





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.





AUTHORIZED REPRESENTATIVE DESIGNATION FORM

Participant (Veteran) Name	Authorized Representative Name

Participants in the Veteran Directed Care (VDC) program can select an Authorized Representative (AR) to assist them with managing their services. This person assists with program compliance and employer responsibilities. The AR can be a guardian, family member or other supporter. AR cannot be an employee (caregiver).

Participant's Authorized Representative Designation

I, the Participant (named above), designate and authorize the AR (named above) to direct and manage my VDC services on my behalf.

Participant Signature

Date

Authorized Representative Responsibilities and Attestation

I, the AR, understand and agree with my role to plan and manage the Participant's VDC services.

My AR designation may be revoked at any time by the Participant or myself.

My AR responsibilities include, but are not limited to:

- Assist with completing all Participant VDC program enrollment paperwork.
- Hire, train, schedule, and supervise employees.
- Verify and sign employee timesheets.
- Monitor the Participant's budget and not overspend monthly funds.
- Develop an emergency backup plan to use when regularly scheduled employees are unable to provide service.

I affirm to know the Participant's healthcare needs. I will assist them with participating in all aspects of this program.

Authorized Representative Signature

Date





Veteran Directed Care Program
FISCAL EMPLOYER AGENT SERVICE AGREEMENT

This Agreement is between Consumer Direct for Colorado, LLC doing business as Consumer Direct Care Network Colorado (CDCN) and the following person:

☐ Check here if you are the **Participant**.

My name is: _____. I will be directing my services under this Agreement.

☐ Check here if you are the Participant's **Authorized Representative (AR)**.

My name is: _____. I will be directing the Participant's services under this Agreement.

The Participant's name is: _____.

A. Introduction

1. In this Agreement:

- "Participant" refers to the Veteran who receives Veteran Directed Care (VDC) services.
- "You" refers to the person directing the Participant's services, either the Participant or the Participant's AR.
- "Party" shall mean either You or CDCN individually. "Parties" shall mean You and CDCN together.
- "Employee" refers to an individual who is hired by You to provide authorized services to the Participant.

2. VDC services are authorized by the Denver Regional Council of Governments (DRCOG). A Spending Plan outlines the services and supports the Participant uses to maintain independence at home and in the community.

3. Through this agreement, You have chosen CDCN as your Fiscal Employer Agent (FEA). FEA services give the Participant maximum choice and control specific to their services.

4. CDCN contracts with DRCOG to serve as your FEA. CDCN will provide You with payroll and payroll reporting services, as authorized under IRS Procedure Code 70-6. CDCN will file payroll taxes on your behalf using the Participant/AR's Federal Employer Identification Number (FEIN).

5. Through your FEIN, You are the Employer of Record (EOR) of Employees. You will hire, manage, and dismiss Employees.

B. Participant/AR Responsibilities – You agree to:

1. Complete all the forms required by CDCN for FEA services. This includes federal and state tax forms, unemployment forms and CDCN forms. Failure on your part to provide required information or to submit a complete packet may result in an Employee's wages being delayed or paid by You.

2. Work with CDCN to:

- Obtain a Federal Employer Identification Number.



- Submit paperwork to CDCN for vendor reimbursements in a timely manner only for approved services and goods.
 - Monitor CDCN's monthly budget tracking reports and not use more service hours than what is approved in the Participant's authorized budget.
3. Follow all VDC program rules, CDCN policies, and federal and state employment regulations:
- Recruit, interview, check references, hire, train, schedule, manage, and dismiss Employees. You will direct day-to-day services and resolve conflicts that arise.
 - Employees must receive an Okay to Work form from CDCN before they can start work.
 - Do not discriminate against potential or current Employees for race, creed, color, national origin, sex, age, disability, marital status, sexual orientation, or any other status protected by law. This applies to all employment decisions, including recruitment, hiring, schedule/hour changes, lay off, and dismissal. You accept full responsibility for following equal opportunity laws and requirements so that each Employee is treated fairly and consistently.
4. Review and approve Employee timesheets (paper or on the Web Portal) according to the CDCN payroll schedule. Ensure hours on the timesheet are true and accurate. You can be held liable for fraudulent time approval.
5. Report to CDCN with five (5) business days changes to the Participant's or Employee's name, address, telephone number, hospitalization, or employment status.
6. Report immediately to appropriate authorities suspected abuse, neglect, exploitation, or health risk, i.e. Adult Protective Services, CDCN, and DRCOG.
7. Appoint a temporary AR if You are not capable or available to direct the care.

C. Participant/AR Acknowledgment of Limitations of CDCN Payment Obligation:

CDCN will not pay for tasks and services that are not authorized on the Veteran's Spending Plan. You must monitor the Participant's budget and not use more service hours or budget amounts than what is approved. CDCN is not responsible to pay for:

- Unauthorized overtime and services.
- Overlap of services - two Employees working at the same time.

You agree to reimburse CDCN for payment of any unauthorized wages and expenses.

D. Agency Responsibilities – CDCN agrees to:

1. Provide You with:
- Participant enrollment packet within three weeks of referral from DRCOG. You are also offered a face-to-face enrollment meeting with CDCN to successfully complete the packet.
 - Employee enrollment packets.
 - Monthly budget tracking reports.
 - Customer complaint process.



2. Perform payroll and accountant tasks for You, including:

- Pay Employee's wages on a bi-weekly schedule.
- Perform background checks on Employees You want to hire. Results will be provided to DRCOG for hiring determination.
- Withhold and arrange Workers' Compensation coverage for your Employees.
- Process and file all Employer-related taxes in the aggregate using your individual FEIN.
- Follow all IRS and state reporting guidelines, including obtaining all proper federal and state authorizations for the FEA program.
- Submit all claims for services to DRCOG on your behalf.

E. Terms and Conditions

Term and Termination: This Agreement starts when it is signed by You and CDCN. Either Party can end the Agreement at any time. CDCN will follow Program Policy and Guidelines when determining service termination is necessary. If CDCN ends the Agreement, You will be notified by email or regular US mail. You agree that ending the Agreement means services from CDCN will stop.

If termination is due to switching to another FEA, it must be done correctly so the tax transition for employee records is accurate. The switch must occur at the end of a quarter or calendar year and follow necessary transfer procedures.

Indemnification: You are in the best position to oversee your employees' actions when they are working for You. Due to this, You agree to indemnify CDCN. This means that if your employees cause property damages or a legal dispute while working for You, You are responsible for paying all damages and legal fees, if damages and fees are assessed to CDCN. CDCN is also not responsible for employees' theft of personal belongings. CDCN is not liable for your employees' actions and damages incurred.

Partial Invalidity: If part of this Agreement is found to be wrong, it does not mean the whole Agreement is not correct. The rest of the Agreement must be followed.

Arbitration: A dispute about this Agreement is handled by an independent arbitrator at the location of the dispute. Parties will split the cost of the arbitrator. Each Party will handle their own legal fees. Parties may agree to another arbitration process.

State Law: If Parties cannot solve a problem through negotiation or talking about the problem, then Colorado laws apply. Any legal action related to this Agreement must be held in the county where CDCN is located.

Modification of Agreement: The Agreement can be changed. Changes must be in writing, signed and dated by both parties.

Timely Notification: Both Parties agree to notify each other in a timely manner about the duties in this Agreement.

Assignment: CDCN may sell, assign or transfer this Agreement to another provider without notice. The new owner will have the same rights, benefits, and duties in this Agreement. If this happens,





Veteran Directed Care Program
FISCAL EMPLOYER AGENT SERVICE AGREEMENT

You will receive written notice about the new owner. You may not assign the Agreement without written permission from CDCN.

Modification of Tax Forms: You authorize CDCN to make applicable changes to the Employer of Record's tax forms. These changes will be noted on the Data Form.

Workers Compensation Program: You and your employee must follow CDCN's safety program rules. If not, work-related injuries may be denied coverage under the Workers' Compensation program.

Waiver of Terms and Conditions: Failure to enforce, failure to exercise the benefit of, or waiving the breach of one or more of the Agreement Terms and Conditions does not mean this action will continue in the future. Going forward, both Parties understand the rights and privileges of the Agreement are in full effect.

Relationship of Parties: In this Agreement CDCN is your Fiscal Employer Agent. The only employment arrangement is between You and your Employee. In this arrangement, You are the Employer of Record where You set the working terms with your Employee. CDCN does not control or direct how You and your Employees perform your duties.

Entire Agreement: This Agreement and other written materials describe the complete understanding between You and CDCN. Any verbal agreements do not apply. All agreements must be put in writing.

F. Conclusion:

This Agreement is between You and CDCN. It is not a contract/guarantee of employment for Employees. CDCN does not control or direct how You or the Employees perform duties and responsibilities. You are the direct (managing) employer and Employer of Record of Employees. You are responsible for recruiting, hiring, training and supervising Employees. You are also responsible for monitoring your approved budget and not overspending.

By signing, the Parties agree to follow the Responsibilities, Limitations of CDCN Payment Obligations, and Terms and Conditions stated above.

_____ Participant/AR Name	_____ Signature	_____ Date
_____ CDCN Representative Name	_____ Signature	_____ Date





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



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			
4a	Mailing address (room, apt., suite no. and street, or P.O. box)	5a	Street address (if different) (Don't 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) ► _____ ☐ 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) ► _____ ☐ 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			
13	Highest number of employees expected in the next 12 months (enter -0- if none). If no employees expected, skip line 14. <table><tr><td>Agricultural</td><td>Household</td><td>Other</td></tr></table>		Agricultural	Household	Other	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. ☐
Agricultural	Household	Other				
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 ☐ Wholesale-agent/broker ☐ Real estate ☐ Manufacturing ☐ Finance & insurance ☐ Accommodation & food service ☐ Wholesale-other ☐ Retail ☐ Other (specify) ► _____					
17	Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided.					
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		Designee's telephone number (include area code)			
	Address and ZIP code		Designee's fax number (include area code)			
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 ►			



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)**

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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
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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**

--

Date

/	/
---	---

Print your name here

--

Print your title here

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Best daytime phone

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Now give this form to the agent to complete.



220100AP19999

Colorado Sales Tax and Withholding Account Application

A	1. Reason for Filing This Application			
	☐ Original Application for a New Business		☐ Change in Managing Partners, Members, or Officer of an Existing Business	
	☐ Add a New Physical Location to an Existing Account		☐ Change of Ownership for an Existing Business	
Enter the existing Colorado Account Number		Complete line 9 to report existing business sold to a new owner or change in entity structure of an existing business		
2. Indicate Type of Organization. If you are not an individual, you must have a FEIN number.				
☐ Individual/Sole Proprietor ☐ 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 ☐ Nonprofit (Charitable)				
B	Business Information			
	1a. Last Name (If registering as TIN)		1b. First Name	
	Check the applicable box and write your SSN or ITIN in box 1b ☐ SSN ☐ ITIN		1b. TIN (Required)	
2a. Business Name (If registering as FEIN)		2b. Trade Name / DBA (If applicable)		2c. FEIN (Required)
3. Proof of Identification				
☐ State DL/ID ☐ Passport ☐ Other				
Principal Place of Business (Do not use PO Box)				
4a. Principal Address		4b. City	4c. State	4d. ZIP
4b. County		5. Phone Number	6. Email Address	
Email Opt In For				
☐ Return Filing ☐ Tax Updates ☐ Revenue Online Instructions ☐ Tax Rate Changes (2x/Year) ☐ Marketplace Information				
Mailing Address (If different from the principal address)				
7a. Business Name		7b. Attention to (First, Last Name)		
7c. Mailing Address		7d. City	7e. State	7f. ZIP





220100AP29999

Owners/Partners/Members/Officers (all fields below are required)

8a. Last Name		First Name		Job Title	
8b. SSN		8c. Phone Number		Is this person responsible for tax compliance? (Required) ☐ Yes ☐ No	
8d. Home Address		City		State	ZIP

Additional Owners/Partners/Members/Officers on a separate paper

Business acquisition or purchase, complete the following

9a. Prior Business Name		Prior Owner's Last Name, First Name		9b. Date of Acquisition (MM/YYYY)	
9c. Address		City		State	ZIP
					9d. Prior Owner's FEIN

Sales Tax Account (Fees Apply)**1. Indicate Type of Sale**☐ Wholesaler ☐ Retail-Sales ☐ Charitable**2a. License Start Date or First Day of Sale Required (MM/YYYY)**

CO Account Number - Site (Dept Use Only)

2b. Filing Frequency: If SALES TAX collected is:☐ Wholesale Only - Annually ☐ Under \$300/month - Quarterly ☐ Seasonal, write in the months in business
☐ \$15/month or less - Annually ☐ \$300/month or more - Monthly**3. Complete the questionnaires below**

Do you sell alcohol?	☐ Yes ☐ No	Is your business in a Special taxing district?	☐ Yes ☐ No
Do you sell tobacco?	☐ Yes ☐ No	Do you sell EXCLUSIVELY through the marketplace?	☐ Yes ☐ No
Do you sell Prepaid Wireless?	☐ Yes ☐ No	Are you a Marketplace Facilitator?	☐ Yes ☐ No
Do you rent out rooms for 30 days or less?	☐ Yes ☐ No	If you are a Marketplace Facilitator, do you also sell products?	☐ Yes ☐ No
Do you rent motor vehicles for 30 days or less?	☐ Yes ☐ No	Do you sell taxable items that will be delivered by a motor vehicle (including deliveries made by a third-party)?	☐ Yes ☐ No

****If you sell both medical and recreational marijuana, a separate application must be filled out for each**Do you sell Medical Marijuana? ☐ Yes ☐ No Do you sell Recreational Marijuana? ☐ Yes ☐ No**4. List the specific products you sell and/or services you provide (Required) or indicate the NAICS code. To look up the code, go to www.naics.com/search**

● NAICS Code





220100AP39999

Withholding Account (No Fees Apply)						
D	1. Indicate Type of Withholding:					
	☐ W2 Withholding	● 2. Filing Frequency: If W2 wage withholding tax amount is ☐ \$1 - \$6,999/Year - Quarterly ☐ \$7,000 - \$49,999/Year - Monthly ☐ \$50,000+/Year-Weekly				
	☐ 1099 Withholding	● 3. Filing Frequency: If 1099 withholding tax amount is ☐ \$1 - \$6,999/Year - Quarterly ☐ \$7,000 - \$49,999/Year - Monthly ☐ \$50,000+/Year-Weekly				
	☐ W-2G (Gaming Withholding) ☐ Oil/Gas Withholding		Filing Frequency is monthly		● 4. First Day of Payroll Required (MM/YYYY)	
E	Period Covered (Dept Use Only)		Fees for Licenses (See Instructions)			
	From	To				
	MM/YY		● (0020-810)	State Sales Tax Deposit	● (355)	● \$
	MM/YY	MM/YY	● (0100-750)	Wholesale License	● (999)	● \$
	MM/YY	MM/YY	● (0080-750)	Retail-Sales Tax License	● (999)	● \$
	MM/YY	MM/YY	● (0160-750)	Charitable License	● (999)	● \$
	Mail and Make Checks Payable to: Colorado Department of Revenue PO Box 17087 Denver, CO 80217-0087			Amount Owed ● \$		
	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, Member, or Officer (Required)		Job Title		Date (MM/DD/YYYY)	





200145 19999

Colorado Tax Information Authorization or Power of Attorney

1. Taxpayer Information.

Taxpayer Name (Last, First or Entity), required*		Tax ID Number, required*		Phone Number	
Spouse Name (Last, First), if applicable		Tax ID Number, if applicable		Phone Number	
Current Mailing Address (if new, mark here: ☐)		City		State	ZIP Code

2. Acts Authorized. Mark either a) or b), required*

- ☐ **a) TAX INFORMATION AUTHORIZATION.** For the tax matters authorized on line 4, I/we hereby appoint the person(s) authorized on line 3 as designee(s) to receive and inspect the taxpayer's confidential tax information from the Colorado Department of Revenue. An individual contact name must be entered on line 3. If a firm or organization is listed on line 3, this authorization will apply to all of its employees, unless this box is marked:
- ☐ I am appointing only the individual(s) listed on line 3.

OR

- ☐ **b) POWER OF ATTORNEY.** For the tax matters authorized on line 4, I/we hereby appoint the person(s) authorized on line 3 as attorney(s)-in-fact to represent the taxpayer before the Colorado Department of Revenue. The individual(s) listed on line 3 may receive and inspect the taxpayer's confidential tax information and may perform the acts that the taxpayer may perform—to include signing returns, other forms, agreements, consents, or similar documents—but to exclude endorsing or otherwise negotiating any check issued by the Department, and substituting or adding another representative.

3. Person(s) Authorized. If applicable, mark here: ☐ I/we also authorize the person(s) listed on the attached page(s).

Individual Appointee or Contact Name (Last, First), required*		Title or Relationship to Taxpayer		Phone Number, required*	
Firm or Organization Name, if applicable		Email Address		Fax Number	
Mailing Address		City		State	ZIP Code
Individual Appointee or Contact Name (Last, First), if applicable		Title or Relationship to Taxpayer		Phone Number	
Firm or Organization Name, if applicable		Email Address		Fax Number	
Mailing Address		City		State	ZIP Code

4. Tax Matters Authorized. This form is effective for all tax periods and all tax and account types within the scope of section 39-21-102, C.R.S., as in effect on the date of the signature(s) below, unless a specific tax period(s) and/or tax or account type(s) is entered here:

Specific Tax Period (MM/YY – MM/YY)	Specific Tax or Account Type	Specific Tax Period (MM/YY – MM/YY)	Specific Tax or Account Type
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5. Revocation or Retention of Prior Forms. This form will automatically revoke and replace any prior form of the same type on file with the Colorado Department of Revenue for the same tax account(s) and period(s), unless this box is marked:

- ☐ I/we do not want to revoke a prior form of the same type, and a copy of those to remain in effect is attached.

6. Expiration or Revocation of This Form. This form will automatically expire four years after it is signed, unless an earlier or later expiration date (up to 10 years after signing) is entered here: To revoke or withdraw from a form already submitted, see the instructions.

Expiration Date (MM/DD/YY)

7. Taxpayer Signature. If I sign this form as a corporate officer, partner, guardian, executor, receiver, estate administrator, trustee, or other agent or employee, I affirm under penalty of perjury that I have the legal authority to execute this form on behalf of the taxpayer.

Signatory Name (Last, First), if applicable	Taxpayer Signature, required*	Date (MM/DD/YY), required*
Title or Relationship to Taxpayer, if applicable	Spouse Signature, if applicable	Date (MM/DD/YY), if applicable

Required Fields: If any are incomplete, this form is invalid. To resubmit, it must be signed again. See the instructions.

Submission: Submit with a protest or separately, at Colorado.gov/RevenueOnline, or by mail to
COLORADO DEPARTMENT OF REVENUE, PO Box 17087, Denver, CO 80217-0087.

11008



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 | ☐ Joint Venture |
| ☐ General Partnership | ☐ Limited Partnership |
| ☐ Corporation | ☐ Limited Liability Partnership |
| ☐ "S" Corporation | ☐ Limited Liability Limited Partnership |
| ☐ Association | ☐ Limited Liability Company (reported as corporation on Internal Revenue Service Form 8832) |
| ☐ Trust | ☐ Limited Liability Company (reported as sole proprietor or partnership on Internal Revenue Service Form 8832) |
| ☐ Estate | ☐ Stock Sale (only complete page 1 of this application and sign on page 4) |
| ☐ Government | ☐ Other _____ |
| ☐ Religious Organization | |
| ☐ 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)

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

Mailing Address if Different From Above (include city, state, and ZIP code, and in-care-of name, if applicable)

Telephone Number

Legal Name of Owner, Partner, or Corporate Officer

Title

Social Security Number

Telephone Number

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

Complete Address of Owner, Partner, or Corporate Officer (Residence or P.O. Box, include city, state, and ZIP code)

Cellular Telephone Number

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)

Payroll-Records Location (provide complete address; include city, state, and ZIP code)

Payroll-Records Telephone Number

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 _____



Department Use Only

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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

10872



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☐ Yes ☐ No

Legal Business Name	UI Account Number	FEIN
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Legal Business Name	UI Account Number	FEIN
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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
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Legal Business Name	UI Account Number	FEIN
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Was this business entity purchased as a franchise from a corporation or franchisee? ☐ Yes ☐ No

- a. An employer has improperly classified an individual when an employer-employee relationship exists, as determined in subsection (2)(f) of this section and Section 8-70-115, C.R.S., but the employer has not classified the individual as an employee.
- b. An "employer-employee" relationship shall be presumed to exist when work is performed by an individual for remuneration paid by an employer, unless to the satisfaction of the Department the employer demonstrates that the individual is an exempt person or independent contractor.
- c. A person shall not knowingly incorporate or form, or assist in the incorporation or formation of, a corporation, partnership, limited liability corporation, or other entity, or pay or collect a fee for use of a foreign or domestic corporation, partnership, limited liability corporation, or other entity for the purpose of facilitating, or evading detection of, a violation of this section.
- d. A person shall not knowingly conspire with, aid and abet, assist, advise, or facilitate an employer with the intent of violating the provisions of this chapter.

(III) Upon a finding that the employer, with willful disregard of the law, misclassified employees, the director may:

- (A) Impose a fine of up to \$5,000 per misclassified employee for the first misclassification with willful disregard, and for a second or subsequent misclassification with willful disregard, a fine of up to \$25,000 per misclassified employee; and
- (B) Upon a second or subsequent misclassification with willful disregard, issue an order prohibiting the employer from contracting with, or receiving any funds for the performance of contracts from the state for up to two years after the date of the director's order. Upon the issuance of such order, the director shall notify state departments and agencies as necessary to ensure enforcement of the order.

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
Signature of Company Officer			Date

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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)	
Business Location Address Only (No P.O. Box Number)	City	State	ZIP Code

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
	Email Address

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
	Email Address

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
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)	*Date
☐ SIDES (To add employer account information to SIDES), or go to: http://info.uisides.org	

* 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.		

