Form **SS-4** (Rev. December 2017)

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.)

▶ **Go to *www.irs.gov/FormSS4* for instructions and the latest information.**

▶ **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

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

3 Executor, administrator, trustee, "care of" name
ASTROCARE CLASS EMPLOYER AGENT

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) ▶ **HCSR USING FISCAL/EMPLOYER AGENT**
- ☐ Estate (SSN of decedent) _____
- ☐ Plan administrator (TIN) _____
- ☐ Trust (TIN of grantor) _____
- ☐ Military/National Guard
- ☐ Farmers' cooperative
- ☐ REMIC
- ☐ State/local government
- ☐ Federal government
- ☐ 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 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
	X	

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) ▶ HCSR USING FISCAL/EMPLOYER AGENT

17 Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided.
HCSR 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
RHONDA HUNT c/o ASTROCARE CLASS EMPLOYER AGENT

Designee's telephone number (include area code)
281-931-5500

Address and ZIP code
14950 HEATHROW FOREST PKWY STE 300 HOUSTON TX 77032

Designee's fax number (include area code)
281-931-5514

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.

Applicant's telephone number (include area code)

Name and title (type or print clearly) ▶

Applicant's fax number (include area code)

Signature ▶ Date ▶

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 16055N Form **SS-4** (Rev. 12-2017)

Do I Need an EIN?

File Form SS-4 if the applicant entity does not 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	Does not currently have (nor expect to have) employees	Complete lines 1, 2, 4a–8a, 8b–c (if applicable), 9a, 9b (if applicable), and 10–14 and 16–18.
Hired (or will hire) employees, including household employees	Does not already have an EIN	Complete lines 1, 2, 4a–6, 7a–b (if applicable), 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10–18.
Opened a bank account	Needs an EIN for banking purposes only	Complete lines 1–5b, 7a–b (if applicable), 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]	Does not 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, 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 optional), 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 1–6, 9a, 10–12, 13–17 (if applicable), and 18.
Is a withholding agent for taxes on non-wage income paid to an alien (i.e., 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 (if applicable), 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, 9a, 10, and 18.
Is a single-member LLC (or similar single-member entity)	Needs an EIN to file Form 8832, 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 (Under Sections 6038A and 6038C of the Internal Revenue Code)	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 does not have employees.

[2] However, do not 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] Do not use the EIN of the prior business unless you became the "owner" of a corporation by acquiring its stock.

[4] However, grantor trusts that do not 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* on page 4 of the instructions. **Note**: State or local agencies may need an EIN for other reasons, for example, hired employees.

[8] See *Disregarded entities* on page 4 of 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.

Instructions for Form 2678

Section references are to the Internal Revenue Code.

Future Developments

For the latest information about developments related to Form 2678 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/form2678.*

Purpose of Form

Use Form 2678 if you want to:

• Request approval to have an agent file returns and make deposits or payments of Federal Insurance Contributions Act (FICA) taxes, Railroad Retirement Tax Act (RRTA) taxes, income tax withholding (ITW), or backup withholding; or

• Revoke an existing appointment.

Do not use prior versions of this form. All prior versions are obsolete. IRS will not accept them.

Can Employers Appoint Agents to Report, Deposit, and Pay Federal Unemployment Tax Act (FUTA) Tax?

Generally, employers cannot appoint an agent to report, deposit, and pay FUTA tax. However, if you are an employer who receives home care service, you may ask IRS to approve an agent to act on your behalf for FUTA tax purposes. Check the box in the footnote in Part 2, line 5.

To appoint an agent to act for FUTA tax purposes, you must also appoint the agent to act for FICA taxes and ITW purposes.

How to Complete the Form

Part 1: Why You Are Filing This Form

In Part 1, you will check a box to indicate why you are filing Form 2678.

• If you are an employer or payer and you want to appoint an agent, check the box that says, "You want to **appoint** an agent for tax reporting, depositing, and paying."

• If you are an employer, payer, or agent and you want to revoke an existing appointment, check the box that says, "You want to **revoke** an existing appointment."

Part 2: Employer or Payer Information

• If you are an employer or payer, enter your employer identification number (EIN), name, trade name, and address.

• If you are an agent revoking an existing appointment, enter the EIN, name, trade name, and address of the employer or payer for whom you have been authorized to act. The employer's or payer's signature is not required.

On line 5, check the boxes for all forms for which you want to:

• Request approval to appoint an agent to file on your behalf, or

• Revoke an agent's existing appointment.

If you are only appointing an agent for some employees, payees, or payments, check the box under *For SOME employees/payees/payments.*

Example 1. You are an employer. You appoint an agent to file returns and deposit FICA taxes and ITW related to biweekly wage payments that you paid your employees. However, you make bonus wage payments directly to your employees, not through the agent. You should report the bonus payments on a return filed using your EIN.

Example 2. You are an employer. You appoint an agent to file returns and deposit FICA taxes and ITW for biweekly wage payments that you paid to your employees. However, you make biweekly wage payments directly to your company's executives. You should report the wage payments to the executives on a return filed using your EIN.

If you are an employer or payer and you are requesting authorization to appoint an agent, sign and date Form 2678 in Part 2. Then give the form to the agent to complete and sign Part 3.

If you are an employer or payer and you want to revoke an existing appointment, sign and date Form 2678 in Part 2. Complete Part 3. Then send the form to the address for your location under *Where To File,* later.

Part 3: Agent Information

• If you are an employer or payer and you are requesting authorization to appoint an agent, have the agent complete and sign Part 3.

• If you are an employer or payer and you want to revoke an existing appointment, complete Part 3. The agent's signature is not required. Then send the form to the address for your location under *Where To File*, later.

• If you want to accept an appointment as an agent or you are an agent who wants to revoke an existing appointment, complete Part 3 with your information. Then sign and date the form where indicated. Send the form to the address for the employer's or payer's location under *Where To File,* later.

Note. If an agent is a corporate officer, partner, or tax matters partner, the agent must have the authority to execute this appointment of agent.

Filing Form 2678

Send Form 2678 to the address for the employer's or payer's location under *Where To File,* later. We will send a letter to the employer or payer and to the agent after we have approved the request. For agents of home care service recipients, we will send the approval letter only to the agent.

The authorization to act as an agent is effective on the date shown in the letter. Until we approve the request, the agent is not liable for filing any tax returns or making any deposits or payments.

Only one signature is required to revoke an agent's appointment. If an existing appointment is revoked, the IRS cannot disclose confidential tax information to anyone other than the employer or payer for periods after the appointment is revoked.

If an agent's appointment is revoked, we will send both the employer or payer and the agent a letter confirming the revocation. For agents of home care service recipients, we will send the letter confirming the revocation only to the agent. **The revocation is effective on the date shown in the letter.**

Where To File

If you are in...						Send your form to...
Connecticut Delaware District of Columbia	Florida Georgia Illinois Indiana	Kentucky Maine Maryland Massachusetts	Michigan New Hampshire New Jersey New York	North Carolina Ohio Pennsylvania Rhode Island	South Carolina Vermont Virginia West Virginia Wisconsin	Department of the Treasury Internal Revenue Service Cincinnati, OH 45999
Alabama Alaska Arizona Arkansas California	Colorado Hawaii Idaho Iowa Kansas	Louisiana Minnesota Mississippi Missouri Montana	Nebraska Nevada New Mexico North Dakota	Oklahoma Oregon South Dakota Tennessee	Texas Utah Washington Wyoming	Department of the Treasury Internal Revenue Service Ogden, UT 84201
No legal residence or place of business in any state						Department of the Treasury Internal Revenue Service Ogden, UT 84201
Exempt organization or government entity						Department of the Treasury Internal Revenue Service Ogden, UT 84201-0046

Agent Responsibilities After Appointment

Reporting, Depositing, and Payment Requirements

Agents must follow the procedures for employment taxes in Rev. Proc. 2013-39, 2013-52 I.R.B. 830, available at *www.irs.gov/irb/2013-52_IRB/ar15.html* and for backup withholding in Rev. Proc. 84-33. Agents for employers who are home care service recipients receiving home care services through a program administered by a federal, state, or local government agency may also use this form. These agents may be referred to as fiscal/employer agents, household employer agents, and home care service recipient agents.

All agents, employers, and payers remain liable for filing all returns and making all tax deposits and payments while this appointment is in effect. If an agent contracts 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 tax deposits or payments and the third party fails to do so, the agent, employer, and payer remain liable.

Filing Schedule R (Form 940) and Schedule R (Form 941)

An agent for a home care service recipient that files an aggregate Form 940, Employer's Annual Federal Unemployment (FUTA) Tax Return, must complete Schedule R (Form 940), Allocation Schedule for Aggregate Form 940 Filers, and file it with the aggregate Form 940.

An agent who files an aggregate Form 941, Employer's QUARTERLY Federal Tax Return, must complete Schedule R (Form 941), Allocation Schedule for Aggregate Form 941 Filers, and file it with the aggregate Form 941.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on Form 2678 to carry out the Internal Revenue laws of the United States. The principal purpose of this information is to permit you to appoint an agent to act on your behalf. You do not have to appoint an agent; however, if you choose to appoint an agent, you must provide the information requested on Form 2678. Our authority to collect this information is section 3504. Section 6109 requires you and the agent to provide your identification numbers. Failure to provide this information could delay or prevent processing your appointment of agent. Intentionally providing false information could subject you and the agent to penalties.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law.

Generally, tax returns and return information are confidential, as required by section 6103. However, section 6103 allows or requires the IRS to disclose or give the information shown on this form to others as described in the Code. For example, we may disclose your tax information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

The time needed to complete and file Form 2678 will vary depending on individual circumstances. The estimated average time is:

Recordkeeping . . . . . 1 hr., 5 min.

Learning about the law or the form . . . . . 54 min.

Preparing, copying, assembling, and sending the form to the IRS . . . . . 13 min.

If you have any comments concerning the accuracy of these time estimates or suggestions for making Form 2678 simpler, we would be happy to hear from you. You can send us comments from *www.irs.gov/formspubs.* Click on *More Information* and then click on *Give us feedback.* Or you can send your comments to Internal Revenue Service, Tax Forms and Publications Division, 1111 Constitution Ave. NW, IR-6526, Washington, DC 20224. **Do not** send Form 2678 to this address. Instead, see *Where To File* above.

Form 2678 Employer/Payer Appointment of Agent

(Rev. December 2024) Department of the Treasury — Internal Revenue Service

OMB No. 1545-0029

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.

Sign your name here

Print your name here

Print your title here

Date / /

Best daytime phone

Now give this form to the agent to complete.

Part 3: **Agent Information: If you'll be an agent for an employer or payer, or want to revoke an appointment, complete this part.**

6 Agent's employer identification number (EIN) 03 – 0606805

7 Agent's name (not trade name) RHONDA HUNT

8 Trade name (if any) ASTROCARE CLASS EMPLOYER AGENT

9 Address

14950 HEATHROW FOREST PKWY STE 300
Number Street Suite or room number

HOUSTON | TX | 77032
City State ZIP code

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

☑ Check here if the employer is a home care service recipient receiving home care services through a program administered by a federal, state, or local government agency.

Under penalties of perjury, I declare that I have examined this form and any attachments, and to the best of my knowledge and belief, they are true, correct, and complete.

Sign your name here

Print your name here RHONDA HUNT

Print your title here VICE PRESIDENT

Date / /

Best daytime phone 281-931-5500

Form **8655**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Reporting Agent Authorization

► **Information about Form 8655 and its instructions is at *www.irs.gov/Form8655.***

OMB No. 1545-1058

Taxpayer

1a Name of taxpayer (as distinguished from trade name)		**2 Employer identification number (EIN)**
1b Trade name, if any		**4** If you are a seasonal employer, check here . . . . . ☐
3 Address (number, street, and room or suite no.)		**5** Other identification number (optional)
City or town, state, and ZIP code		
6 Contact person	**7** Daytime telephone number 281-931-5500	**8** Fax number 281-931-5514

Reporting Agent

9 Name (enter company name or name of business) ASTROCARE CLASS EMPLOYER AGENT	**10 Employer identification number (EIN)** 03-0606805
11 Address (number, street, and room or suite no.) 14950 HEATHROW FOREST PKWY STE 300	
City or town, state, and ZIP code HOUSTON TX 77032	
12 Contact person RHONDA HUNT	**13** Daytime telephone number 281-931-5500 / **14** Fax number 281-931-5514

Authorization of Reporting Agent to Sign and File Returns (**Caution:** See *Authorization Agreement*)

15 Indicate the tax return(s) to be signed and filed. For quarterly returns, use "YYYY/MM" format. "MM" is the last month of the quarter for which the authorization begins (for example, "2018/09" for third quarter of 2018). For annual returns, use "YYYY" format to indicate the year for which the authorization begins.

940		941		940-PR	N/A	941-PR	N/A	941-SS	N/A	943	
943-PR	N/A	944	N/A	945	N/A	1042		CT-1			

Authorization of Reporting Agent to Make Deposits and Payments (**Caution:** See *Authorization Agreement*)

16 Indicate the tax return(s) for which the reporting agent is authorized to make deposits or payments. Use the "YYYY/MM" format to enter the month in which the authorization begins (for example, "2018/08" for August 2018).

940		941		943		944	N/A	945		720	
1041	N/A	1042	N/A	1120	N/A	CT-1	N/A	990-PF	N/A	990-T	N/A

Duplicate Notices to Reporting Agents

17 Check here to request the IRS to issue to the reporting agent duplicate copies of notices and correspondence regarding returns filed and deposits or payments made by the reporting agent . . . . . ☐

Disclosure Authorization for Forms Series W-2, 1099, and/or 3921/3922

18a The reporting agent is authorized to receive otherwise confidential taxpayer information from the IRS to assist in responding to certain IRS notices relating to the Form W-2 series information returns. This authority is effective for calendar year forms beginning _____.

b The reporting agent is authorized to receive otherwise confidential taxpayer information from the IRS to assist in responding to certain IRS notices relating to the Form 1099 series information returns. This authority is effective for calendar year forms beginning _____.

c The reporting agent is authorized to receive otherwise confidential taxpayer information from the IRS to assist in responding to certain IRS notices relating to the Forms 3921 and 3922. This authority is effective for calendar year forms beginning .

State or Local Authorization (**Caution:** See *Authorization Agreement*)

19 Check here to authorize the reporting agent to sign and file state or local returns related to the authorization granted on line 15 and/or line 16 . . ☐

Authorization Agreement

I understand that this agreement does not relieve me, as the taxpayer, of the responsibility to ensure that all tax returns are filed and that all deposits and payments are made and that I may enroll in the Electronic Federal Tax Payment System (EFTPS) to view deposits and payments made on my behalf. If line 15 is completed, the reporting agent named above is authorized to sign and file the return indicated, beginning with the quarter or year indicated. If any starting dates on line 16 are completed, the reporting agent named above is authorized to make deposits and payments beginning with the period indicated. Any authorization granted remains in effect until it is terminated or revoked by the taxpayer or reporting agent. I am authorizing the IRS to disclose otherwise confidential tax information to the reporting agent relating to the authority granted on line 15 and/or line 16, including disclosures required to process Form 8655. Disclosure authority is effective upon signature of taxpayer and IRS receipt of Form 8655. The authority granted on Form 8655 will not revoke any Power of Attorney (Form 2848) or Tax Information Authorization (Form 8821) in effect.

Sign Here

I certify I have the authority to execute this form and authorize disclosure of otherwise confidential information on behalf of the taxpayer.

Signature of taxpayer	Title	Date
	HCSR	

Instructions

What's New

Fax number. The fax number for Form 8655 is changed to 855-214-7523. When faxing Forms 8655, please send no more than 25 forms in a single transmission. If possible, please send faxes directly from your computer instead of from a fax machine.

Updated instructions for lines 15 and 16. The instructions for lines 15 and 16 have been clarified and now appear at the lines themselves. Please use the "YYYY/MM" format instead of the "MM/YYYY" format.

Former line 17a removed. The authorization agreement at the bottom of the form provides the disclosure authority previously covered by line 17a.

Increasing or decreasing authority. The instructions with regard to increasing or decreasing authority have been clarified. See *Authority Granted.*

Termination and Revocation. The instructions have been updated to distinguish between these terms and to explain the procedure for each. See *Terminating or Revoking an Authorization.*

Purpose of Form

Use Form 8655 to authorize a reporting agent to:

• Sign and file certain returns. Reporting agents must file returns electronically except as provided under Rev. Proc. 2012-32. You can find Rev. Proc. 2012-32 on page 267 of Internal Revenue Bulletin 2012-34 at *www.irs.gov/pub/irs-irbs/irb12-34.pdf*. See Pub. 3112, IRS *e-file* Application and Participation, for information about e-filing and getting the reporting agent PIN;

• Make deposits and payments for certain returns. Reporting agents must make deposits and payments electronically, generally through the Electronic Federal Tax Payment System (EFTPS.gov). See Pub. 4169, Tax Professional Guide to EFTPS, and Rev. Proc. 2012-33;

• Receive duplicate copies of tax information, notices, and other written and/or electronic communication regarding any authority granted; and

• Provide IRS with information to aid in penalty relief determinations related to the authority granted on Form 8655.

Note. An authorization does not relieve the taxpayer of the responsibility (or from liability for failing) to ensure that all tax returns are filed timely and that all federal tax deposits (FTDs) and federal tax payments (FTPs) are made timely. A reporting agent must notify its client of that fact and must recommend that it enroll in the Electronic Federal Tax Payment System (EFTPS) to view EFTPS deposits and payments made on the client's behalf. A reporting agent must provide this notification, in writing, upon entering into an agreement with the client and at least quarterly thereafter for as long as it provides services to that client. Sample language and other details may be found in Rev. Proc. 2012-32, Section 5.05.

Authority Granted

Once Form 8655 is signed, any authority granted is effective beginning with the period indicated on lines 15, 16, 18a, 18b, and/or 18c and continues indefinitely unless terminated or revoked by the taxpayer or reporting agent. No authorization or authority is granted for periods prior to the period(s) indicated on Form 8655.

Where authority is granted for any form, it is also effective for related forms such as the corresponding non-English language form, amended return, (Form 941-X, 941-X(PR), 943-X, 944-X, 945-X, or CT-1X), or payment voucher. For example, Form 8655 can be used to provide authorization for Form 944-SP using the entry spaces for Form 944. The form also can be used to authorize a reporting agent to make deposits and payments for other returns in the Form 1120 series, such as Form 1120-C, using the entry space for Form 1120 on line 16.

Disclosure authority is effective upon signature of taxpayer and IRS receipt of Form 8655. Any authority granted on Form 8655 does not revoke and has no effect on any authority granted on Forms 2848 or 8821, or any third-party designee checkbox authority.

To increase the authority granted to a reporting agent by a Form 8655 already in effect, submit another signed Form 8655, completing lines 1–14 and any line on which you want to add authority. To decrease the authority granted to a reporting agent by a Form 8655 already in effect, send a signed, written request to the address under *Where To File.* The preceding authorization remains in effect except as modified by the new one.

Where To File

Send Form 8655 to:

Internal Revenue Service
Accounts Management Service Center
MS 6748 RAF Team
1973 North Rulon White Blvd.
Ogden, UT 84404

You can fax Form 8655 to the IRS. The number is 855-214-7523. When faxing Forms 8655, please send no more than 25 forms in a single transmission. If possible, please send faxes from your computer instead of a fax machine.

Additional Information

Additional information concerning reporting agent authorizations may be found in:

• **Pub. 1474,** Technical Specifications Guide for Reporting Agent Authorization and Federal Tax Depositors.

• **Rev. Proc. 2012-32.**

Substitute Form 8655

If you want to prepare and use a substitute Form 8655, see Pub. 1167, General Rules and Specifications for Substitute Forms and Schedules. If your substitute Form 8655 is approved, the form approval number must be printed in the lower left margin of each substitute Form 8655 you file with the IRS.

Terminating or Revoking an Authorization

If you have a valid Form 8655 on file with the IRS, the filing of a new Form 8655 indicating a new reporting agent terminates the authority of the prior reporting agent beginning with the period indicated on the new Form 8655. However, the prior reporting agent is still an authorized reporting agent and retains any previously granted disclosure authority for the periods prior to the beginning period of the new reporting agent's authorization unless specifically revoked.

If the taxpayer wants to revoke an existing authorization, such that the reporting agent would no longer be authorized to act or receive information for previously authorized tax periods, send a copy of the previously executed Form 8655 to the IRS at the address under *Where To File,* above. Re-sign the copy of the Form 8655 under the original signature. Write "REVOKE" across the top of the form. If you do not have a copy of the authorization you want to revoke, send a statement to the IRS. The statement of revocation must indicate that the authority of the reporting agent is revoked and must be signed by the taxpayer. Also, list the name and address of each reporting agent whose authority is revoked.

A reporting agent may terminate its authority by filing a statement with the IRS, either on paper or using a delete process. A reporting agent wanting to revoke its authority must submit the request in writing. The statement must be signed by the reporting agent (if filed on paper) and identify the name and address of the taxpayer and authorization(s) from which the reporting agent is withdrawing. For information on the delete process, see Pub. 1474.

Who Must Sign

Electronic signature. For guidance on optional electronic signature methods, including approved methods of authentication and signature and additional items that must appear on the Form 8655, see Pub. 1474, section 01.03.

Sole proprietorship. The individual owning the business.

Corporation (including a limited liability company (LLC) treated as a corporation). Generally, Form 8655 can be signed by: (a) an officer having legal authority to bind the corporation, (b) any person designated by the board of directors or other governing body, (c) any officer or employee on written request by any principal officer, and (d) any other person authorized to access information under section 6103(e).

Partnership (including an LLC treated as a partnership) or an unincorporated organization. Generally, Form 8655 can be signed by any person who was a member of the partnership during any part of the tax period covered by Form 8655.

Single member LLC treated as a disregarded entity. The owner of the LLC.

Trust or estate. The fiduciary.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Our authority to request this information is Internal Revenue Code sections 6011, 6061, 6109, and 6302 and the regulations thereunder. We use this information to identify you and record your reporting agent authorization. You are not required to authorize a reporting agent to act on your behalf. However, if you choose to authorize a reporting agent, you are required to provide the information requested, including your identification number. Failure to provide all the information requested may prevent or delay processing of your authorization; providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement agencies and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law.

The time needed to complete and file Form 8655 will vary depending on individual circumstances. The estimated average time is 1 hour, 7 minutes.

If you have comments concerning the accuracy of this time estimate or suggestions for making Form 8655 simpler, we would be happy to hear from you. You can send us comments from *www.irs.gov/formspubs*. Click on *More Information* and then click on *Give us feedback*. Or you can send your comments to Internal Revenue Service, Tax Forms and Publications Division, 1111 Constitution Ave. NW, IR-6526, Washington, DC 20224. **Do not** send Form 8655 to this address. Instead, see *Where To File*, earlier.

Form **8821**

(Rev. January 2018)

Department of the Treasury
Internal Revenue Service

Tax Information Authorization

► **Go to *www.irs.gov/Form8821* for instructions and the latest information.**

► **Don't sign this form unless all applicable lines have been completed.**

► **Don't use Form 8821 to request copies of your tax returns or to authorize someone to represent you.**

OMB No. 1545-1165

For IRS Use Only

Received by:

Name

Telephone

Function

Date

1 Taxpayer information. Taxpayer must sign and date this form on line 7.

Taxpayer name and address	Taxpayer identification number(s)	
	Daytime telephone number	Plan number (if applicable)

2 Appointee. If you wish to name more than one appointee, attach a list to this form. **Check here if a list of additional appointees is attached** ► ☐

Name and address	
RHONDA HUNT 14950 HEATHROW FOREST PKWY STE 300 HOUSTON TX 77032	CAF No. 0303-69850R PTIN Telephone No. 281-931-5500 Fax No. 281-931-5514 Check if new: Address ☐ Telephone No. ☐ Fax No. ☐

3 Tax Information. Appointee is authorized to inspect and/or receive confidential tax information for the type of tax, forms, periods, and specific matters you list below. See the line 3 instructions.

☐ By checking here, I authorize access to my IRS records via an Intermediate Service Provider.

(a) Type of Tax Information (Income, Employment, Payroll, Excise, Estate, Gift, Civil Penalty, Sec. 4980H Payments, etc.)	**(b)** Tax Form Number (1040, 941, 720, etc.)	**(c)** Year(s) or Period(s)	**(d)** Specific Tax Matters
EMPLOYMENT TAXES	941, 941X, 941R, 941RX		
EMPLOYMENT TAXES	940,940X, 940R, 940RX		
W-2'S, W-2C'S, W-3'S, W-3C'S			

4 Specific use not recorded on Centralized Authorization File (CAF). If the tax information authorization is for a specific use not recorded on CAF, check this box. See the instructions. If you check this box, skip lines 5 and 6 . . . . . ► ☐

5 Disclosure of tax information (you **must** check a box on line 5a or 5b unless the box on line 4 is checked):

a If you want copies of tax information, notices, and other written communications sent to the appointee on an ongoing basis, check this box . . . . . ► ☐

Note. Appointees will no longer receive forms, publications, and other related materials with the notices.

b If you don't want any copies of notices or communications sent to your appointee, check this box . . . . . ► ☐

6 Retention/revocation of prior tax information authorizations. If the line 4 box is checked, skip this line. If the line 4 box isn't checked, the IRS will automatically revoke all prior Tax Information Authorizations on file unless you check the line 6 box and attach a copy of the Tax Information Authorization(s) that you want to retain. . . . . ► ☐

To revoke a prior tax information authorization(s) without submitting a new authorization, see the line 6 instructions.

7 Signature of taxpayer. If signed by a corporate officer, partner, guardian, partnership representative, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute this form with respect to the tax matters and tax periods shown on line 3 above.

► **IF NOT COMPLETE, SIGNED, AND DATED, THIS TAX INFORMATION AUTHORIZATION WILL BE RETURNED.**

► **DON'T SIGN THIS FORM IF IT IS BLANK OR INCOMPLETE.**

Signature | Date

Print Name | Title (if applicable)

ASTROCARE C.L.A.S.S., INC.

14950 Heathrow Forest Parkway #300, Houston, Texas 77032
(281) 931-5500-Office, (281) 931-5514-Fax

WRITTEN AUTHORIZATION TO APPLY FOR EIN ACCOUNT ON-LINE VIA THE INTERNET

I,_____, give Astrocare, CLASS, Inc. authorization to obtain an Employee Identification Account Number on my behalf via the internet.

Employer Signature _____

Date _____

Astrocare, CLASS, Inc. Representative Signature _____

Date _____

ASTROCARE C.L.A.S.S., INC.

14950 Heathrow Forest Parkway #300, Houston, Texas 77032
(281) 931-5500-Office, (281) 931-5514-Fax

WRITTEN AUTHORIZATION TO APPLY FOR TWC ACCOUNT NO. ON-LINE VIA THE INTERNET

I,_____, give Astrocare, CLASS, Inc. authorization to obtain a Texas Workforce Commission Account Number on my behalf via the internet.

Employer Signature _____

Date _____

Astrocare, CLASS, Inc. Representative Signature _____

Date _____

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

This form can be completed online at
www.texasworkforce.org

STATUS REPORT

This report is **required** of every employing unit, and will be used to determine liability under the Texas Unemployment Compensation Act.
If you have employment in Texas on a farm or ranch, please complete Form c-1fr, available online.

Identification Section

1. Account Number assigned by TWC (if any)	2. Federal Employer ID Number	3. Type of ownership (check one)
4. Name		☐ corporation/pa/pc ☐ limited partnership ☐ partnership ☐ estate ☐ individual (sole proprietor/domestic) ☐ trust ☐ limited liability company ☐ other (specify) _____
5. Mailing address 14950 HEATHROW FOREST PKWY STE 300		

6. City	7. County	8. State	8(a). Zip code	9. Phone Number
HOUSTON TX 77032-3840	HARRIS	TX	77032-3840	281-931-5500

10. Business address where records or payrolls are kept: (if different from above)

Address City State Zip Phone Number

11. Owner(s) or officer(s) [attach additional sheet if necessary]

Name	Social Security No.	Title	Residence Address, City, State, Zip

12. Business locations in Texas [attach additional sheet if necessary]

Trade name	Street Address, City, Zip	Kind of business	No. of employees

13. If your business is a chartered legal entity, enter:

Charter number	State of Charter	Date of Charter	Registered agent's name

Registered agent's address	Original legal entity name, if name has changed

Employment section

	Month	Day	Year
14. Enter the date you first had employment in Texas (do not use future date):			
15. Enter the date you first paid wages to an employee in Texas (do not use future date):			
16. If your account has been inactive: Enter the date you resumed employment in Texas:			
Enter the date you resumed paying wages in Texas:			
17. Enter the ending date of the first quarter you paid gross wages of $1,500.00 or more:			
18. Enter the Saturday date of the 20th week that individuals were employed in Texas. (All weeks should be in the same calendar year. Count a week if anyone performed any service for any portion of any day. The services do not have to be performed on the same day of the week, in consecutive weeks or by the same employee. If you do not reach 20 weeks of employment in the first calendar year of operation, begin again with the second calendar year and count until you reach 20 weeks in that year.) Do not use future dates			
19. If you hold an exemption from Federal Income Taxes under Internal Revenue Code Section 501(c)(3), attach a copy of your Exemption Letter. Also, enter the ending date of the 20th week of the calendar year in which 4 or more persons were employed in Texas:			

20. Enter the year(s) your organization was liable for taxes under the Federal Unemployment Tax Act:
(begin with most recent year)

____ (year) ____ (year) ____ (year) ____ (year)

21. Does this employer employ any U.S. citizens outside of the U.S.? ☐ Yes ☑ No

Domestic - Household Employment Section

Complete 22 only if you have domestic or household employees (includes maids, cooks, chauffeurs, gardeners, etc.)

22. Enter the ending date of the first calendar quarter in which you paid gross wages of $1,000 or more to employees performing domestic service:	Month	Day	Year

Nature of Activity Section

23. Describe fully the nature of activity in Texas, and list the principal products or services in order of importance:
Personal assistance services provided at home for the care and protection of

24. If the business in Texas was acquired from another legal entity, you must complete items 24-26. If a partial acquisition occurred, the predecessor/successor may jointly submit information regarding a partial transfer of experience.

a) Previous owner's TWC Account Number (if known) _____

b) Date of acquisition _____

c) Name of previous owner(s) _____

d) Address _____

e) City _____ State _____ Zip _____

What portion of business was acquired? (check one) ☐ all ☐ part (specify) _____

25. On the date of the acquisition, was the previous owner(s), or any partner(s), officer(s), shareholder(s), other owner(s) or a person related by blood or marriage to any of these individuals, holding a legal or equitable interest in the predecessor business, also an owner, partner, officer, shareholder, or other owner of a legal or equitable interest in the successor business? ☐ Yes ☐ No

If "Yes", check all that apply: ☐ same owner, officer, partner, or shareholder ☐ sole proprietor incorporating

☐ same parent company ☐ other (describe below)

If "No," on the date of the acquisition, did the previous owner(s), partner(s), officer(s), shareholder(s), other owner(s) or a person related by blood or marriage to any of these individuals, holding a legal or equitable interest in the predecessor business, hold an option to purchase such an interest in the successor business?

☐ yes ☐ no

26. After the acquisition, did the predecessor continue to:

- Own or manage the organization that conducts the organization, trade or business?
- Own or manage the assets necessary to conduct the organization, trade or business?
- Control through security or lease arrangement the assets necessary to conduct the organization, trade or business?
- Direct the internal affairs or conduct of the organization, trade or business?

☐ Yes ☐ No

If "Yes" to any of above, describe: _____

Voluntary Election Section

27. A non-liable employer may elect to pay state unemployment tax voluntarily. If an employer elects to do so, the employer is obliged to pay taxes for a minimum of two calendar years, beginning with January 1 of the first year of the election. The employer may withdraw the election by written request, at the end of the 2-year period, if not yet liable under the Texas Unemployment Compensation Act. To elect this option, complete the following:

☐ Yes, effective Jan. 1, ___ I wish to cover all employees (except those performing service(s) which are specifically exempt in the Texas Unemployment Compensation Act).

Signature Section

I hereby certify that the preceding information is true and correct, and that I am authorized to execute this Status Report on behalf of the employing unit named herein. (this report must be signed by the owner, officer, partner **or** individual with a valid Written Authorization on file with the Texas Workforce Commission)

Date of signature:

Month _____ Day _____ Year _____ Sign here➔ _____ Title HCSR

Driver's license number _____ State _____ E-mail address _____

Individuals may receive, review and correct information that TWC collects about the individual by emailing to open.records@twc.state.tx.us or writing to: TWC Open Records, 101 E. 15th St., Rm. 266, Austin, TX 78778-0001.

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: RHONDA HUNT
2. PHONE NO. (281) 931-5500
3. TWC ACCT NO. _____
4. FEID NO. _____

*(5) BY THIS INSTRUMENT, _____
(Name of Grantor)

(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 ASTROCARE CLASS EMPLOYER AGENT
(Name of Authorized Grantee)

(9) whose TWC ACCOUNT NO. is 13-440410-8

and whose address is 14950 HEATHROW FOREST PKWY STE 300 HOUSTON TX 77032,

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) _____
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

INSTRUCTIONS FOR WRITTEN AUTHORIZATION

To represent Employing Unit in its Relations with the Texas Workforce Commission

Description of information required on front of document. *Failure to complete the items with an asterisk (*) will result in the document being returned as incomplete.

1. Enter the name of the contact person responsible for answering any questions pertaining to state unemployment insurance taxes.

2. Enter Contact person's telephone number including Area Code.

3. Enter the Account Number assigned to the Grantor by Texas Workforce Commission. **If the Grantor does not have a number, a Form C-1, Status Report, should be submitted.**

4. Grantor's Federal Employer Identification Number.

*5. Name of Grantor.

6. Type of ownership (individual [sole proprietorship], partnership, corporation, trust, limited liability company, estate, etc.)

7. Grantor's current mailing address.

*8. **IMPORTANT:** Name of Grantee who is being appointed.

9. Grantee's Texas Workforce Commission Account Number and address.

*10. **Printed name, signature and title:** The Written Authorization must be signed by the (1) individual, if the Grantor is a sole proprietor; (2) a responsible and duly authorized member or officer having knowledge of its affairs, if the Grantor is a partnership or other unincorporated organization; (3) the president, vice president, or other principal officer, if the Grantor is a corporation; or, (4) the fiduciary, if a trust or estate.

*11. Dated Signed.

NOTE! WRITTEN AUTHORIZATION MAY BE REVOKED BY GRANTOR OR GRANTEE.

Individuals may receive, review and correct information that TWC collects about the individual by emailing to open.records@twc.state.tx.us or writing to TWC Open Records, 101 E. 15th St., Rm. 266, Austin, TX 78778-0001.

CDS questions needs answering before we can start the CDS process

Is the client a: Minor ☐ Adult ☐

Who will be the employer? _____

If an adult, the client will be the employer unless the client has a legal guardian.

If the client, as an employer, is not capable of making decisions, a Designated Representative (DR) should be appointed. If the DR is not a family member, then a Criminal History must be obtained to determine eligibility.

If there is a legal guardian, the legal guardian must be the employer.

If the client is a minor, one of the parents must be the employer.

Has the employer ever obtained a Sole Proprietor EIN in their name: Yes ☐ No ☐

Has the employer been on the CDS program before or now: Yes ☐ No ☐

Employer's name as it is on Social Security card please print _____

Employer's Social Security number_____

Employer's email _____

Employer's best contact phone number _____

Verify address _____

Number of employees to hire _____ (each employee must fill out their own New Hire paperwork)

TWC Account Number and EIN if already established for the CDS Program_____
Note that no other active business can be using the same TWC account number and EIN that is being used for CDS services.

The sooner we start the CDS process the, the better chances of getting services started and attendants paid on time. It is up to you to ensure all CDS documents are filled out completely and signed in order for attendants to get paid on time. You must do all of the HHSC Policy Training and Electronic Visit Verification require training, I am sending another email for this information.

CDS documentation is processed in 4 phases

1. New Hire Employee
2. Employer Documentation
3. Budget
4. Approval (note that this may be delayed if any information is incorrect, missing or if changes are made)

To ensure all documentation is completed correctly and signed, send back to Grant@astrocarehealth.com asap. This will ensure program will start on the effective date and that all attendants will get paid.

Please note this process is time restricted must be completed before your effective date to CLASS. If the required steps are not completed by you, you will not be able to move forward and your attendants will not get paid. Please comply to ensure timely receipt of HHSC required documentations and comply with HHSC Rules and Regulations.

Name: _____ Date_____
Please sign and return to grant@astrocarehealth.com

I've also included the below:

- CDS Employer Manual/Handbook
  - https://hhs.texas.gov/laws-regulations/handbooks/cds/consumer-directed-services-handbook
- HHSC Policy Training
  - Course Name: Initial EVV Policy Training Webinar for CDS Employers (webinar recording)
  - On Demand Training Link: https://register.gotowebinar.com/recording/1093861650182990849
  - Must register an account with the learning portal to sign up and access training
- EVV (Electronic Visit Verification) Required Training Checklist
  - https://vestaevv.com/cds-employer/
  - This is the way the employee will clock in and out
- Payroll Schedule
- New Hire Packet
  - The employee will have to fill this packet out
  - We will also need a copy of license, SS card, as well as a current CPR certification

TEXAS Health and Human Services

Form 1722
June 2020-E

Consumer Directed Services

Employer's Selection for Electronic Visit Verification Responsibilities

The 21st Century Cures Act is a federal law that requires states to implement Electronic Visit Verification (EVV) for all Medicaid personal care services requiring an in-home visit by a service provider, including services delivered through the Consumer Directed Services (CDS) option.

EVV is an electronic documentation system used to verify that services have been provided. The EVV system electronically documents the following information for each service visit:

- the type of service provided;
- name of the person receiving the service;
- name of the service provider (CDS employee);
- the location, including the address, where the service is provided;
- date and time the service delivery begins (clock in time);
- date and time the service delivery ends (clock out time); and
- other information HHSC determines is necessary to ensure the accurate adjudication of Medicaid claims.

When a CDS employee provides a service requiring EVV to a person, the employee must clock in to the EVV system when services begin and clock out of the EVV system when services end, using an approved electronic verification method. An electronic verification method is the method the employee will use to clock in and clock out of the EVV system. Approved methods include a mobile application, landline phone and alternative device.

The CDS employer is responsible for training the employee on clocking in and clocking out of the EVV system and must ensure the CDS employee uses the EVV system to record service visits.

Visit maintenance is the process for making corrections to clock in and clock out information in the EVV system to accurately reflect the delivery of services. For example, the CDS employer, or their Financial Management Services Agency (FMSA), must perform visit maintenance if an employee clocks in through the EVV system at the beginning of a shift but forgets to clock out at the end of the shift. In this case, the CDS employer or FMSA will add the clock out time and adjust the time worked in the EVV system. All required visit maintenance must be completed before the FMSA submits an EVV claim for payment.

	For FMSA Use Only
1. Name of Person Receiving Services:	3. Identification Number:
2. CDS Employer's Name (if different from the person receiving services):	4. Relation to Person Receiving Services:

The CDS employer acknowledges:

My FMSA has explained my responsibilities for using EVV.

I understand that I must complete the following required EVV trainings prior to using the EVV system:

- EVV system training conducted by the EVV vendor or my FMSA; and
- EVV policy training conducted by my FMSA, the Texas Health and Human Services Commission (HHSC) or my managed care organization (MCO), if I have one.

I understand that I will not receive access to the EVV system until I have taken the EVV system training.

I understand that I must use the EVV system listed below, chosen by my FMSA.

EVV Vendor Name: DATALOGIC SOFTWARE, INC.

EVV System Name: VESTA

EVV System Contact Information: info@vestaevv.com

Selection for EVV Visit Maintenance Responsibilities:

I understand that I am always responsible for approving the time my employee has worked. Also, I understand that for a service requiring EVV, I can enter my approval of the time worked in the EVV system or I can request that the FMSA confirm my approval of the time worked in the EVV system.

Further, I understand that I must choose to perform visit maintenance in the EVV system, or I can choose to delegate the performance of visit maintenance to my FMSA. If I delegate visit maintenance to my FMSA, I must enter in the EVV system my approval of any changes made by the FMSA as part of visit maintenance or I must have the FMSA confirm in the EVV system my approval of any changes. I choose the following option:

- ◯ Option 1: I will enter my approval of the time my CDS employee worked in the EVV system and I will perform visit maintenance in the EVV system.
- ◯ Option 2: I will enter my approval of the time my CDS employee worked in the EVV system. I delegate the performance of visit maintenance to the FMSA. After the FMSA completes visit maintenance, I will enter my approval in the EVV system of any changes to time worked made by the FMSA, if necessary, as part of visit maintenance.
- ◯ Option 3: The FMSA will confirm my approval of the time my CDS employee worked in the EVV system. I delegate the performance of EVV visit maintenance to the FMSA.

I understand that regardless of the option I have chosen, I must receive training on the EVV system, including training on clocking in and clocking out of the EVV system, and I must train my CDS employees on how to clock in and clock out of the EVV system.

I understand that the FMSA will review EVV visits to ensure the time worked by a CDS employee is within the hours authorized on the person's service plan and the CDS budget.

☐ I elect to have my Designated Representative (DR) assist me with the EVV responsibilities described on this form.

I understand that my DR must take the EVV system training and EVV policy training prior to assisting me with using the EVV system.

I agree to complete a new form if any of the information provided on this form changes or if I want to choose a different option than that identified above.

I agree that the selections made on this form will become effective on: _____
Date

_____ _____
Signature — CDS Employer Date

_____ _____
Signature — Designated Representative (if applicable) Date

_____ _____
Signature — FMSA Representative Date

TEXAS Health and Human Services

Form 1726
August 2015-E

Consumer Directed Services (CDS)

Relationship Definitions in Consumer Directed Services
Employer's Acknowledgement and Certification

Definitions:

1. The **individual** is the individual receiving services who is either:
   - a **minor**, that is, a person who is under age 18 (17 and younger); or
   - an **adult** who is a person age 18 or older.

2. The **legally authorized representative (LAR)** is a person who is:
   - a natural parent, legal/adopted parent, a stepparent or a managing conservator when the individual is a **minor**; or
   - the current court-appointed guardian of an individual of any age.

3. An **employer** is defined as:
   - an **individual** receiving services who is an **adult** with no legally appointed guardian;
   - an LAR of the individual; or
   - a foster parent who must also have written authorization from the Texas Department of Family and Protective Services (DFPS) to be the employer.

4. A **designated representative (DR)** is a willing adult the employer chooses to act as the primary contact and decision maker for the employer through the CDS option. However, the employer still retains responsibility for CDS requirements.

5. A **spouse** is a person married to another person. The term “married” includes marriage “with formalities” and marriage “without formalities” (common law), as defined in Texas Family Code, Title 1, Chapter 2, Subchapter E, Marriage without Formalities, located at the following website: www.statutes.legis.state.tx.us/Docs/SDocs/FAMILYCODE.pdf.

6. A **service provider** is defined as:
   - an **employee**, a **contractor** or a **vendor** providing services to an individual in the CDS option; **and** is:
     - a qualified person who is age 18 or older who meets the requirements of the individual's program and of the CDS option for service delivery; or
     - a qualified person representing a qualifying **entity** (contractor or vendor) providing services to an individual in the CDS option.

The service provider must <u>not</u> be:

- the employer or the employer's spouse (however, the spouse may be employed in Consumer Managed Personal Attendant Services [CMPAS] for the CDS option);
- the individual's spouse (does not apply to CMPAS);
- the DR or the DR's spouse;
- the individual's LAR, which would include a parent, guardian, managing conservator or stepparent of a minor-age individual, or the guardian of an individual of any age;
- the primary caregiver in Primary Home Care (PHC), Community Attendant Services (CAS) or Family Care (FC);
- a person who lives with the individual, related or not, in the Home and Community-based Services (HCS) program (only applies to respite) or in the Texas Home Living (TxHmL) program (only applies to respite);
- a person who lives with the individual (if the primary caregiver is the Community First Choice Personal Assistance Services/ Habilitation service provider and resides with the individual) in the Community Living Assistance and Support Services (CLASS) program (only applies to respite);
- a DFPS foster parent in the HCS or TxHmL programs; or
- a person who is related to the individual within the fourth degree of consanguinity or within the second degree of affinity in the TxHmL program (only applies to behavioral support and adaptive aids).

Employer's Acknowledgement and Certification

I, the employer, certify that I understand the above information. I understand that persons who do not meet the program relationship requirements must not be a service provider, employed as an employee, or retained as a contractor, entity or vendor in the CDS option. I understand hiring an ineligible service provider may constitute Medicaid fraud.

Printed Name of Employer	Printed Name of Financial Management Services Agency (FMSA) Representative
Signature — Employer	Signature — FMSA Representative
Date	Date

TEXAS Health and Human Services

Form 1735
August 2018-E

Consumer Directed Services

Employer and Financial Management Services Agency Service Agreement

The name of the individual receiving services is, _____, hereafter referred to as the Individual.

The Individual's community-based services program is _____ and will be called the program in this Agreement. It is understood that this program is paid for out of federal Medicaid and state funds, and is administered by the Texas Health and Human Services Commission (HHSC).

The name of the employer is _____, hereafter referred to as the Employer.

The Employer is the ◯ individual, ◯ parent of a minor or ◯ court-appointed guardian of the Individual.

This Agreement is between the Employer and _____, Financial Management Services Agency (FMSA) located in _____ Texas, which will be called the FMSA in the rest of this Agreement. The FMSA has a contract to provide financial management services with

◯ HHSC, ◯ a managed care organization, or contracted to provide services in the state of Texas.

The Employer agrees to each of the following requirements:

1. To receive orientation, ongoing training and assistance from the FMSA. [initials]
2. To prepare a budget (with the assistance and approval of the FMSA) for each service delivered through Consumer Directed Services (CDS), based on an approved service plan for the Individual's program. [initials]
3. To follow each service budget and revised budget with FMSA approval. [initials]
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. [initials]
5. To give prior or immediate notice (when prior notice is not an option) to the FMSA of any change in the status of the Individual. Examples of change would be notice of loss of Medicaid eligibility, turning age 21, changing from one community-based services program to another, or transferring to another FMSA. [initials]
6. To follow the CDS option rules (40 Texas Administrative Code, Chapter 41) and all _____ program rules, polices and procedures applicable to the CDS option identified in the attached addendum. [initials]
7. To notify the program case manager or service coordinator and the FMSA of each hospitalization and admission into an institution and any change of telephone number, address or residency within 24 hours of the event. [initials]
8. To make sure that CDS program services are not used while the Individual is hospitalized, residing in an institution, or not eligible for Medicaid or the program. [initials]
9. To follow all employer and employment-related laws and regulations of federal, state and local agencies. The Employer acknowledges responsibility and liability for such laws and regulations even if he or she chose a Designated Representative (DR). [initials]
10. To assume employer-related responsibilities and liabilities to include at least: [initials]
    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 that results in budget reductions.
    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.
11. That neither HHSC nor the FMSA have or share any employment-related liability. [initials]

12. 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 CDS. [initials]
13. To be accountable for the funds spent through the CDS option and understand that a CDS 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 on the service plan or implementation plan, will be reported to the appropriate authorities for investigation and possible prosecution as Medicaid fraud. [initials]
14. To terminate the CDS option and return to the agency delivered services if the Employer is not able or willing to following the program, CDS and/or employer-related rules and regulations. [initials]
15. To ensure protection of the individual receiving services and preserve evidence in the event of a Department of Family and Protective Services Adult Protective Services investigation of an allegation of abuse, neglect, or exploitation against a CDS employee, DR, FMSA representative, or case manager or service coordinator. [initials]

The FMSA agrees:

1. To provide face-to-face orientation to the employer in the home of the Individual prior to beginning of the CDS option.
2. To provide ongoing training and assistance as requested or needed by the Employer.
3. To assist the Employer in the development of a budget for each service delivered through CDS and to approve the budget when calculations are validated.
4. 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) or service provider can start.
5. 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.
6. To deny payment to any employee or service provider for services delivered while the Individual was not eligible for services through his/her program or CDS.
7. To adhere to all applicable HHSC rules, policies and procedures related to the Individual's program and to the CDS option.
8. 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.
9. To adhere to and accept liability for federal, state and local laws and regulations related to employer-agent and employer-representative responsibilities.
10. 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.
11. To maintain an ongoing account balance of all transactions.
12. 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 Form 1720, Appointment of Designated Representative, or Form 1721, Revocation of Appointment of Designated Representative.
2. That billable activities must not precede the date the Individual is eligible to participate in the program or in the CDS option 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 a 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 described on Form 1734, Service Provider and Employer Certification of Relationship Status for CDS; 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 CDS 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 CDS option, voluntarily or involuntarily;
   b. the Individual is no longer eligible for the HHSC program or the funding source;
   c. the Employer requests a transfer and the transfer to a different FMSA is completed in compliance with the Individual's program transfer policy; 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

Employer Printed Name	FMSA Representative Printed Name
Signature - Employer	Signature - FMSA Representative
Date	Date / FMSA Vendor Number

TEXAS Health and Human Services

Consumer Directed Services (CDS)

Service Provision Requirements Addendum

Community Living Assistance and Support Services (CLASS)

All services must meet a need you discussed with your service planning team (SPT) and must be approved on your service plan (Form 3621, CLASS — Individual Plan of Care, or Form 3621-Revised, CLASS — Individual Plan of Care).

Services Available Under the CDS Option

Community First Choice (CFC) Personal Assistance Services/Habilitation (PAS/HAB): Refer to the CFC Addendum.

In-Home Respite: Respite is provided for the planned or emergency short-term relief of the unpaid primary caregiver who lives with the individual. Respite is provided when the primary caregiver is temporarily unavailable to provide supports due to non-routine circumstances. Respite tasks are the same as habilitation. If your respite provider does nursing tasks listed on your habilitation plan, then you must either name the tasks that you will train and supervise on Form 1733 or work with the CDS nurse to delegate and supervise these tasks. The respite provider cannot live with the individual receiving services if the primary caregiver is the CFC PAS/HAB service provider and resides in the same household as the individual.

Out-of-home respite can be provided in:

- an adult foster home licensed or certified by the Texas Health and Human Services Commission (HHSC),
- a licensed assisted living facility,
- a licensed nursing facility,
- a licensed intermediate care facility, or
- an approved outdoor camp that meets health and welfare requirements of HHSC and has American Camping Association accreditation.

Nursing: A registered nurse (RN), or a licensed vocational nurse (LVN) under the supervision of an RN, must provide only those tasks listed on the approved nursing plan developed by your CDS RN and approved by a medical practitioner.

Physical Therapy: The therapist must follow the plan of care.

Occupational Therapy: The therapist must follow the plan of care.

Speech, Hearing and Language Services: The therapist must follow the plan of care.

Cognitive Rehabilitation Therapy (CRT): Cognitive rehabilitation therapy is a service that assists an individual in learning or relearning cognitive skills that have been lost or altered because of damage to brain cells/chemistry in order to enable the individual to compensate for the lost cognitive functions, including reinforcing, strengthening or reestablishing previously learned patterns of behavior or establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems. Services are provided in accordance with the plan of care developed by the assessor.

Employment Assistance: Employment assistance helps the individual locate paid employment in the community and includes:

- identifying an individual's employment preferences, job skills, and requirements for a work setting and work conditions;
- locating prospective employers that offer employment compatible with an individual's identified preferences, skills and requirements; and
- contacting a prospective employer on behalf of an individual and negotiating the individual's employment.

Supported Employment: Supported employment is provided in order to sustain competitive employment for an individual who, because of a disability, requires intensive ongoing support to be self-employed, work from home or perform in a work setting at which individuals without disabilities are employed. Individuals receiving supported employment earn at least minimum wage (if not self-employed). Supported employment includes employment adaptations, supervision and training related to an individual's assessed needs.

Support Consultation: Individuals may also access support consultation if they and their SPT decide it is a necessary support to assist the individual in successfully using the CDS option.

Transportation (Habilitation): Provided for the use of transportation activities, as outlined in an individual's transportation plan.

CFC Support Management: Refer to the CFC Addendum.

I have read and understand the services ..... _____
Initials

Who Cannot Be Hired to Provide Your Services

- Employer or employer's spouse
- Individual receiving services or individual's spouse
- Designated representative (DR), if you have one
- DR's spouse
- Legally authorized representative (LAR) — if under age 18, the individual's parent, foster parent, managing conservator, stepparent or court-appointed guardian; if age 18 or over, the individual's court-appointed guardian
- LAR's spouse

Note: The respite provider cannot live with the individual receiving services if the primary caregiver is the CFC PAS/HAB service provider and resides in the same household as the individual.

I have read and agree not to hire any of the above as a service provider ..... _____
Initials

Service Delivery Documentation

- Time sheet

or

- Electronic Visit Verification (EVV) record, if applicable

I have read and agree to follow the service delivery documentation requirements ..... _____
Initials

Service Backup Plans

- The CDS employer (individual or LAR) is responsible for developing a backup plan (Form 1740, Service Backup Plan) for services that the SPT determines are critical to the individual's health and safety. The case manager must approve the backup plan.
- The case manager will review the backup plan on an annual basis and may request a revised backup plan if it is found ineffective.

I have read and agree to the service backup plan requirements ..... _____
Initials

Other Special Requirements

- The employee may only perform tasks authorized on the individual plan of care (IPC).
- The employee cannot provide services to other family members.
- Nurses must sign Form 1747, Acknowledgement of Nursing Requirements, and conform to the Texas Board of Nursing (BON) Nursing Practice Act before providing services and must keep required documentation in the individual’s home. An LVN must sign Form 1747-LVN, Licensed Vocational Nurse (LVN) Supervision, and conform to the BON Nursing Practice Act before providing services and must keep required documentation in the individual’s home.
- Employee bonuses must be included in the CDS employer budget and must be accrued from hours that the employee has worked. Hours not used during the service plan year cannot be converted to a bonus.
- The employer cannot submit a time sheet to the Financial Management Services Agency (FMSA) for time the employee worked while the individual was in the hospital or any other institutional setting.
- The employer must keep a copy of all CDS employer forms for each employee, except the criminal history report, in the home.

I have read and agree to follow the special requirements ..... _____
Initials

Employee Qualifications

For all services, the employee must:

- be age 18 or older;
- have no criminal convictions listed by state law that prohibit employment in a health care setting;
- have no conviction of Medicaid fraud or abuse;
- not be listed on the Employee Misconduct Registry (EMR) or Nurse Aide Registry (NAR);
- meet and maintain provider qualifications as required by the program and/or by state or federal law;
- be able and willing to meet the needs of the individual receiving services and, with training, be able to follow direction from the employer and the designated representative;
- have a valid Social Security number, regardless of residence, and provide appropriate documentation required for the completion of Form I-9, Employment Eligibility Verification, for verification of citizenship and immigrant status as required by the federal government; and
- maintain a current driver's license and insurance if transporting the individual.

For nurses and therapists: Nurses and therapists must meet and maintain professional licensure qualifications as required by the program and/or state or federal law.

For supported employment and employment assistance: If providing supported employment or employment assistance, the employee must be at least age 18 or older and satisfy one of these options:

Option 1: Have —

- a bachelor's degree in rehabilitation, business, marketing or a related human services field; and
- six months of paid or unpaid experience providing services to people with disabilities.

Option 2: Have —

- an associate's degree in rehabilitation, business, marketing or a related human services field; and
- one year of paid or unpaid experience providing services to people with disabilities.

Option 3: Have —

- a high school diploma or a Certificate of High School Equivalency (general equivalency diploma [GED] credentials), and
- two years of paid or unpaid experience providing services to people with disabilities.

For cognitive rehabilitation therapy: The service provider must be:

- a **psychologist** licensed by the Texas State Board of Examiners of Psychologists under Title 3 of the Texas Occupations Code, Subtitle H, Chapter 501, Psychologists;
- a **speech-language pathologist** licensed under Title 3 of the Texas Occupations Code, Subtitle G, Chapter 401, Speech-Language Pathologists and Audiologists; or
- an **occupational therapist** licensed under Title 3 of the Texas Occupations Code, Subtitle H, Chapter 454, Occupational Therapists.

I have read and agree to hire providers who meet the qualifications ..... _____
Initials

Training Requirements for All Service Providers

- Must have current training certification in cardiopulmonary resuscitation (CPR) and choking prevention that includes an in-person evaluation by a qualified instructor verifying the service provider's ability to perform these actions.
- Must complete orientation and training as specified by the individual/employer.
- Must pass criminal history and other applicable registry checks.
- Must maintain a current driver's license and insurance if transporting the individual.

Training Requirements for All Service Providers (continued.)

- Must complete orientation, including an overview of related conditions and training in the necessary activities, before delivering services. The CDS employer is responsible for providing this training and must document all initial and ongoing training, including what was discussed, on Form 1732, Management and Training of Service Provider, and send Form 1732 to the FMSA within 30 calendar days after hiring the service provider and every year within 30 calendar days after the service provider's hire anniversary date.
- Must complete training on the nursing tasks listed on Form 1733.

I have read and agree to ensure providers meet the training requirements ..... _____
Initials

The case manager, FMSA or HHSC utilization review staff can look at your CDS paperwork. It is important to keep a copy of all your CDS forms, except the criminal history report, easily accessible.

I have read, understand and agree to comply with the HHSC program requirements. If I do not follow these requirements, I understand that I can be reported to the appropriate authorities for Medicaid fraud.

Employer or Designated Representative Signature	Date

TEXAS
Health and Human Services

Consumer Directed Services (CDS)

Service Provision Requirements Addendum

Community First Choice (CFC)

Services Available Under the CDS Option

CFC Personal Assistance Services (PAS): Services that provide assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), as defined in 42 CFR §441.505, through hands-on assistance, supervision, and/or cueing. Such assistance is provided to an individual based on the individual's person-centered service plan. CFC personal assistance services include:

- non-skilled assistance with the performance of ADLs and IADLs;
- household chores necessary to maintain the home in a clean, sanitary and safe environment;
- escort services, which consist of accompanying, but not transporting, and assisting an individual to access personal assistance services or activities in the community; and
- assistance with health-related tasks, as defined in 42 CFR §441.505 in accordance with state laws.

CFC Habilitation (HAB): Acquisition, maintenance and enhancement of skills necessary for an individual to accomplish ADLs, IADLs and health-related tasks. This service is provided to allow an individual to reside successfully in a community setting by assisting the individual to acquire, retain and improve self-help, socialization and daily living skills, or assisting with and training the individual on ADLs and IADLs. Personal assistance may be a component of CFC habilitation for some individuals. CFC habilitation includes training, which is interacting face-to-face with an individual, to train the individual in activities such as:

- self-care;
- personal hygiene;
- household tasks;
- mobility;
- money management;
- community integration, including how to get around in the community;
- use of adaptive equipment;
- personal decision making;
- reduction of challenging behaviors to allow individuals to accomplish ADLs, IADLs and health-related tasks; and
- self-administration of medication.

CFC Support Management: Voluntary training on how to select, manage and dismiss attendants.

I have read and understand the services ..... _____
Initials

Who Cannot Be Hired or Paid with Medicaid Funds to Provide Your Services

- Employer
- Employer's spouse
- Individual receiving services
- Individual's spouse
- Designated representative (DR), if you have one
- DR's Spouse
- Legally authorized representative (LAR) — if under age 18, the individual's parent, foster parent, managing conservator, stepparent or court-appointed guardian; if age 18 or over, the individual's court-appointed guardian
- LAR's spouse

I have read and agree not to hire any of the above as a service provider ..... _____
Initials

Service Delivery Documentation

- Form 1745, Service Delivery Log with Written Narrative/Written Summary

I have read and agree to follow the service delivery documentation requirements ..... _____
Initials

Service Backup Plans

- The CDS employer (individual or LAR) is responsible for developing a backup plan (Form 1740, Service Backup Plan) for services that are required by program rules or that the service planning team thinks are critical to ensuring the individual's health and safety. The case manager or service coordinator must approve the backup plan.
- The case manager or service coordinator will review the backup plan on an annual basis and may request a revised backup plan if it is found ineffective.

I have read and agree to the service backup plan requirements ..... _____
Initials

Other Special Requirements

- The employee may only provide services allowed on the individual plan of care.
- The employee may only provide services for the individual, not for a family member or other persons residing in the home.
- Employee bonuses must be included in the CDS employer budget and must be accrued from hours that the employee has worked. Hours not used during the service plan year cannot be converted to a bonus.
- The employer cannot submit a time sheet to the Financial Management Services Agency (FMSA) for time the employee worked while the individual was in the hospital or any other institutional setting.
- The employer must keep a copy of all CDS employer forms for each employee, except the criminal history report, in the home.

I have read and agree to follow the special requirements ..... _____
Initials

Employee Qualifications

For all services, the employee must:

- be age 18 or older;
- have a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma; or
  - documentation of a proficiency evaluation of the employee's experience and competence to perform job tasks, including an ability to provide the services needed by the individual, as demonstrated through a written competency-based assessment; and
  - at least three personal references from people not related by blood that evidence the person's ability to provide a safe and healthy environment for the individual;
- have a valid Social Security number, regardless of residence, and provide appropriate documentation required for the completion of Form I-9, Employment Eligibility Verification, for verification of citizenship and immigrant status as required by the federal government; and
- have no criminal convictions listed by state law that prohibit employment in a health care setting;
- have no conviction of Medicaid fraud or abuse;
- not be on the Employee Misconduct Registry or Nurse Aide Registry list; and
- not be on the state and federal lists of excluded individuals and entities.

I have read and agree to follow the special requirements ..... _____
Initials

Training Requirements for All Service Providers

- Before providing direct services to an individual, the service provider must complete specific training provided by the CDS employer.
- The CDS employer must document all initial and ongoing training activities on Form 1732, Management and Training of Service Provider, and send Form 1732 to the FMSA within 30 calendar days after hiring the service provider and every year within 30 calendar days after the service provider's hire anniversary date.

If the employer chooses to use the CDS exemption from nursing delegation (Form 1733, Employer and Employee Acknowledgement of Exemption from Nursing Licensure for Certain Services Delivered through Consumer Directed Services), the employer provides training for any nursing tasks listed on Form 1733.

I have read and agree to ensure providers meet the training requirements ..... _____
Initials

The case manager or service coordinator, FMSA or HHSC utilization review staff can talk with the individual about the services available through the CDS option and may ask to review employer forms. Please keep forms easily accessible.

I have read, understand and agree to comply with the CFC requirements. If I do not follow these requirements, I understand that I can be reported to the appropriate authorities for Medicaid fraud.

Employer or Designated Representative Signature	Date

TEXAS Health and Human Services

Form 1736
September 2024

Consumer Directed Services (CDS) Option

Documentation of Employer Orientation by Financial Management Services Agency

Person or Member Name	Program Name
Employer Name	Relationship to Person or Member

Financial Management Services Agency (FMSA) Contact Information

Contact Person	Area Code and Phone No.	Area Code and Fax No.

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

Orientation Location – ◯ In Person ◯ Audio or Visual

Street Address	City	State	ZIP Code

Orientation Session

FMSA 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 checks the box for each topic covered.

- ☐ Employer budget
- ☐ Hiring process or new hire packet
- ☐ Timesheet due dates and payday schedule
- ☐ How to report abuse, neglect and exploitation
- ☐ FMSA's operating hours and complaint procedure
- ☐ CDS Option Employer Manual
- ☐ Form 1735, 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 current Chapter 264, Consumer Directed Services Option, of the Texas Administrative Code, Title 26, Part 1; and the topics in the CDS Option Employer Manual.

Printed Name of Employer _____ **Signature of Employer** _____ **Date** _____

Printed Name of FMSA Representative _____ **Signature of FMSA Representative** _____ **Date** _____

Others in Attendance

DR is required if appointed at the time of the orientation.

Printed Name	Relationship to Employer	Signature	Date

TEXAS Health and Human Services

Form 1739
October 2013-E

Consumer Directed Services

Service Provider Agreement

This agreement is between the **Texas Health and Human Services Commission** (HHSC), the state Medicaid agency; a **Financial Management Services Agency** (FMSA); and a **service provider** providing services to one or more individuals through the Consumer Directed Services (CDS) Option.

The **service provider,** _____ ☐ an individual or

☐ an entity, located at (Address) _____ ,

_____; Telephone _____ Fax _____

The service provider agrees to:

- provide services, items or goods that are authorized prior to purchase to individuals in home and community support programs in accordance with program rules and policy;
- keep records of purchased services, items and goods in accordance with program rules and policy;
- accept checks from the FMSA as full and complete payment for authorized services, items or goods purchased for individuals served through home and community-based programs;
- neither impose on or accept from individuals any additional charges for the services, items or goods paid for by the check; and
- provide records and other information upon request to the individual, the FMSA, HHSC, or their representative.

The FMSA and HHSC agree:

- that the FMSA will pay the service provider for services, items or goods provided to the individual in accordance with this agreement and program rules and policy; and
- to allow the service provider to charge the individual for approved upgrades or purchases not authorized or paid for in accordance with this agreement, program rules and policy.

The service provider, FMSA and HHSC mutually agree that:

- the FMSA _____ , doing business in _____ , provides financial management services (FMS) to the individual receiving services for purchases from the service provider;
- the FMSA is responsible for acquiring the completed agreement and retaining the original on behalf of HHSC;
- payment from the FMSA will not be issued prior to the receipt of this agreement by the FMSA;
- payment from the FMSA is funded by HHSC with government funds; and
- the FMSA is not a Texas or federal government agency.

This agreement is effective _____ , and terminates when the service provider is no longer providing services to individuals through the FMSA.

Service Provider or Representative* (Print)	Service Provider or Representative* (Signature)	Date

FMSA Representative* (Print)	FMSA Representative* (Signature)	Date

** If the service provider is an entity, a representative from the entity with authorization to negotiate this agreement on behalf of the entity must sign.*