CONSUMER DIRECT CARE NETWORK

Note: To fill out the forms in this PDF packet on your computer before printing, complete this Data Form first, then review the remaining documents to verify data inserted properly. This packet is set up for double sided paper printing.

Clear Form

PARTICIPANT DATA FORM

Participant (Veteran) Information

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

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

City _____ **State** CO **Zip** _____ **County** _____

☐ Yes ☐ No – Is physical address within the limits of a city?

☐ Yes ☐ No – Is physical address within the city limits of Aurora, Denver, Glendale, Greenwood Village or Sheridan?

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

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

Gender ☐ Male ☐ Female **Date of Birth** _____ **Social Security #** ____-____-____

Emergency Contact _____ _____ _____
Name *Phone* *Relationship*

Authorization Start Date or Reactivation Start Date _____

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

If yes, Agent Name: _____

Authorized Representative Information *(if applicable)*

Name _____ _____ _____
First *Middle* *Last*

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

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

Prior Employer of Record (EOR)?

☐ Yes ☐ No – Is Participant switching their EOR? If yes, previous EOR name: _____

New Employer of Record (EOR) Information

EOR Relationship to Participant ☐ Participant (self) ☐ Authorized Representative ☐ Other (describe): _____

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

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

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

Date of Birth _____ **Social Security #** ____-____-____

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

If yes, Account Info: ____ - _____ _____ _____ _____
FEIN *Business Tax Withholding Acct #* *Unemployment Tax Acct #* *SUTA Rate*

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

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

Business Start Date: / /

**Attach legal guardianship paperwork*

PARTICIPANT (VETERAN) ENROLLMENT CHECKLIST

Participant (Veteran) Name	Representative Name (if applicable)

Welcome to Consumer Direct Care Network (CDCN)!

Please complete the forms listed below, including this one (except in some instances those labeled "if applicable" may not be necessary). Check off each item upon completion. If you would like a paper copy of these forms, please let us know and we will return copies to you.

CDCN and Tax Forms

1. ☐ Participant Data Form
2. ☐ Participant Enrollment Checklist (this form)
3. ☐ Authorized Representative Designation Form (if applicable)
4. ☐ Fiscal Employer Agent Services Agreement
5. ☐ Monthly Reports Preference Form
6. ☐ SS-4 Application for Employer Identification Number (EIN)
7. ☐ 2678 Employer/Payer Appointment of Agent
8. ☐ CR 0100AP Colorado Sales Tax & Withholding Account Application
9. ☐ DR 0145 Colorado Tax Information Designation and Power of Attorney for Representation
10. ☐ UITL-100 Application for Unemployment Insurance Account
11. ☐ UITL-18 Power of Attorney

Supplements *(Discuss and keep for future use)*

- Employer Packet Instructions
- Payroll Calendar
- Online Timesheet Instructions
- Vendor Payment Request Form
- Status Change Form

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

CONSUMER DIRECT CARE NETWORK

AUTHORIZED REPRESENTATIVE DESIGNATION FORM

Participant (Veteran) Name	Representative Name

Participants in the Veteran Directed Care (VDC) program can appoint a responsible adult to assist them with managing their services. This person can be a guardian, family member or other supporter who willingly accepts the role as the veteran's advocate and will assist them with program compliance and employer responsibilities.

Authorized Representative Designation

I, the veteran named above, hereby designate and authorize _____, (*Representative's name*) to act as my Authorized Representative to direct and manage my services in the VDC program on my behalf.

_____ _____

Participant Signature *Date*

Authorized Representative Responsibilities and Attestation

I understand and agree with my role as an Authorized Representative, which includes actively planning and managing the veteran's services under the VDC program.

I understand that my appointment as an Authorized Representative may be revoked at any time by the veteran or myself.

I understand my responsibilities as a Representative will include, but are not limited to:

- Assisting to complete all paperwork to enroll the veteran in the VDC program,
- Hiring, training, scheduling and supervising employees,
- Verifying and signing employee timesheets,
- Monitoring the veteran's budget, and
- Developing an emergency backup plan for instances when regularly scheduled workers are unable to provide service.

I affirm that I know the veteran well, that I understand their healthcare needs, and that I will help them with all aspects of participating in this program.

_____ _____

Representative Signature *Date*

CONSUMER DIRECT CARE NETWORK

Veteran Directed Care Program

FISCAL EMPLOYER AGENT SERVICE AGREEMENT

This Fiscal Employer Agent Services Agreement (Agreement) is made and entered into between Consumer Direct for Colorado, LLC doing business as Consumer Direct Care Network Colorado (CDCN) and _____ Participant, and/or _____ their Guardian and/or _____ Authorized Representative, if appointed by Participant.

1. The "Participant" is the Veteran receiving services under the Veteran Directed Care (VDC) program.
2. An "Authorized Representative" (AR) may be designated by the Participant to manage day-to-day employee activities on the Participant's behalf.
3. The "Employer" is the Federal Employer Identification Number (FEIN) Holder, who is the Employer of Record and of Fact, and can employ persons to provide services to the Participant. The Employer of Record may be the Participant or their Authorized Representative.
4. CDCN is the "Fiscal Employer Agent" (F/EA), and as authorized under IRS Revenue Procedure 70-6 for the purpose of payroll and payroll reporting services, will file on behalf of the Employer/FEIN Holder.
5. The Denver Regional Council of Governments (DRCOG) is the "Authorizing Agency" that governs services and authorizes the Participant's budget. Authorizing Agency recognizes that CDCN, acting as the F/EA, will provide Financial Management Service (FMS) to the Participant/AR.

Responsibilities of Participant/AR

1. Complete all of the forms required by CDCN for its FMS services. This includes accurately filling out all required IRS and state tax and unemployment forms. Failure on part of the Participant/AR to provide required FEIN information or to submit a complete packet may result in a delay in employee payment or the Participant/AR paying out of pocket.
2. Obtain a Federal Employer Identification Number (FEIN) with the assistance of CDCN.
3. Follow all VDC program policies, CDCN policies, and all federal and state employment laws, regulations, and rules.
4. Recruit, interview, check references, hire, train, schedule, manage, and dismiss each employee who provides services. This includes directing the day-to-day care of the Participant and working out conflicts between Employer and employee.
5. Not allowing an employee to begin work until receiving an "Okay to Work" form from CDCN authorizing an employment start date. This is to ensure all employee paperwork has been received, reviewed and approved by CDCN and that Authorizing Agency has approved the Employee's background check.
6. Provide equal employment opportunities to all employees and interested employees without breaking discrimination law as to race, creed, color, national origin, sex, age, disability, marital status, sexual orientation, or any other status protected by law in all employment decisions, including recruitment, hiring, changing schedules and number of hours worked, lay off, and

dismissal, and all other terms and conditions of employment. The Participant/AR accepts full and specific responsibility for following equal opportunity laws and requirements regarding Employees. Each employee is to be treated fairly and consistently.

7. Direct employees so that services are not provided while a Participant is in the hospital, nursing home, or other long-term care facility.
8. Review and approve employee work-time records through online time entries or paper time sheets. Records must be submitted in a timely manner according to the CDCN payroll schedule. The Participant/AR can be held accountable for approving records that contain fraudulent information and result in over-billing Authorizing Agency.
9. Ensure employees only work the approved number of hours. The Participant/AR is responsible for making the payment of any wages and expenses that exceed the amount authorized in the Veteran's Spending Plan, or result in an employee working unauthorized overtime.
10. Monitor budget tracking reports provided by CDCN and keep all expenditures within the Participant's authorized budget.
11. Submit paperwork to CDCN for reimbursement to vendors in a timely manner, and only for goods or services approved on the Participant's authorized budget.
12. Immediately Report:
    a. Any possible fraud to the CDCN Fraud Hotline 1-877-532-8530.
    b. Abuse, neglect and exploitation of vulnerable adult to appropriate authorities, Authorizing Agency, and CDCN.
    c. Participant or employee changes within five (5) working days of the change to CDCN. Types of changes to report include: name, address, hospitalization, contact information or employment status.
13. Appoint a temporary Authorized Representative if the Participant or current Authorized Representative is not capable or available to direct the Participant's care.

Responsibilities of CDCN

1. Provide the Participant/AR with all forms and documents necessary to enroll in the VDC program within three weeks of referral from Authorizing Agency. CDCN offers face-to-face enrollment meeting to successfully complete all enrollment materials.
2. Perform background checks on prospective employees the Participant/AR wishes to hire. Results of background screening will be provided to Authorizing Agency for hiring determination.
3. Issue an Employee Enrollment Packet to Participant/AR.
4. Pay wages to employee on a bi-weekly schedule, in accordance with the time records approved by the Participant/AR.

5. Provide Workers' Compensation coverage to employees.
6. Deposit employer-related taxes in the aggregate using Employer of Record's individual FEIN.
7. Follow all IRS and State reporting guidelines.
8. Track the total number of budgeted service hours used and provide reports (by mail or online) to the Participant/AR detailing funds expended, funds remaining, and for planned savings and emergency backup. The Participant/AR is responsible for monitoring tracking reports and not using more service hours than approved.
9. Submit all claims for services to the Authorizing Agency on behalf of the Employer.
10. Obtain Fiscal Employer Agency authorization pursuant to IRS procedure code 70-6 and follow all IRS guidelines including obtaining all proper Federal and State authorizations.
11. Follow all tax exemptions and withholdings as stated on Employee's W-4, and process all tax withholdings & filings including Federal and State income taxes, FICA, Medicare tax, FUTA, and SUTA, and any other mandated withholding, as appropriate, on behalf of the Employer.
12. Inform Participant/AR of Customer Complaint Process and work to resolve any problem.

Limitations on CDCN Payment Obligation

If Participant/AR authorizes use of all hours before the end of the authorization period, Participant/AR will need to make other service arrangements. Additionally, CDCN will not pay for any goods or services that are not authorized by the Authorizing Agency.

Additional Agreement Terms and Conditions

1. **Term and Termination:** This Agreement will be effective as of the signature date noted on the last page of the Agreement and will continue until terminated. Both CDCN and Participant/AR have the right to terminate this Agreement at any time. If CDCN terminates this agreement, CDCN will notify Participant by email or by regular US mail.
2. **Partial Invalidity:** If any portion of this Agreement does not apply to Participant/AR, changes over time, or is determined to be illegal or invalid, that part of the Agreement shall be modified to the extent possible to give it its intended effect and/or meaning, and all remaining provisions of the Agreement shall continue in full force and effect.
3. **Arbitration:** If Participant/AR or CDCN decide that they are unable to resolve a disagreement within thirty (30) days of notification to the other party regarding the dispute, Participant/AR and CDCN will choose someone from the American Arbitration Association together (known as an independent arbitrator) to work out the disagreement. The cost of the person chosen will be paid equally by both Participant/AR and CDCN. The decision of the arbitrator may be given to a judge in the event the decision is not accepted by either party. All arbitration pursuant to this clause shall be conducted in the State of Colorado, in the same district in which the CDCN office is located.

4. **Governing Law:** This Agreement shall in all respects be construed in accordance with and governed by the laws of the State in which your local office is situated, without regard to its conflict of laws rules. Participant/AR and CDCN agree that the courts in the Judicial District in which your primary State office sits shall have exclusive jurisdiction with respect to any controversy or dispute arising out of or relating to this Agreement and not resolved pursuant to the terms of this Agreement.

5. **Indemnification and Hold Harmless:** Participant/AR and CDCN (the "Indemnifying Party") agree to save and hold each other (the "Indemnified Party") harmless from and against, and will indemnify each other for, any liability, loss, cost, expense or damage whatsoever caused by reason of any injury sustained by any person or to property by reason of any act, neglect, default or omission of Indemnifying Party. If Indemnified Party is sued in court or compelled to arbitrate for damages by reason of any of the acts of Indemnifying Party, Indemnifying Party will defend said action on behalf of Indemnified Party. Alternatively, and with agreement of Indemnifying Party, Indemnified Party may defend the same and any expenses, including reasonable attorney's fees that Indemnified Party may pay or incur in defending said action and the amount of any judgment, award or settlement that Indemnified Party may be required to pay will be promptly reimbursed by Indemnifying Party upon demand.

6. **Waiver of Terms and Conditions:** The failure of Participant/AR or CDCN in any one or more instances to enforce one or more of the terms and conditions of this Agreement or to exercise any of its rights or privileges, or the waiver of any breach of such terms or conditions, shall not be construed as thereafter waiving any such terms, conditions, rights or privileges, and the same shall continue and remain in force and effect as if no waiver had occurred.

7. **Timely Notification:** The Participant/AR and CDCN agree that all contact must occur in a timely way. Any notice will be given immediately, so that neither Employer nor CDCN is hurt by a delay.

8. **Modification of Agreement:** Any changes to the terms of this Agreement must be in a separate writing, signed and dated by Participant/AR and CDCN.

9. **Modification of Tax Forms:** Participant/AR authorizes CDCN to make applicable changes to the Employer's tax forms. These changes would be the result of updates noted on the Data Form.

10. **Privacy:** All activities related to this Agreement shall adhere to state and federal confidentiality laws and regulations; including, without limitation the Administrative Simplification provision of the Health Insurance Portability and Accountability Act ("HIPAA") and regulations promulgated thereunder, 45 C.F.R. Parts 160 – 164 (the "Regulations"), as amended.

11. **Worker Injury:** If the Participant/AR and Employee do not follow CDCN's safety program policies, safety training requirements, and injury reporting procedures, a reported work-related injury may be denied coverage under the Worker' Compensation program.

12. **Decision to Serve:** CDCN can choose to not serve the Participant. This will happen if the Participant/AR does not follow policies and procedures or if the Participant's health and safety needs cannot be met with the self-directed program. CDCN will discuss their concerns with the

Participant/AR and the Authorizing Agency. If necessary, the Participant's case manager will assist the Participant/AR with transitioning services within thirty (30) days.

13. **Entire Agreement:** This Agreement constitutes the entire agreement between Participant/AR and CDCN and supersedes all prior oral and written statements. This Agreement may be modified, amended or changed only by a written document signed by both Participant/AR and CDCN. This Agreement shall not create any benefits, rights, privileges, remedies or claims for, in, by, or on behalf of any parties who are not signatories to this Agreement.

Conclusion

The FEIN Holder is the Employer (of Fact and of Record). The Participant/AR understands and accepts responsibility for recruiting, hiring, training, supervising and terminating their Employee(s). The Participant/AR is responsible for the actions of their Employees while they are providing services.

Acceptance of this Agreement is shown by signing below.

CDCN Representative, Printed Name	*Signature*	Date
Participant or Guardian, Printed Name	*Signature*	Date
Authorized Representative, Printed Name	*Signature*	Date

CONSUMER DIRECT CARE NETWORK

MONTHLY REPORTS PREFERENCE FORM

Veteran Name	Representative Name (if applicable)

Consumer Direct Care Network (CDCN) is responsible for providing Participants monthly spending reports detailing funds expended, funds remaining, and funds accumulated for planned savings and emergency backup.

These reports can be viewed in two ways – view them online or wait to receive them by mail. As a Participant with CDCN you have secure access to our online Web Portal (https://cdcnportal.com/) which allows you to monitor your budget balances in *real time*. This means that when payroll and vendor payments are processed, the balance information is automatically updated. Using the Web Portal, a Participant can immediately know the balance and status of each budget category.

In order to increase efficiency and reduce waste, we are offering each Participant the option of not receiving a paper version of budget reports each month. No matter which option you choose, you will always have access to the electronic reports on the Web Portal.

How would you prefer to review your *Spending Reports*?

I would like to (choose one):

☐ Receive paper reports monthly from CDCN via US Mail

OR

☐ Access and review online reports on CDCN's secure Web Portal

Participant/Authorized Rep. Name *Participant/Authorized Rep. Signature* *Date*

Form **SS-4**
(Rev. December 2019)
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
HCSR

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

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

4a Mailing address (room, apt., suite no. and street, or P.O. box)
100 Consumer Direct Way, Suite 303-CO

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

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

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

6 County and state where principal business is located

7a Name of responsible party

7b SSN, ITIN, or EIN

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

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

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

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

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

Group Exemption Number (GEN) if any ►

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

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

- ☐ Started new business (specify type) ► _____
- ☐ Hired employees (Check the box and see line 13.)
- ☐ Compliance with IRS withholding regulations
- ☑ Other (specify) ► **HCSR**
- ☐ Banking purpose (specify purpose) ► _____
- ☐ Changed type of organization (specify new type) ► _____
- ☐ Purchased going business
- ☐ Created a trust (specify type) ► _____
- ☐ Created a pension plan (specify type) ► _____

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

12 Closing month of accounting year **December**

13 Highest number of employees expected in the next 12 months (enter -0- if none). If no employees expected, skip line 14.

Agricultural	Household	Other
0	**0**	**0**

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

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

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

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

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

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

Third Party Designee

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

Designee's name
Nathyn Snyder

Designee's telephone number (include area code)
406-532-1900

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

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

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

Applicant's telephone number (include area code)

Name and title (type or print clearly) ► **Home Care Service Recipient**

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. 12-2019)

05151

Form **2678** **Employer/Payer Appointment of Agent**

(Rev. August 2014) Department of the Treasury — Internal Revenue Service

OMB No. 1545-0748

Use this form if you want to request approval to have an agent file returns and make deposits or payments of employment or other withholding taxes or if you want to revoke an existing appointment.

- If you are an employer or payer who wants to request approval, complete Parts 1 and 2 and sign Part 2. Then give it to the agent. Have the agent complete Part 3 and sign it.

  Note. This appointment is not effective until we approve your request. See the instructions for filing Form 2678 on page 3.

- If you are an employer, payer, or agent who wants to revoke an existing appointment, complete all three parts. In this case, only one signature is required.

For IRS use:

Part 1: Why you are filing this form...

(Check one)

☑ You want to **appoint** an agent for tax reporting, depositing, and paying.

☐ You want to **revoke** an existing appointment.

Part 2: Employer or Payer Information: Complete this part if you want to appoint an agent or revoke an appointment.

1 Employer identification number (EIN) ☐☐ – ☐☐☐☐☐☐☐

2 Employer's or payer's name (not your trade name) HCSR

3 Trade name (if any)

4 Address

100 Consumer Direct Way (Number Street) Suite 303-CO (Suite or room number)

Missoula (City) MT (State) 59808 (ZIP code)

(Foreign country name) (Foreign province/county) (Foreign postal code)

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

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

*Generally you cannot appoint an agent to report, deposit, and pay tax reported on Form 940, Employer's Annual Federal Unemployment (FUTA) Tax Return, unless you are a home care service recipient.

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

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

X **Sign your name here**

Print your name here

Print your title here HCSR - Household Employer

Date / /

Best daytime phone

Now give this form to the agent to complete.

CR 0100AP (07/06/18)
COLORADO DEPARTMENT OF REVENUE
Registration Center Section
PO Box 17087
Denver CO 80217-0087

Colorado Sales Tax Withholding Account Application

You can now apply online, see page 3 for more information. If applying by paper, read the instructions (on page 4) before completing this form.

A

1. Reason for Filing This Application — Required
☑ Original Application ☐ Change of Ownership ☐ Additional Location

Do you have a Department of Revenue Account Number? ☐ Yes ☑ No

If Yes, Account Number

2. Indicate Type of Organization. If you are not an individual you must have a FEIN number.

☑ Individual	☐ Limited Liability Company (LLC)	☐ Corporation/'S' Corp.	☐ Government
☐ General Partnership	☐ Limited Liability Partnership (LLP)	☐ Association	☐ Joint Venture
☐ Limited Partnership	☐ Limited Liability Limited Partnership (LLLP)	☐ Estate/Trust	☐ Non–Profit (Charitable)

B

1a. Last Name or Business Name	First Name	Middle initial

1b. Proof of Identification (Requirements – See page 4)

2a. Trade Name/ Doing Business As (If applicable, and for informational purposes only)	2b. FEIN (required)	2c.SSN
N/A		

Physical Place of Business

3a. Principal Address (A Colorado address is required if a location in the state)	City	State	Zip
		CO	

3b. County	3c. If business is within limits of a city, what city?	3d. Phone Number
		( )

Mailing address — enter mailing address here if different than the physical address

4a. Last Name or Business Name	First Name	Middle Initial	4b. Phone Number
Consumer Direct			(**406**) **532-1900**

4c. Mailing Address	City	State	Zip
100 Consumer Direct Way, Suite 303	**Missoula**	**MT**	**59808**

5. List specific products (you must list the products you sell) and/or services you provide and Explain In Detail in section 5a. below.

Do you sell alcohol?	☐ Yes	☑ No	Do you rent out items for 30 days or less?	☐ Yes	☑ No
Do you sell tobacco products?	☐ Yes	☑ No	Do you sell Prepaid Wireless?	☐ Yes	☑ No
Is your business in a special taxing district?	☐ Yes	☐ No	Do you sell medical marijuana?	☐ Yes	☑ No
Do you rent motor vehicles for 30 days or less?	☐ Yes	☑ No	Do you sell adult usage marijuana?	☐ Yes	☑ No

5a. List specific products and/or services you provide and Explain In Detail

Home care service recipient (IRS Code Sec. 3504) who employs workers to provide services in a private home due to disability and/or aging.

6a. Owner/Partner/ Corp. Officer Last Name	Owner/Partner/ Corp. Officer First Name	Middle Initial

6b. Title	6c. FEIN	6d. SSN	6e. Phone Number
Household Employer			( )

6f. Address	City	State	Zip
		CO	

7a. Owner/Partner/ Corp. Officer Last Name	Owner/Partner/ Corp. Officer First Name	Middle Initial
N/A		

7b. Title	7c. FEIN	7d. SSN	7e. Phone Number
			( )

7f. Address	City	State	Zip

(Form continued on page 2)

09960

If you acquired the business in whole or in part, complete the following:

8a. Prior Last Name or Business Name	First Name	Middle Initial	8b.Date of Acquisition (MM/DD/YY)
N/A			

8c. Address	City	State	Zip

C

1. If seasonal, mark each business month: ☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ Jun ☐ Jul ☐ Aug ☐ Sep ☐ Oct ☐ Nov ☐ Dec

2a. **Filing Frequency:** If sales tax is collected:
☐ $15.00/ month or less — Annually ☐ Under $300/ month — Quarterly
☐ Wholesale Only — Annually ☐ $300/ month or more — Monthly

2b. First Day of Sales (MM/DD/YY)

3. Indicate which applies to you: ☐ Retail-Sales ☐ Wholesaler ☐ Charitable ☐ Retailers-Use

Revenue Registration Account Number (Dept. Use Only)

D

1. Filing frequency If wage withholding amount is **W2** (Withholding of $50,000 plus see Section D page 6)
☑ $1 – $6,999/Year — Quarterly ☐ $7,000 – $49,999/ Year — Monthly ☐ $50,000 +/ Year — Weekly

2. ☑ **W2** Withholding ☐ **1099** Withholding

1a. Filing frequency If wage withholding amount is **1099** (Withholding of $50,000 plus see Section D page 6)
☐ $1 – $6,999/Year — Quarterly ☐ $7,000 – $49,999/ Year — Monthly ☐ $50,000 +/ Year — Weekly

2a. ☐ **Oil/Gas** Withholding

3a. First Day of Payroll, if applicable (MM/DD/YY)

3b. Payroll Records Phone Number
(**406**) **532-1900**

E

Period Covered From MM/YY	Period Covered To MM/YY	Fees (see fees on page 3)				
		(0020-810)	State Sales Tax Deposit	**(355)**	$	00
	12/	(0080-750)	Sales Tax License	**(999)**	$	00
	12/	(0100-750)	Wholesale License	**(999)**	$	00
		(1000-750)	Wage W2 Withholding	**(999)**	$	00
		(1020-750)	1099 Withholding	**(999)**	$	00
	12/	(0160-750)	Charitable License	**(999)**	$	00

Mail to and Make Checks Payable to:
Colorado Department of Revenue,
PO Box 17087
Denver, CO 80217-0087

Amount Owed $ .00

The State may convert your check to a one time electronic banking transaction. Your bank account may be debited as early as the same day received by the State. If converted, your check will not be returned. If your check is rejected due to insufficient or uncollected funds, the Department of Revenue may collect the payment amount directly from your bank account electronically.

F

I declare under penalty of perjury in the second degree that the statements made in this application are true and complete to the best of my knowledge.

Signature of Owner, Partner, or Corporate Officer Required	Title	Date (MM/DD/YY)
	Household Employer	

(See fees and additional information on page 3)

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DR 0145 (12/09/13)
COLORADO DEPARTMENT OF REVENUE
Taxation Business Group
Denver, CO 80261-0009
www.TaxColorado.com

130145 19999

Tax Information Designation and Power of Attorney for Representation

Office Use Only
Date Received:

Taxpayer Last Name or Business Name	First Name	Middle Initial	SSN, CAN or FEIN
Spouse's Last Name, if returns are filed jointly	First Name	Middle Initial	SSN or CAN
N/A			
Address	City	State	Zip
		CO	

Mark only one (the department will accept the federal form 2848, Power of Attorney and Declaration of Representative, in lieu of this document):

☐ Tax Information Authorization: Marking this box allows the department to disclose your confidential tax information to your designee. You may designate a person, agency, firm or organization. See Section 39-21-113 (4) (b).

☑ Power of Attorney for Representation: Mark this box if you want a person to "represent" you. This means the person may receive confidential information and may make tax decisions on your behalf.

For ☑ All Tax years or ☐ Specific tax years/filing periods:

I hereby appoint the following person as Designee for Tax Information or Attorney for Representation:

Last Name	First Name	Middle Initial
Snyder	**Nathyn**	**A**

Mailing Address			Phone Number
100 Consumer Direct Way, Suite 304			**406-532-2986**
City	State	Zip	Fax Number
Missoula	**MT**	**59808**	**406-532-8588**

Name of business/firm (if applicable)
Consumer Direct Care Network Colorado - Consumer Direct for Colorado as Fiscal Agent, LLC

Representative's title or relationship to taxpayer
FEA Manager

Last Name	First Name	Middle Initial

Mailing Address			Phone Number
City	State	Zip	Fax Number

Name of business/firm (if applicable)

Representative's title or relationship to taxpayer

The above-named is authorized to receive my confidential information and/or represent me before the Colorado Department of Revenue for:

☐ All tax matters until this authorization is revoked in writing, **or**

☑ Specific tax matters as follows (mark all that apply):

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130145 29999

☐ State Sales Tax	Period (MM/DD/YY-MM/DD/YY) –	☐ Partnership Income Tax	Period (MM/DD/YY-MM/DD/YY) –
☐ State Consumer Use Tax	Period (MM/DD/YY-MM/DD/YY) –	☑ Withholding Income Tax	Period (MM/DD/YY-MM/DD/YY) 1/1/2020 – 12/31/2079
☐ Individual Income Tax	Period (MM/DD/YY-MM/DD/YY) –	☐ All Department-Administered Sales Taxes	Period (MM/DD/YY-MM/DD/YY) –
☐ Corporate Income Tax	Period (MM/DD/YY-MM/DD/YY) –	☐ All Department-Administered Consumer Use Taxes	Period (MM/DD/YY-MM/DD/YY) –
☐ Fiduciary Income Tax	Period (MM/DD/YY-MM/DD/YY) –	☐ Other tax (specify)	Period (MM/DD/YY-MM/DD/YY) –

If other, please explain

Signature of Taxpayer(s)

- I acknowledge the following provision: Actions taken by a Power of Attorney representative are binding, even if the representative is not an attorney. Proceedings cannot later be declared legally defective because the representative was not an attorney.
- Corporate officers, partners, fiduciaries, or other qualified persons signing on behalf of the taxpayer(s): I am authorized to sign this form on behalf of the entity or person identified above as the taxpayer because:
  - I am the taxpayer
  - The taxpayer is a corporation, and I am the corporate officer
  - The taxpayer is a partnership, and I am a partner
  - The taxpayer is a trust, and I am the trustee
  - The taxpayer is a decedent's estate, and I am the estate administrator
  - The taxpayer is a receivership, and I am the receiver
  - Other (if none of the above, then explain what representative capacity you have for the taxpayer)
- If a tax matter concerns a joint return, both spouses must sign if joint representation is requested. Taxpayers filing jointly may authorize separate representatives.

Signature	Print Name	Date (MM/DD/YY)

Title (if applicable)	Daytime telephone number

Spouse Signature (if joint representation)	Print Name	Date (MM/DD/YY)
N/A		

Declaration of Representative — I am authorized to represent the taxpayer(s) identified above for the tax matter(s) specified.

Signature	Date (MM/DD/YY)	Title
		FEA Manager

Note: This authorization form automatically revokes and replaces all earlier tax information designations and/or earlier powers of attorney for representation on file with the Colorado Department of Revenue for the **same** tax matters and years or periods covered by this form. **Attach a copy of any other tax information authorization or power of attorney you want to remain in effect.**

If you do not want to revoke a prior authorization, taxpayer sign here	Spouse signature if returns are filed jointly

Please complete the following, **if known** (for routing purposes only). Otherwise, you may mail this document or submit an electronically scanned copy of the document through Revenue Online, *www.Colorado.gov/RevenueOnline*

Revenue Employee	
Division	Section
Telephone Number	Fax Number

Send to: Colorado Department of Revenue Denver, CO 80261-0009

If this tax information authorization or power of attorney form is not signed, it will be returned.

Colorado Department of Labor and Employment, Unemployment Insurance Employer Services, P.O. Box 8789, Denver, CO 80201-8789
303-318-9100 (Denver-metro area) or 1-800-480-8299 (outside Denver-metro area)
www.colorado.gov/cdle/ui

Department Use Only
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APPLICATION FOR UNEMPLOYMENT INSURANCE ACCOUNT AND DETERMINATION OF EMPLOYER LIABILITY

Complete and mail this application to the address at the top of this page to register your business with us for unemployment insurance (UI) purposes. We will review your application and determine whether you must provide UI coverage for your employees. **All** items must be completed. If an item is not applicable (NA) to you or your business, enter "NA." You can provide additional information at the bottom of page 4 of this application or attach additional sheets of paper.

1. First Date of Payroll in Colorado (**Do not** provide a future date. If the first date of payroll in Colorado has not occurred, **do not** complete this application.)

2. Provide the reason for filing this application.
☑ Original application ☐ Reinstatement of existing account Account Number _____
☐ Change of ownership (enclose a copy of the sales agreement and a list of the board of directors for the new business and all acquired businesses)

3. Type of Organization (check only one box)
☑ Individual/Sole Proprietor
☐ General Partnership
☐ Corporation
☐ "S" Corporation
☐ Association
☐ Trust
☐ Estate
☐ Government
☐ Religious Organization
☐ Joint Venture
☐ Limited Partnership
☐ Limited Liability Partnership
☐ Limited Liability Limited Partnership
☐ Limited Liability Company (reported as corporation on Internal Revenue Service Form 8832)
☐ Limited Liability Company (reported as sole proprietor or partnership on Internal Revenue Service Form 8832)
☐ Stock Sale (only complete page 1 of this application and sign on page 4)
☐ Other _____
☐ Nonprofit as defined by section 501(c)(3) of the Internal Revenue Code (enclose a copy of your exemption letter from the Internal Revenue Service)
☐ Other Nonprofit _____

4. Basic Information—Provide the requested employer, address, and contact information.

Legal Business Name (Enter the actual name of the business registered with the Secretary of State, including suffixes such as Inc or LLC, if applicable)

Trade Name/Doing-Business-As Name (if applicable)	Federal Employer Identification Number (required)
N/A	

Street Address of Principal Place of Business in Colorado (provide a residence address only if it is the only Colorado address; include city, state, and ZIP code)

Telephone Number	Cellular Telephone Number	E-mail Address	Web-site Address
		N/A	**N/A**

Mailing Address if Different From Above (include city, state, and ZIP code, and in-care-of name, if applicable)	Telephone Number
c/o Consumer Direct, 100 Consumer Direct Way Ste 303, Missoula, MT 59808	**406-532-1900**

Legal Name of Owner, Partner, or Corporate Officer	Title	Social Security Number	Telephone Number
	Household Employer		
Complete Address of Owner, Partner, or Corporate Officer (Residence or P.O. Box, include city, state, and ZIP code)			Cellular Telephone Number
Legal Name of Owner, Partner, or Corporate Officer	Title	Social Security Number	Telephone Number
N/A	**N/A**	**N/A**	**N/A**
Complete Address of Owner, Partner, or Corporate Officer (Residence or P.O. Box, include city, state, and ZIP code)			Cellular Telephone Number
N/A			**N/A**

Attach additional sheets of paper if there are additional owners, partners, or corporate officers.

Bank Name and Address (provide complete address; include city, state, and ZIP code)
US Bank, 1635 S. Russell St., Missoula, MT 59801

Payroll-Records Location (provide complete address; include city, state, and ZIP code)	Payroll-Records Telephone Number
100 Consumer Direct Way Ste 304, Missoula, MT 59808	**406-532-1900**

Office Use Only Coding "Q" Number _____ Coding Date _____ Input "Q" Number _____
Account Type _____ NAICS _____ Organization Code _____ Liability Code _____ Liability Date _____
Qualifying Date _____ Status Code _____ UITR-1 _____

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5. Has this business paid wages or paid other remuneration in lieu of wages such as dividends ("S" corporation only), bonuses, draws, or disbursements?
☑ Yes ☐ No
NOTE: Wages include payments made to corporate officers performing any services in Colorado.
If **Yes**, provide the federal employer identification number (FEIN) if different than the FEIN provided in Item **4** or the UI account number if different than the account number provided in Item **2** if applicable. N/A

6. Has this business paid any individual who is considered to be a contractor or subcontractor? ☐ Yes ☑ No

7. Has the business issued or does it intend to issue IRS Form 1099-MISC to any individual. ☐ Yes ☑ No
If **Yes** to Item **6** or **7**, describe the type of work performed _____

8. Is this business an employee-leasing company (i.e., does it lease employees to other businesses or management companies)? ☐ Yes ☑ No

9. Are the employees of this business hired through an employee-leasing company or management company? ☐ Yes ☑ No
If **Yes**: Provide the name of the employee-leasing or management company _____
Provide the FEIN and/or UI account number _____

10. Is this business an individual/sole proprietor? ☑ Yes ☐ No
If **Yes**, are there any employees other than the individual, his or her spouse, or his or her children under the age of 21? ☑ Yes ☐ No

11. Is this business a partnership or limited liability organization? ☐ Yes ☑ No
If **Yes**, are there any employees other than the partners or members of the limited liability organization? ☐ Yes ☐ No

12. Select the item that best describes the business's activity in Colorado (check only one box) and provide specific detail below. For additional information regarding these industry descriptions, call Labor Market Information (LMI) at **303-318-8850** or contact LMI in writing at **633 17th Street, Suite 600, Denver, CO 80202**. Additional information is available online at lmigateway.coworkforce.com/lmigateway.

- ☐ Agricultural (list crops, animals, and/or services provided)
- ☐ Mining (list product being mined and/or services performed)
- ☐ Utilities (list type and services performed)
- ☐ Transportation, Communication, or Public Utilities (list type)
- ☐ Retail Trade (list type of product sold and to whom)
- ☐ Wholesale Trade (list type of product sold and to whom)
- ☐ Service (list type and explain in detail)
- ☐ Finance, Insurance, or Real Estate (list type and explain in detail)
- ☐ Manufacturing and Assembly (list materials used and products rendered)
- ☐ Government (list type of agency)
- ☑ Household/Domestic
- ☐ Other _____

Construction—General Contractor
- ☐ Residential
  - ☐ Single Family
  - ☐ Multiple Family
- ☐ Commercial
  - ☐ Industrial/Warehouse
  - ☐ Other Commercial
- ☐ Speculative Builder/For Sale by Owner
- ☐ Subcontractor (explain in detail)

Heavy Construction
- ☐ Highway and Steel Construction
- ☐ Bridge, Tunnel, and/or Elevated Highway
- ☐ Water, Sewer, Pipeline, and/or Communication
- ☐ Other Heavy Construction

Provide specific detail regarding the business's activity in Colorado. If more than one service is provided, indicate which is predominant.
Home care service recipient (IRS Code Sec. 3504) who employs workers to provide services in a private home due to disability and/or aging.

NOTE: If the business's entire activity is seasonal or if it has seasonal occupations, a request for seasonal designation can be made by completing and returning Form UITL-5, Request for Seasonal Determination. To obtain this form, go to www.colorado.gov/cdle/ui, click on **Forms and Publications**, and then click on **Employer Forms**. If you have any questions regarding seasonal status, call us at one of the telephone numbers at the top of the initial page of this application.

13. Worksite Information—Provide the following information for each physical location in Colorado. **Do not** provide P.O. boxes, payroll, or accountant addresses. If an employee works from his or her home, you must provide the employee's residence address. Attach additional sheets of paper for more than one physical location in Colorado.

Complete Physical Street Address of Worksite (include city, state, and ZIP code)

Worksite Telephone Number	Worksite Contact Person	Average Number of Employees in a Typical Month
		2

14. Business Acquisition—For purposes of this application, an acquisition is defined as the purchase or transfer of any or all of the assets and/or employees of a previously established business. If this business entity was acquired, in accordance with CESA 8-76-104, we must make a determination regarding the purpose of the business acquisition. If you have any questions regarding the acquisition of a business, call us at one of the telephone numbers at the top of the initial page of this application. Enclose a copy of the sales agreement and a list of the board of directors for the new business and all acquired businesses.

Is the business entity completing this application as a result of a business acquisition? ☐ Yes ☑ No If **No**, skip to Item **17**.
If **Yes**: Provide the date of acquisition _____
Check one of the boxes below to indicate the type of acquisition and complete Items **15** and **16**.
☐ Total Business Acquisition or Employee Transfer—This business acquired **all** of the organization, trade, or business or **substantially all** of the assets of at least one employer or utilizes the services of 90 percent or more of the total number of employees from another employer.
NOTE: This can include a reorganization of a current business.
☐ Partial Business Acquisition or Employee Transfer—This business acquired **some** of the organization, trade, or business or assets of at least one employer or utilizes the services of less than 90 percent of the total number of employees from another employer.
NOTE: This can include a reorganization of a current business.

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15. Did the business entity acquire or hire any workers from the prior business who are now employed with the new business? ☐ Yes ☐ No

If **Yes**: How many employees were acquired? _____

How many employees did the prior business have during its last four pay periods? Last Pay Period _____

Second-to-Last Pay Period _____ Third-to-Last Pay Period _____ Fourth-to-Last Pay Period _____

16. Provide the following information regarding the prior employer.

Prior Legal Business Name	Prior FEIN or UI Account Number
Name of Prior Owner	Current Telephone Number of Prior Owner
Complete Current Address of Prior Owner (include city, state, and ZIP code)	

17. In accordance with the Colorado Employment Security Act (CESA), employers are required to provide UI coverage if one of the following conditions are met. Employers can meet these conditions through the employment of full-time, part-time, and temporary workers (including temporary agricultural workers with an H-2A visa).

NOTE: Calendar quarters are defined as January–March, April–June, July–September, and October–December.

Check the appropriate box and provide the corresponding information that is requested.

Commercial, **Industrial**, **or Professional Organization** (as defined in CESA 8-70-113)

☐ Paid one or more workers a total of $1,500 in gross wages during any calendar quarter in the current or preceding calendar year

Date on which you paid $1,500 in gross wages during a calendar quarter to meet this requirement _____

☐ Employed one or more workers for some portion of a day in 20 different calendar weeks during the current or preceding calendar year (all 20 calendar weeks must occur within the same calendar year)

NOTE: The services do not have to be performed in consecutive weeks or by the same employee.

Date on which you first employed a worker for some portion of a day to meet this requirement _____

Date on which you employed a worker for some portion of a day in the 20th calendar week to meet this requirement _____

Agricultural Employer (as defined in CESA 8-70-120)

☐ Paid one or more agricultural workers a total of $20,000 in gross wages during any calendar quarter in the current or preceding calendar year

Date on which you paid $20,000 in gross wages during a calendar quarter to meet this requirement _____

☐ Employed ten or more workers for some portion of a day in 20 different calendar weeks during the current or preceding calendar year (all 20 calendar weeks must occur within the same calendar year)

NOTE: The services do not have to be performed in consecutive weeks or by the same ten employees.

Date on which you first employed ten workers for some portion of a day to meet this requirement _____

Date on which you employed ten workers for some portion of a day in the 20th calendar week to meet this requirement _____

Household/Domestic-Services Employer (as defined in CESA 8-70-121)

☑ Paid one or more workers performing domestic services in a private home, local college club, or local chapter of a fraternity or sorority a total of $1,000 in gross wages during any calendar quarter in the current or preceding calendar year

Date on which you paid one or more workers $1,000 in gross wages during a calendar quarter to meet this requirement _____

Nonprofit Organization, Including Political Subdivision (exempt under section 501[c][3] of the Internal Revenue Code and as defined in CESA 8-70-118)

☐ Political Subdivision/Government

☐ Had four or more workers employed anywhere in the U.S. in any calendar quarter in the current calendar year or preceding calendar year

NOTE: The services do not have to be performed in consecutive weeks or by the same four employees.

Date on which you first employed at least one worker in Colorado _____

Date on which you first employed four workers anywhere in the U.S. to meet this requirement _____

Date on which you employed four workers anywhere in the U.S. in the 20th calendar week to meet this requirement _____

Type of services provided _____

18. Has the owner, partner, or corporate officer of this business entity owned or operated any business in Colorado or does the owner, partner, or corporate officer currently own or operate any other business in Colorado? ☐ Yes ☑ No

If **Yes**, provide the information requested below for each business regardless of whether it is still in operation or related to this business entity. In addition, provide the requested information for all affiliated businesses. Attach additional sheets of paper if necessary.

Legal Business Name	UI Account Number	FEIN
Legal Business Name	UI Account Number	FEIN

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19. Will the business entity file a consolidated federal tax return, including Internal Revenue Service Form 851, with any other business or entity?
☐ Yes ☑ No
If **Yes**, provide the information requested below for each business or entity included in the consolidated tax return. Attach additional sheets of paper if necessary.

Legal Business Name	UI Account Number	FEIN
N/A	**N/A**	**N/A**
Legal Business Name	UI Account Number	FEIN
N/A	**N/A**	**N/A**

20. Is this business entity the result of a reorganization of a previously existing business entity or entities? ☐ Yes ☑ No
If **Yes**, provide the information requested below for all business entities. Attach additional sheets of paper if necessary.
NOTE: Attach a copy of your reorganization plan. Provide the names of all corporate officers for all entities, a statement explaining the reason for the reorganization, and any cost-benefit analysis that was completed in relation to the reorganization.

Legal Business Name	UI Account Number	FEIN
N/A	**N/A**	**N/A**
Legal Business Name	UI Account Number	FEIN
N/A	**N/A**	**N/A**

21. Was this business entity purchased as a franchise from a corporation or franchisor? ☐ Yes ☑ No
Was this business entity purchased as a franchise from a corporation or franchisee? ☐ Yes ☑ No

22. Please provide additional information or comments in the space provided below. If you are providing information relative to a question above, please note the question number.

Information/Comments

I certify under penalty of perjury that the above information is true, accurate, and complete to the best of my knowledge. I understand that there are severe penalties for providing false statements and willfully misrepresenting information in order to reduce UI rates.

Name of Company Officer (please print)	Title	
Telephone Number	Alternate Telephone Number	E-mail Address
	N/A	**N/A**
Signature of Company Officer		Date

The completion of this application is for UI purposes only. If you need to register your business in Colorado for other purposes such as establishing wage withholding, applying for a state sales tax license, or registering a trade name, complete Form CR 0100, Colorado Business Registration. The Colorado Business Registration is available at www.colorado.gov/revenue.

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Colorado Department of Labor and Employment, Division of Unemployment Insurance, P.O. Box 8789, Denver, CO 80201-8789
303-318-9100 (Denver-metro area) or 1-800-480-8299 (outside Denver-metro area), Fax 303-318-9214
www.colorado.gov/cdle/ui

POWER OF ATTORNEY

Please print the information below. Instructions for completing this form are provided on the reverse.

Employer Information

Employer Name	Trade Name	Employer Account Number (Required)	
	N/A		
Business Location Address Only (No P.O. Box Number)	City	State	ZIP Code
		CO	

Acceptance of New Power of Attorney

Effective Date of Acceptance _____

Your acceptance of a new power of attorney supersedes any existing power of attorney previously approved by the Unemployment Insurance (UI) Division.

Power of Attorney Complete Name and Address (No Abbreviations)	Telephone Number
Consumer Direct Care Network Colorado - Consumer Direct for Colorado as Fiscal Agent, LLC **100 Consumer Direct Way, Suite 304** **Missoula, MT 59808**	**406-532-1900** Email Address **taxdept@consumerdirectcare.com**

Complete Mailing Address For UI Premium Information and/or forms such as: Wages Paid and Premiums Owed, Billing Statements, and UI Rate Notice.	Telephone Number
Consumer Direct Care Network Colorado - Consumer Direct for Colorado as Fiscal Agent, LLC **100 Consumer Direct Way, Suite 304** **Missoula, MT 59808**	**406-532-1900** Email Address **taxdept@consumerdirectcare.com**

Complete only if the benefits mailing address is different from the premiums mailing address you provided above.

Complete Mailing Address For UI Benefits Information and/or forms such as: Requests for Job-Separation Information and Wages Reported and Possible Charges.	Telephone Number
	Email Address

Power-of-Attorney Signature

Print Name of the Power of Attorney Representative (Required)	Title
Nathyn Snyder	**FEA Manager**
Power of Attorney Representative Signature (Required)	Date

Employer Approval

I hereby grant permission to the above-named entity or individual to act on my behalf for the purpose stated on this document.

Print Name of the Employer Official (Required)	Title
Signature of Employer Official (Required) ☑ SIDES (To add employer account information to SIDES), or go to: http://info.uisides.org	*Date

* Additional input must be received within 6-months from the date in the Employer Approval section.

Office Use Only	Date	Q-Identification Number
Power of attorney is approved and input into the UI system.		