Participant Enrollment Packet

Welcome! We are happy to help you become an employer. You will be an employer in the Participant Direction Option (PDO). This packet contains the forms and information you will need. Once filled out, you will be set up as an employer. Then you can start your services. Some forms give Consumer Direct Care Network (CDCN) permission to file employer taxes for you. CDCN will also send paychecks to your employees. Please contact CDCN if you have any questions.

Customer Service Contact Information

CDCN
4577 N. Nob Hill Road, Suite 206
Sunrise, FL 33351-4715
Mon-Fri, 8 am – 5 pm (excluding holidays)

Phone: 954-368-2069, Toll-Free 1-877-270-9580
Toll-Free Fax: 1-877-344-0999
Email: infoCDFL@ConsumerDirectCare.com
Web: www.consumerdirectfl.com

Enrollment Packet Forms and Form Explanations

(These forms must be returned to CDCN.)

Orientation and Enrollment Checklist	Checklist of all forms. Use this to make sure all forms are completed.
Participant Data Form	This form gives basic information about you. It will be used to set you up in our system. It gives CDCN the information needed to complete your tax forms.
Participant Agreement and Acknowledgement Form	This is the contract between you and CDCN. It also reviews policies and roles in the program.
SS-4 Application for Employer Identification Number (EIN)	This is a federal form. It is used to obtain a Federal Employer Identification Number (FEIN). This is needed for filing and reporting taxes.
2678 Employer/Payer Appointment of Agent	This form appoints CDCN to take care of employer tax responsibilities. This allows CDCN to withhold taxes from your employees' paychecks. CDCN will then deposit those taxes with the IRS.
DR-1 Florida Business Tax Application	This is a state form for Florida's Re-Employment Tax. This is also called the unemployment tax.
DR-835 Power of Attorney	This is a state form. It permits CDCN to file state payroll taxes for you.
PDO Consent Form	With this form you agree to participate in the PDO and follow the rules.
Participant Emergency and Backup Plan	This is your backup plan. This is used when scheduled workers do not show up. It is a list of people who can help if needed.

(See reverse.)

Participant Enrollment Packet

Representative (Rep) Forms and Form Explanations

(Only use if you have a Rep.)

PDO Representative Agreement	This is the form the Rep uses to agree to participate in the PDO. It describes duties and program rules.
Information Needed for Fingerprinting	Complete all fields. CDCN will use the information to register the Rep. This will be done online for a fingerprint background screening.
Attestation of Compliance with Background Screening Requirements	This is part of the background check. The Rep must attest that they have not been found guilty of the criminal offenses listed on the form.
Care Provider Background Screening – Privacy Policy Acknowledgement	This is a notice and privacy statement from the Florida Department of Law Enforcement and FBI. It explains how your fingerprint records are kept. It gives information on your right to privacy. Please sign this form. It will show that you received it.

Supplements and Instructions

(Keep these documents for reference.)

Payroll Calendar	This calendar shows when time sheets are due. Please submit time sheets by those dates. It also shows when pay checks are issued. Your employee will receive this calendar as well.
Online Time Sheet Instructions	Online time sheets are the preferred method for submitting time worked. This reduces time sheet errors. Fewer errors ensures that your employees get paid on time. Internet access is required. Please use online time sheets.
Paper Time Sheets and Time Sheet Instructions	This is a paper time sheet. Use this sheet for completing paper time sheets. Refer to the instructions if have questions.
Feedback Form	Please use this form to give feedback to CDCN. Your feedback is valued. We want to hear from you.
Fingerprint Registration Procedure	This is part of the background check. All employees and Reps need one. It explains the process for fingerprinting.
List of Barring Offenses	This is part of the background check. It is a list of criminal offenses. All employees and Reps must pass a background check. If they have an offense on this list, they cannot work for you.
RT-83 – Notice to Employees regarding Florida Reemployment Assistance Program	This notice must be posted for your employee(s). They can read it and know about their rights. This notice is about the Florida Reemployment Assistance Program.

UnitedHealthcare Community Plan

Questions?
We're here to help. United Healthcare Community & State.
Toll-Free 800-791-9233 and TTY/TTD 711,
Monday through Friday, 8:00 a.m. to 8:00 p.m.

UnitedHealthcare Community Plan does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free member phone number listed on your health plan member ID card, TTY 711, Monday through Friday, 8:00 a.m. to 7:00 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html

Phone:
Toll-free **1-800-368-1019**, **1-800-537-7697** (TDD)

Mail:
U.S. Dept. of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201

If you need help with your complaint, please call the toll-free member phone number listed on your member ID card.

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan member ID card, TTY 711, Monday through Friday, 8:00 a.m. to 7:00 p.m.

UnitedHealthcare Community Plan no da un tratamiento diferente a sus miembros en base a su sexo, edad, raza, color, discapacidad o nacionalidad.

Si usted piensa que ha sido tratado injustamente por razones como su sexo, edad, raza, color, discapacidad o nacionalidad, puede enviar una queja a:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130

UHC_Civil_Rights@uhc.com

Usted tiene que enviar la queja dentro de los 60 días de la fecha cuando se enteró de ella. Se le enviará la decisión en un plazo de 30 días. Si no está de acuerdo con la decisión, tiene 15 días para solicitar que la consideremos de nuevo.

Si usted necesita ayuda con su queja, por favor llame al número de teléfono gratuito para miembros que aparece en su tarjeta de identificación del plan de salud, TTY 711, de lunes a viernes, de 8:00 a.m. a 7:00 p.m.

Usted también puede presentar una queja con el Departamento de Salud y Servicios Humanos de los Estados Unidos.Usted también puede presentar una queja con el Departamento de Salud y Servicios Humanos de los Estados Unidos.

Internet:
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Formas para las quejas se encuentran disponibles en:
http://www.hhs.gov/ocr/office/file/index.html

Teléfono:
Llamada gratuita, **1-800-368-1019**, **1-800-537-7697** (TDD)

Correo:
U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201

Si necesita ayuda para presentar su queja, por favor llame al número gratuito para miembros anotado en su tarjeta de identificación como miembro.

Ofrecemos servicios gratuitos para ayudarle a comunicarse con nosotros. Tales como, cartas en otros idiomas o en letra grande. O bien, puede solicitar un intérprete. Para pedir ayuda, llame a Servicios para Miembros al **1-800-791-9233, TTY 711**, de lunes a viernes, de 8:00 a.m. a 7:00 p.m.

UnitedHealthcare®
Community Plan

ATTENTION: If you do not speak English, language assistance services, at no cost to you, are available. Call **1-800-791-9233, TTY 711**.

ATENCIÓN: Si no habla inglés, los servicios de asistencia de idiomas están disponibles sin costo para usted. Llame al **1-800-791-9233, TTY 711**.

ATANSYON: Si w pa pale Anglè, gen sèvis èd pou lang ki disponib san w pa peye anyen. Rele **1-800-791-9233, TTY 711**.

ВНИМАНИЕ: Если Вы не говорите по-русски, Вы можете воспользоваться бесплатной языковой помощью. Позвоните по телефону **1-800-791-9233, телетайп 711**.

ATENÇÃO: Se não fala inglês, estão disponíveis serviços de assistência linguística sem nenhum custo para si. Ligue para o **1-800-791-9233, TTY 711**.

注意：如果您不會說英文，您可獲得免費語言協助服務。請致電 **1-800-791-9233，聽障專線 (TTY) 711**。