire your employees. This service delivery option gives you more independence and control over who works for you, the hours they work, and how services are delivered.
Who is CDS in Texas?	We are a financial management services agency. We will conduct background checks on new employees for you, process your timesheets, withhold taxes, and track your program funds. Details can be found in the Employer Service Agreement and Form 1581 which presents an Overview.
Who is the employer?	You are the employer unless you have a guardian. If you have a court-appointed guardian, then that individual will be the employer.
What are my responsibilities as an employer?	As the employer, you hire, train, supervise, and terminate your employees. You must ensure that you have back-up services if your regular employee cannot work. You submit accurate timesheets for work performed and ensure that the narrative portion of the timesheet is completed.
How do I enroll?	You will complete this enrollment package with a representative from the Central Texas Council of Governments. They will forward all the documents to us. We will then enroll you; notify you of background results within 48 hours of receiving the new employee information; and set you up for payroll processing.
How is time worked recorded?	This packet contains a timesheet. You will need to make copies. You can also download the timesheet from our website www.cdsintexas.com. See the Payday Schedule in this packet for how and when to submit your timesheet.
How is my employee paid?	The application packet has forms for direct deposit to a bank account or pre-paid card, or the employee can select our paycard. When your payroll is processed, you will receive an email notification.
When is payday?	This packet contains the payroll schedule. Payday is every other Friday. If Friday is a holiday, payday is Thursday.
What if my employee does not receive a paycheck?	Check to see if there is a fax or email confirmation. If there is not, re-send and call our office to let us know about the late timesheet. If there is confirmation of receipt, call our office. We should be able to locate the missing timesheet, and we will process as quickly as possible.
How do I get my payroll records?	We will send you quarterly reports that show how many hours have been worked, any payments made for reimbursable expenses, and how must money has been used from your budget.
What else do I need to know?	If you are in the hospital or other facility or lose eligibility, your employee cannot work.
How do I contact CDS in Texas?	Call your Service Advisor, Cassie Barnette. You can reach her at 210-798-3779 or 877-675-7331, ext. 1624, or email Cbarnette@cdsintexas.com or VD@cdsintexas.com. Our website is www.cdsintexas.com. Follow us on Facebook at http://www.facebook.com/CDSinTexas. Hours are from 8:00a.m. to 5:00 p.m. Monday - Friday.

Other important things to know	• You certify your timesheets as true and correct. Never sign blank timesheets. Submitting incorrect timesheets may be considered fraud.
	• Any over or under payment of payroll will be corrected as soon as possible but no later than the next payroll.
	• Everyone has a responsibility to report abuse, neglect or exploitation (1-800-252-5400).
	• Work with your employees until they fully understand what you expect from them.
	• Make sure your employees know how to notify you if they cannot work a scheduled shift.
Is there anything else I need to do?	***YES !!*** If any of your information changes -- your name, your address, your banking information, your telephone number, your email address -- use the Change of Information form which is on our webiste, or call to have a copy sent to you.

Consumer Directed Services (CDS) Option Overview in the VD-HCBS Program

This information will help you decide if you want to participate in the **Veteran Directed Home and Community Based Services (VD-HCBS)** option for services available for delivery.

If you or your legally authorized representative (LAR) chooses the VD-HCBS option, one of you must be the employer of your service providers for those services to be delivered through VD-HCBS.

- The employer (individual or LAR) may appoint an adult as the designated representative (DR) to assist or to perform employer responsibilities in the VD-HCBS option. If the employer is not able to complete a self- assessment for VD-HCBS, a DR must be appointed.
- You will be eligible for Support Consultation Services to provide additional assistance and training for employer responsibilities in VD-HCBS.
- The employer or DR must:
  - o select a financial management service (FMS) agency to administer fiscal management services, provide orientation services to the employer and to act as the employer's agent with governmental agencies.
  - o hire, fire, train and manage your service providers. Service providers include employees, contractors and vendors. Some services may require that backup service providers be available to deliver services when the regular provider is not available.
  - o control how your allocated program funds for each service are spent on wages and benefits for your employee(s) and pay for services delivered by contractors and vendors.

Your VD-HCBS service coordinator will advise you of the FMS Agency currently used to pay for services provided with a set amount of money from your allocated funds.

Becoming an Employer

As an employer in the VD-HCBS option, you have the benefit of controlling your authorized service funds. You set wages and benefits for your employees within the spending limits for the service rate. Benefits may include bonuses and health insurance for your employee(s). You also have the benefit of hiring and managing your own employees, backup employees and other service providers.

Being an employer in the VD-HCBS option also has many responsibilities. You are required to recruit, hire, manage and, if necessary, dismiss or fire your service providers (employees, contractors and vendors). You must provide training for your employees. You may want to purchase training for your employees through your budget. You are also assuming responsibility to verify that each service provider:

- meets the eligibility requirements of your program; and
- completes all required paperwork.

TEXAS
Health and Human Services

Employer Responsibilities in the VD-HCBS Program

Form 1582
November 2015-E
Adapted VD-HCBS

The **"employer"** in the Veteran Directed Home and Community Based Services VD-HCBS option is the individual receiving services or, when applicable, the individual's legally authorized representative (LAR).

Employer Responsibilities

To participate in the VD-HCBS option, you must be able to perform all employer tasks required, or you may appoint a willing adult as your **designated representative** (DR) to assist you or to perform employer responsibilities and tasks for you.

As an employer, your responsibilities include:

- recruiting, hiring, training, managing and firing your employees and other service providers (service providers include employees, contractors and vendors);
- setting wages and benefits for your employees within funds allocated for services elected to be delivered through the VD-HCBS option;
- conducting criminal history checks or asking the Financial Management Services Agency (FMSA) you select to obtain the report;
- evaluating each service provider's job performance;
- approving, signing and submitting time sheets, invoices and receipts to the FMSA for payment to your employee(s) and service providers;
- having the FMSA verify eligibility of each applicant before you hire or retain for employment or service delivery;
- resolving employee and service provider concerns and complaints;
- maintaining a personnel file on each service provider;
- developing and implementing backup service plans for services determined by the individual's planning team to be critical to the individual's health and welfare; and

Note: The VD-HCBS option and the agency option are each funded by public funds, Veterans Administration, or other federal money. Discriminating against applicants and employees based on race, creed, color, national origin, sex, age, or disability or sexual orientation is prohibited and against the law. The employer is accountable for the funds spent through the VD-HCBS option.

Service Coordinator Responsibilities

Your service coordinator is responsible for informing you about the VD-HCBS option and reviewing the self- assessment tool with you to help you determine if the VD-HCBS option is right for you. In addition, the responsibilities of your case manager or service coordinator include:

- assessing your service level needs;
- coordinating the development of the service plan or plan of care;
- providing you with information about the FMSA which will help you manage this option;
- educating you on your rights, responsibilities and resources;
- revising your service plan when your needs change;
- being a resource if you have health, safety or exploitation concerns; and
- monitoring and reviewing your satisfaction with the services provided by the FMSA in accordance with the requirements of your program.

VD-HCBS Option Advantages vs. Potential Risks

Advantages in the VD-HCBS option

- You select and manage the people who provide your services.
- You schedule who provides program services and when they are delivered.
- You train your service providers and supervise the services delivered by your service providers (service providers include employees, contractors and vendors).
- You control the rate of pay for your employee(s) within the spending limits of the unit rate for the service.
- ~~You can offer benefits, such as bonuses, vacation pay, sick pay and insurance, to your employees.~~ VDC
- Your FMSA that will pay your service providers, make deposits and file reports with governmental agencies on your behalf.
- You may be able to recruit eligible service providers, including family members, friends and other persons you know to work for you. The person selected must meet all eligibility requirements of your program to be hired or retained.
- You may appoint someone to assist with employer responsibilities or to perform employer responsibilities for you.
- You may also be able to get additional training and assistance from a FMS support advisor to help you be a successful employer in the VD-HCBS option.

Potential Risks in the VD-HCBS option

- You are responsible for backup arrangements for services to be delivered if your employee or service provider does not show up for work.
- Your service providers are **not** the employees of the FMSA, Veterans Administration, HHSC, any other state or federal agency or any other contracted provider agency.
- As the employer, you are solely responsible and liable for any negligent acts or omissions by you, your employees, other service providers and your DR.
- You are responsible for handling all conflicts with service providers. The FMSA and the individual's other program provider agencies are not involved in these situations.
- You are required to keep and store paperwork for up to five years or possibly longer.
- The employer is ultimately responsible for payroll taxes owed to the Texas Workforce Commission (TWC), and is liable if the FMSA fails to pay. The FMSA assumes full responsibility for payment of payroll taxes owed to the IRS.
- The employer is responsible for meeting all requirements as any employer in any business and can be held liable for failure to meet those requirements.

Signature - Individual/LAR

Date

Relationship of LAR to the Individual Receiving Services

Signature - Service Coordinator

Date

TEXAS Health and Human Services

VD-HCBS) Consumer Self-Assessment

Name of the Individual Receiving Services	Date

1. **If you decide to direct your services:**
   a. Can you train and supervise attendants to perform each of the tasks on your service plan that will be delivered through the VD-HCBS option? ☐ Yes ☐ No
   b. Can you locate and arrange for out-of-home respite services if needed? ☐ Yes ☐ No
2. **If you select the people you want to help you live in the community:**
   a. How will you find and select people, including backup staff, to help you in your home?

   How will you find and select an out-of-home respite provider if needed?

   b. How will you train and supervise the people who work in your home?

   c. How will you tell your employees what you like or don't like about their work?

   d. If you are not satisfied with the work of the employee you hire, how will you handle the situation?

3. **Your Service Coordinator and/or your FMSA will provide initial orientation and ongoing training on how to be an employer and many other things about employer responsibilities in the VD-HCBS option.**
   Are you willing to accept and ask for additional training and help if you need it? ☐ Yes ☐ No
4. **You may appoint someone to act as your designated representative (DR) in the VD-HCBS option.**
   Do you have someone who can help you make important decisions for this VD-HCBS option? ☐ Yes ☐ No
   If yes, who? _____
   What is your relationship to this person? _____
   Comments

☐ I have completed this assessment and **want to participate in the VD-HCBS option**. I am willing and able to be the employer.

☐ I have completed this assessment and **want to participate in the VD-HCBS option and I will select a designated representative** to assist me or to act on my behalf.

☐ I have completed this assessment. **I choose not to participate in the VD-HCBS option** at this time. I may change my mind at any time by notifying my case manager or service coordinator.

Signature - Individual/Legally Authorized Representative (LAR)	Relationship of LAR to the Individual Receiving Services	Date

Signature – Service Coordinator		Date

Signature – Designated Representative (DR)	Relationship of DR to the Individual and LAR	Date

If an individual or LAR (the employer) is not able to complete the Consumer Self-Assessment, a person appointed by the employer to be the employer's DR must be able to complete the Consumer Self-Assessment for the individual receiving services to participate in the VD-HCBS option.

TEXAS
Health and Human Services

Form 1584
June 2015-E

VD-HCBS Consumer Participation Choice

Individual's Name	Individual's No.

My service coordinator has presented adequate information for me to make an informed choice between services through the Agency Option (AO), the Veteran Directed Home and Community Based Services Program. I understand my rights and responsibilities in each option. My signature below documents my choice of how I want my services to be delivered. I understand I can contact my if I wish to change my selection at a later date.

Options Available

☐ **Agency Option**

I elect to have *all* of my direct services delivered by the provider.

_____
Name of Provider

☐ **VD-HCBS Option**

I elect to receive my services available through the VD-HCBS option.

I have selected CDS in Texas as my Financial Management Services Agency (FMSA).
Name of Provider

.

_____ _____
Signature - Individual/Responsible Party **Date**

_____ _____
Signature - Witness Date

_____ _____
Signature - Service Coordinator Date

TEXAS
Health and Human Services

Form 1585
February 2016-E

Acknowledgment of Responsibility for Exemption from Nursing Licensure for Certain Services Delivered through Consumer Directed Services (CDS)

The following text is from Section 531.051, Government Code, Consumer Direction of Certain Services for Persons with Disabilities and Elderly Persons, Subsections (e) and (f):

The consumer in the CDS option acknowledges that, as "the consumer who receives the service," he or she (e)(2)(A) has a functional disability and the service would have been performed by the consumer, or the parent or guardian for the consumer, except for that disability; and if:

(e)(2)(B)(i) the consumer is capable of training the person in the proper performance of the service, the consumer directs the person to deliver the service; or

(e)(2)(B)(ii) the consumer is not capable of training the person in the proper performance of the service, the consumer's parent or guardian is capable of training the person in the proper performance of the service and directs the person to deliver the service.

(f) If the person delivers the service under Subsection (e)(2)(B)(ii), the parent or guardian must be present when the service is performed or immediately accessible to the person who delivers the service. If the person will perform the service when the parent or guardian is not present, the parent or guardian must observe the person performing the service at least once to assure the parent or guardian that the person performing the service can competently perform that service.

The person who delivers the service:

(A) has not been denied a license under Chapter 301, Occupations Code;

(B) has not been issued a license under Chapter 301, Occupations Code, that is revoked or suspended; and

(C) performs a service that is **not expressly prohibited from delegation by the Texas Board of Nursing.**

Per Texas Administrative Code, §225.13,**Tasks Prohibited From Delegation, the following are nursing tasks that cannot be delegated:**

(1) physical, psychological, and social assessment, which requires professional nursing judgment, intervention, referral, or follow-up;

(2) formulation of the nursing care plan and evaluation of the client's response to the care rendered;

(3) specific tasks involved in the implementation of the care plan that require professional nursing judgment or intervention;

(4) the responsibility and accountability for client or client's responsible adult health teaching and health counseling which promotes client or client's responsible adult education and involves the client's responsible adult in accomplishing health goals; and

(5) the following tasks related to medication administration:

(A) calculation of any medication doses except for measuring a prescribed amount of liquid medication and breaking a tablet for administration, provided the RN has calculated the dose;

(B) administration of medications by an injectable route except for subcutaneous injectable insulin or other injectable medication prescribed in the treatment of diabetes mellitus as permitted by §225.12 of this title (relating to Delegation of Administration of Insulin) or other injectable medication prescribed in the treatment of diabetes mellitus and in emergency situations as permitted by §224.6(4) of this title (relating to General Criteria for Delegation) and §225.10(13) of this title (relating to Tasks that May Be Delegated);

(C) administration of medications by way of a tube inserted in a cavity of the body except as permitted by §225.10(10) of this title;

(D) responsibility for receiving or requesting verbal or telephone orders from a physician, dentist, or podiatrist; and

(E) administration of the initial dose of a medication that has not been previously administered to the client unless the RN documents in the client's medical record the rationale for authorizing the unlicensed person to administer the initial dose.

Under §531.052(e), (f) of the Government Code, there are certain services that may be exempt from nursing licensure and can be included in the Individual Service Plan for the CDS option if all the qualifying conditions are met.

Examples include:

(1) bathing, including feminine hygiene;

(2) grooming, including nail care, except for consumers with medical conditions like diabetes;

(3) feeding, including feeding through a permanently placed feeding tube;

(4) routine skin care, including decubitus Stage 1;

(5) transferring, ambulation or positioning;

(6) exercising and range of motion;

(7) the administering of a bowel and bladder program, including suppositories, catheterization, enemas, manual evacuation and digital stimulation;

(8) administering oral medications that are normally self-administered, including administration through a gastrostomy tube; and

(9) non-invasive and non-sterile treatments with low risk of infection.

CDS Consumer

I **elect** to take responsibility for some nursing tasks. I have read the excerpt provided from Government Code §531.051 and under those terms, **I certify the following:**

As the individual who receives the service, I certify that I have a functional disability and I am able to perform this service for myself, except for that disability.

As the individual of the service, I am capable of training the attendant (employee) in the proper performance of the service and take full responsibility in directing and supervising the attendant. I understand that those services that cannot be provided by anybody except a licensed nurse, according to Texas Administrative Code, §225.12, **Tasks Prohibited From Delegation,** must not be provided by the employee.

Legally Authorized Representative (LAR) Directed Services

I **elect** to take responsibility for some nursing tasks for the individual. I have read the excerpt provided from Government Code §531.051 and under those terms, **I certify the following:**

As the LAR of the individual, I am capable of training the attendant (employee) in the proper performance of the service and take full responsibility in directing and supervising the attendant. I will either be present or immediately accessible when the service is performed or will observe the attendant performing the service until I am assured he is able to competently perform the service without my immediate supervision. I understand that those services that cannot be provided by anybody except a licensed nurse, according to Texas Administrative Code, §225.12, **Tasks Prohibited From Delegation,** must not be provided by the employee.

Delegated Service to be Delivered

Under the terms of this provision, I take full responsibility for these tasks. I will train and supervise the attendant in the performance of the task(s) listed below:

In assuming this responsibility, I understand that my home and community support services nurse will no longer supervise or assume any responsibility for the performance of this task(s).

Signature - Individual	Date
Signature - LAR	Date
Signature - Case Manager/Service Coordinator	Date

TEXAS Health and Human Services

Form 1736
June 2014-

Documentation of VD-HCBS Employer Orientation by CTADVRC - Veterans Program

Individual's Name	Program Name
Employer Name	Relationship to Individual

Contact Person CTADVRC - Veterans Programs	Telephone Number	Fax Number

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

Orientation Location

Address		
City	State	ZIP Code

Orientation Session

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

Topics Covered (employer to check topics)

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

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

Employer

Printed Name

Signature

Date

CTADVRC Representative

Printed Name

Signatur

Date

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

Printed Name

Signature

Date

Printed Name

Signature

Date

TEXAS Health and Human Services

VD-HCBS

Service Backup Plan

Form 1740
September 2014-E

Name of Individual	Program	Service*
Employer	Designated Representative (if applicable)	Support Advisor (if applicable)

* A service backup plan is required for each program service delivered through the VD-HCBS option that the service planning team has determined to be critical to the health and welfare of the individual or that is required by program specifications. The service backup plan must be reviewed by the service planning team initially and annually thereafter.

Type of Service Backup Plan	Date of Service Planning Team Meeting	Effective Date of Service Backup Plan
☐ Initial Backup Plan ☐ Revision to Backup Plan		

Reason(s) a service backup plan is required for this service:

1. _____
2. _____
3. _____

Backup Plan Strategies and Sequence	Specific Action(s) to Be Taken in Absence of Service Delivery	Resource Person, Area Code and Telephone Number
1.		
2.		
3.		
4.		
5.		
6.		

Plan Approval:

_____ _____ _____ _____

Employer or Designated Representative Signature | Date | Service Coordinator Signature | Date

Annual Review:

	Yes	No				
Was the backup plan implemented?	☐	☐	SC Initials	_____	Date:	_____
If yes, was the backup plan effective?	☐	☐	SC Initials:	_____	Date:	_____

If the backup plan was ineffective:

Service coordinator requested revision on (date)._____

Service coordinator received backup plan revision on (date)_____

TEXAS Health and Human Services

Form 1826-D
October 2004-E

Veteran Directed Home and Community Base Services

Case Information Release

Section I

Case Name: _____ Case Number: _____

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

Section II

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

Part A – Release of Information: CDS in Texas

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

_____

Check one of the following:

☐ Release all of my case record

☐ Release only the following information:

Part B – Purpose(s) of Release:

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

This authorization expires on: _____

Part C – Signature:

_____ _____

Client or Personal Representatives Signature Date

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

_____

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

Witness: _____ Date: _____

Witness: _____ Date: _____

Section III

Notice to Client

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

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

CDS in Texas

EMPLOYER INSTRUCTIONS AND CHECKLIST

The employer must complete **all** of the forms in the packet to enroll in the VD-HCBS program. Follow the instructions in this packet to enroll properly. **All areas highlighted in yellow must be signed.** *If the veteran or the veteran's Legally Authorized Representative appoints a designated representative, that person can also sign all of the forms except those for the IRS and TWC. If the employer signs with an "X," a witness must write: "Witnessed By," and sign his/her name next to the "X."* **The witness may not be the employee.**

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

REQUIRED FORMS TO RETURN TO CDS IN TEXAS	
☐	**Participant Contact Information** is filled out and signed
☐	**Designation of Representative** is filled out and signed, ***if applicable***
☐	**IRS Form SS-4** is filled out and signed
☐	**IRS Form 2678** is filled out and signed
☐	**TWC Form C-42 Written Authorization** is signed
☐	**Employer Service Agreement** is filled out and signed
☐	**Privacy Practice Notice** is signed
☐	**Direct Deposit Authorization** is filled out and signed
☐	**Voided check, Prepaid Card Form or Bank Letter is attached**
☐	Form 1736 - Documentation of Orientation
☐	Forms 1581, 1582, 1584, and 1585 - Overview of Employer Responsibilities
☐	Form 1740 - Service Backup Plan
☐	Form 1826-D - Case Information Release

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

INSTRUCTIONS FOR REQUIRED FORMS	
PARTICIPANT ENROLLMENT INFORMATION	
Purpose	This Enrollment Information form gathers required demographic information needed for enrollment with CDS in Texas
Instructions	Complete all information requested. Sign and date at bottom of the page
DESIGNATION OF REPRESENTATIVE (*if applicable*)	
Purpose	Complete this form if you wish to designate someone to assist you with the responsibilities of being an employer. **If appointing a DR, this individual must complete the second half of the form.** You both sign and date the form.
Instructions	Fill out the form; the DR initials each task. Both sign and date. If the participant has a guardian, the guardian must sign.
IRS FORM SS-4	
Purpose	Completing this form allows CDS in Texas to apply for a Federal Employer Identification Number (FEIN) with the IRS. By doing this, we avoid reporting under your Social Security number when the W-2 is issued.
Instructions	1) On line 1, print the employer's full name. **It must match the name on the Social Security Card.**
	2) On Line 6, print the county and state where the employer resides.
	3) On Line 7a, print employer's full name again.
	4) On Line 7b, print employer's Social Security Number.
	5) The employer signs and dates form at bottom of page where highlighted in yellow.
IRS FORM 2678	
Purpose	This form appoints CDS in Texas as your agent for the purpose of depositing taxes and filing necessary quarterly reports for the VD-HCBS Program. We are given no access to personal tax information.
Instructions	Employers signs where "X" is seen and dates form. CDS in Texas will complete the rest.
TWC FORM C-42 WRITTEN AUTHORIZATION	
Purpose	This form appoints CDS in Texas as your agent for the purpose of paying state unemployment taxes and filing necessary quarterly reports.
Instructions	The employer signs where highlighted in yellow. CDS in Texas will complete the rest.
EMPLOYER SERVICE AGREEMENT	
Purpose	This form defines the roles and responsibilities of each party under the VD-HCBS Program.
Instructions	Read carefully, print the veteran and employer's name, initial where marked and sign and date where highlighted in yellow.
PRIVACY PRACTICES NOTICE	
Purpose	This notice explains how CDS in Texas will handle your protected health information (PHI).
Instructions	Sign and date on lines provided at the bottom of the page where highlighted in yellow.
DIRECT DEPOSIT AUTHORIZATION	
Purpose	This form gives CDS in Texas authorization to deposit reimbursements in your bank account
Instructions	Read the instructions on the form and fill every box. NOTE: **For checks we must have a voided check or letter from your bank.** **For prepaid cards, we need a statement from the card company showing the card is activated and registered. Your name must be printed on the card. You should be able to login to the card company's website and print this form.**

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

Application for Employer Identification Number

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

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

OMB No. 1545-0003

EIN

Type or print clearly.

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

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

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

4a Mailing address (room, apt., suite no. and street, or P.O. box)

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

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

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 ▶

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

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

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

Group Exemption Number (GEN) if any ▶

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

State

Foreign country

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

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

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

12 Closing month of accounting year **December**

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

If no employees expected, skip line 14.

Agricultural	Household	Other
		1

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

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

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

☐ Construction ☐ Rental & leasing ☐ Transportation & warehousing ☐ Health care & social assistance ☐ Accommodation & food service ☐ Wholesale-agent/broker ☐ Wholesale-other ☐ Retail
☐ Real estate ☐ Manufacturing ☐ Finance & insurance ☑ Other (specify) **HHCSR using Fiscal Employer Agent**

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

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

Third Party Designee

Complete this section **only** if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.

Designee's name
@ CDS IN TEXAS, INC.

Designee's telephone number (include area code)
(210) 798-3779

Address and ZIP code
6243 IH 10 West, Suite 430, San Antonio, Texas 78201

Designee's fax number (include area code)
(210) 798-5200

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

Name and title (type or print clearly) ▶ OWNER

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

Signature ▶

Date ▶

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

Form 2678 Employer/Payer Appointment of Agent

(Rev. August 2014) 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 are 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 is not effective until we approve your request. See the instructions for filing Form 2678 on page 3.

- If you are 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 are 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, 940-PR (Employer's Annual Federal Unemployment (FUTA) Tax Return)*	☑	☐
Form 941, 941-PR, 941-SS (Employer's QUARTERLY Federal Tax Return)	☑	☐
Form 943, 943-PR (Employer's Annual Federal Tax Return for Agricultural Employees)	☐	☐
Form 944, 944(SP) (Employer's ANNUAL Federal Tax Return)	☐	☐
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 cannot appoint an agent to report, deposit, and pay tax reported on Form 940, Employer's Annual Federal Unemployment (FUTA) Tax Return, unless you are a home care service recipient.

☐ Check here if you are 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

Date 10/01/2017

Best daytime phone

Now give this form to the agent to complete.

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

WRITTEN AUTHORIZATION

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

GRANTOR INFORMATION

1. CONTACT NAME: _____ 3. TWC ACCT NO: _____

2. PHONE NO: _____ 4. FEIN NO: _____

*(5) BY THIS INSTRUMENT, _____ (EMPLOYER Name)

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

(7) whose address is _____
(Grantor's current mailing address)

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

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

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

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

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

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

*(11) **Date Signed** _____

MANDATORY INFORMATION

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

CDS in Texas

EMPLOYER SERVICE AGREEMENT WITH CDS IN TEXAS

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

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

The Veteran and/or the LAR agree: **Initial**

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

11) To verify qualifications of an applicant or service provider with the FMSA before offering the applicant or service provider a position or allowing delivery of any services to the Individual through the VD-HCBS Program. _____

12) To be accountable for the funds spent through the VD-HCBS Program and understand that a VD Employer or DR who submits false or fraudulent time sheets, or approves a time sheet of an unqualified service provider, or approves a time sheet for tasks other than those approved by the Agency will be reported to the appropriate authorities for investigation and possible prosecution as fraud. _____

13) To terminate the VD-HCBS options if the Employer is unable or unwilling to follow program rules and/or employer-related rules and regulations. _____

14) To ensure protection of the individual receiving service and preserve evidence in the event of a Department of Family and Protective Services (DFPS) Adult Protective Services (APS) investigation of an allegation of abuse, neglect, or exploitation (ANE) against a VD-HCBS employee, DR, FMSA, or Agency employee or contractor. _____

The Financial Management Services Agency (FMSA) agrees:

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

The Employer and FMSA agree:

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

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

7. That any applicable federal, state or local regulations pertaining to the provision of VD-HCBS are incorporated by reference to this Agreement.

Duration and Modification of Service Agreement

1) This Agreement and referenced rules and regulations constitute the entire Agreement and understanding between the Employer and the FMSA.

2) This Agreement will be in effect as of the date this Agreement is signed by the Employer and the FMSA representative, but must not precede the date the Individual is eligible to participate in the program or CDS.

3) This Agreement will terminate when:
   a. the Individual no longer participates in the VD-HCBS program, voluntarily or involuntarily;
   b. the Individual is no longer eligible for the VD-HCBS program; or
4) This service Agreement is null and void when:
   a. the minor-aged Individual turns 18 years of age, is married or emancipated, and the Employer is not the court-appointed guardian;
   b. the legal status of either the Employer or the Individual changes; or
   c. there is any other change in the status of the Employer or Individual that requires a change in the status of the Employer.

Acknowledgment of Service Agreement:

Dated this the _____ day of _____, 20____

Employer: _____ (please print)

CDS in Texas
By: _____

Signature: _____

Signature: _____

CDS in Texas

PROVIDER NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

We understand that medical information about you and your health is personal. We are committed to protecting your information. We create a record of the services you receive at the Agency. We need this record to provide you with quality support and to comply with certain legal requirements. This notice applies to all of the records generated by us or information received from a third party.

This notice will tell you about the ways in which we may use and disclose information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

KEYS ISSSUES

Use and Disclosures: We use information about you to provide support for the veterans directed program. We may share information with other agencies in order to administer this program and to obtain payment for services. Information may be shared by paper mail, electronic mail, fax, or other methods.

Your Rights: In most cases, you have the right to look at or get a copy of information about you. If you request copies, we will charge you only normal photocopy fees. You also have the right to receive a list of certain types of disclosures of your information that we have made. If you believe that information in your record is incorrect, you have the right to request that we correct the existing information. The Agency will produce approved requested information within 30 days of receipt of written request.

Our Legal Duties: We are required by law to protect the privacy of your information, provide the notice about our information practices, and follow the information.

Complaints: If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The Person listed below can provide you with the appropriate address upon request. If you have any questions or complaints, please email:

compliance@cdsintexas.com

We may use or disclose your protected health information in the following situations without your authorization or opportunity to object: For public health purposes, to respond to or initiate a report of abuse, neglect or exploitation, to state and federal agencies, to coroners, or to others with a legal right to request this information.

To obtain a full copy of our privacy notice write or email to:

Compliance, CDS in Texas
6243 IH 10 West, Suite 430
San Antonio, Texas 78201

Or email: compliance@cdsintexas.com

In general, we may use or disclose your protected health information as required by law and limited to relevant requirements of the law.

Employer Signature: _____ Date: _____

CDS in Texas

DIRECT DEPOSIT AUTHORIZATION AGREEMENT

You must complete this entire form and send all required attachments for your payments to be processed.

REQUESTOR INFORMATION			
Name:		SSN:	
Phone:		DOB:	
Email:			
Address:			

Account Information			
Routing Number	**Account Number**	**Type of Account**	**Submission Reason**
		❒ Checking ❒ Savings ❒ Prepaid Card	❒ Checking ❒ Savings ❒ Prepaid Card
Documentation Attached**			
❒ Financial Institution letter ❒ Voided check ❒ Typed form from card company			

I understand I must attach documentation to this form. All documentation must contain my printed name, account number and routing number. Temporary checks or deposit slips are not acceptable. If using a prepaid card, I must get a statement from the issuing authority demonstrating that this is an active account. I understand I should be able to go to the prepaid card issuer's website to obtain this information.

By signing below I acknowledge that if this form is not submitted timely with acceptable documentation, payments will be delayed. I am authorizing automatic deposits to the account shown above. I authorize CDS in Texas to initiate debit entries for any erroneous deposited amounts. If the account above has been closed or does not contain adequate funds, I authorize the withholding of any erroneous deposit from future payments owed to me.

I understand that any changes to the above account must be immediately submitted to CDS in Texas and agree that CDS in Texas is not responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or my financial institution. **I understand that it is my responsibility to verify the crediting of funds to my account before writing checks or initiating debits against my account** and I will not hold CDS in Texas responsible for any charges I incur from my financial institution as a result of initiating withdrawals before funds are deposited.

_____ DATE: _____

Requestor Signature

CDS in Texas

RATE INFORMATION FOR EMPLOYERS

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

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

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

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

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

[ ] X [ ] = [ ]

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

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

CDS in Texas - 2020 Payroll Schedule

If Friday is a holiday, payday will be on a Thursday

Payroll is processed **bi-weekly** (every other week). Timesheets are **due every other Monday**. **Payday is every other Friday**
NOTE: Beginning October 1, 2020, payroll will be processed **semi-monthy** (twice in one month). Timesheet due dates and paydays will change. Timesheets are due every 1st or the 15th of the month. **Payday will now be every 1st and the 15th**. (If date falls on a weekend, payroll will be processed the Friday prior.

PAY PERIOD	PAYROLL START	END	DUE		PAY DATE
1	12/15/2019	12/28/2019	12/30/2019		01/10/2020
2	12/29/2019	01/11/2020	01/13/2020		01/24/2020
3	01/12/2020	01/25/2020	01/27/2020		02/07/2020
4	01/26/2020	02/08/2020	02/10/2020		02/21/2020
5	02/09/2020	02/22/2020	02/24/2020		03/06/2020
6	02/23/2020	03/07/2020	03/09/2020		03/20/2020
7	03/08/2020	03/21/2020	03/23/2020		04/03/2020
8	03/22/2020	04/04/2020	04/06/2020		04/17/2020
9	04/05/2020	04/18/2020	04/20/2020		05/01/2020
10	04/19/2020	05/02/2020	05/04/2020		05/15/2020
11	05/03/2020	05/16/2020	05/18/2020		05/29/2020
12	05/17/2020	05/30/2020	06/01/2020		06/12/2020
13	05/31/2020	06/13/2020	06/15/2020		06/26/2020
14	06/14/2020	06/27/2020	06/29/2020		07/10/2020
15	06/28/2020	07/11/2020	07/13/2020		07/24/2020
16	07/12/2020	07/25/2020	07/27/2020		08/07/2020
17	07/26/2020	08/08/2020	08/10/2020		08/21/2020
18	08/09/2020	08/22/2020	08/24/2020		09/04/2020
19	08/23/2020	09/05/2020	09/07/2020		09/18/2020
20	09/06/2020	09/19/2020	09/21/2020		10/02/2020
21	09/20/2020	09/30/2020	10/05/2020		10/16/2020
22	10/01/2020	10/15/2020	10/16/2020		10/30/2020
23	10/16/2020	10/31/2020	11/01/2020		11/13/2020
24	11/01/2020	11/15/2020	11/16/2020		11/30/2020
25	11/16/2020	11/30/2020	12/01/2020		12/15/2020
26	12/01/2020	12/15/2020	12/16/2020		12/30/2021
1	12/16/2020	12/31/2020	01/01/2021		01/15/2021

Signed timesheets can be scanned and emailed to : VD@cdsintexas.com

All timesheets are due by 5 PM on the date due, EVEN IF IT IS A HOLIDAY

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

PLEASE USE THE FAX NUMBERS OR EMAIL BELOW TO SEND ALL VETERAN TIMESHEETS

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

Alternate numbers: If above numbers are not working: 866 301 1182 or 866 462 6671 or 877 812 3789

For all Veteran related questions or inquiries, please contact Luis Ochoa

210-798-3779 Ext. 1624
lochoa@cdsintexas.com

If unavailable, please contact Ashley Menchaca at 210-798-3779 Ext. 1664

CDS in Texas - 2021 Payroll Schedule

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

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

PAY PERIOD	PAYROLL START	END	DUE		PAY DATE
1	12/16/2020	12/31/2020	01/01/2020		01/15/2021
2	01/01/2021	01/15/2021	01/16/2021		02/01/2021
3	01/16/2021	01/31/2021	02/01/2021		02/12/2021
4	02/01/2021	02/15/2021	02/16/2021		03/01/2021
5	02/16/2021	02/28/2021	03/01/2021		03/15/2021
6	03/01/2021	03/15/2021	03/16/2021		04/01/2021
7	03/16/2021	03/31/2021	04/01/2021		04/15/2021
8	04/01/2021	04/15/2021	04/16/2021		04/30/2021
9	04/16/2021	04/31/2021	05/01/2021		05/14/2021
10	05/01/2021	05/15/2021	05/16/2021		06/01/2021
11	05/16/2021	05/31/2021	06/01/2021		06/15/2021
12	06/01/2021	06/15/2021	06/16/2021		07/01/2021
13	06/16/2021	06/30/2021	07/01/2021		07/15/2021
14	07/01/2021	07/15/2021	07/16/2021		07/30/2021
15	07/16/2021	07/31/2021	08/01/2021		08/13/2021
16	08/01/2021	08/15/2021	08/16/2021		09/01/2021
17	08/16/2021	08/31/2021	09/01/2021		09/15/2021
18	09/01/2021	09/15/2021	09/16/2021		10/01/2021
19	09/16/2021	09/30/2021	10/01/2021		10/15/2021
20	10/01/2021	10/15/2021	10/16/2021		11/01/2021
21	10/16/2021	10/31/2021	11/01/2021		11/15/2021
22	11/01/2021	11/15/2021	11/16/2021		12/01/2021
23	11/16/2021	11/30/2021	12/01/2021		12/15/2021
24	12/01/2021	12/15/2021	12/16/2021		12/30/2021
1	12/16/2021	12/31/2021	01/01/2022		01/14/2022

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

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

PLEASE USE THE FAX NUMBERS OR EMAIL BELOW TO SEND ALL VETERAN TIMESHEETS

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

Alternate numbers: If above numbers are not working: 866 301 1182 or 866 462 6671 or 877 812 3789

For all Veteran related questions or inquiries, please contact Luis Ochoa

210-798-3779 Ext. 1624
lochoa@cdsintexas.com

If unavailable, please contact Ashley Menchaca at 210-798-3779 Ext. 1664

Veteran Directed - Employee Timesheet

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

Type of Service

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

Veteran Name:

Month:

Employee Name:

Pay Period #

Part 1

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

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

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

USE 24 HOUR TIME

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

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

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

Veteran/DR Signature **Date**

Employee Signature **Date**

Semi-Monthly

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

CDS in Texas

Employer Name:

Employee Name:

Veteran - Directed Home - Service Notes (Required)

Service Date	Written/Narrative Summary of Services Provided

Veteran Directed - Employee Timesheet

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

Type of Service

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

Veteran Name:

Month:

Employee Name:

Pay Period #

Part 2

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

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

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

Veteran/DR Signature **Date**

Employee Signature **Date**

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

USE 24 HOUR TIME

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

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

Semi-Monthly

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

CDS in Texas

Employer Name:

Employee Name:

Veteran - Directed Home - Service Notes (Required)

Service Date	Written/Narrative Summary of Services Provided