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This document is designed for double-sided paper printing.

CONSUMER DIRECT CARE NETWORK

Reset/clear all fields > 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, provide prior account information via IRS and/or State agency documentation.

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

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

**Attach legal guardianship paperwork*

**Business Start Date:** / /

# 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

**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.

*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,

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 |

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 2023)
Department of the Treasury
Internal Revenue Service

# Application for Employer Identification Number

**(For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.)**
**See separate instructions for each line. Keep a copy for your records.**
**Go to *www.irs.gov/FormSS4* for instructions and the latest information.**

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 will generally be $1,000 or less if you expect to pay $5,000 or less, $6,536 or less if you're in a U.S. territory, 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.

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

**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
Mikayla Brinda

Designee's telephone number (include area code)
406-532-8502 ext. 8

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.

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

Applicant's telephone number (include area code)

Applicant's fax number (include area code)

Signature

Date

# Form 2678 Employer/Payer Appointment of Agent

(Rev. December 2023) 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're an employer or payer who wants to request approval, complete Parts 1 and 2 and sign Part 2. Then give it to the agent. Have the agent complete Part 3 and sign it.

  **Note:** This appointment isn't effective until we approve your request. See the instructions for more information.

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

**For IRS use:**

## Part 1: Why you're filing this form.

(Check one)

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

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

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

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

2 **Employer's or payer's name** (not your trade name) 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, Employer's Annual Federal Unemployment (FUTA) Tax Return* (all 940 series) | ☑ | ☐ |
| Form 941, Employer's QUARTERLY Federal Tax Return (all 941 series) | ☑ | ☐ |
| Form 943, Employer's Annual Federal Tax Return for Agricultural Employees (all 943 series) | ☐ | ☐ |
| Form 944, Employer's ANNUAL Federal Tax Return (all 944 series) | ☐ | ☐ |
| Form 945, Annual Return of Withheld Federal Income Tax | ☐ | ☐ |
| Form CT-1, Employer's Annual Railroad Retirement Tax Return | ☐ | ☐ |
| Form CT-2, Employee Representative's Quarterly Railroad Tax Return | ☐ | ☐ |

* Generally, you can't appoint an agent to report, deposit, and pay tax reported on Form 940, unless you're a home care service recipient.

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

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

**Sign your name here**

Print your name here

Print your title here: HCSR - Household Employer

Date / /

Best daytime phone

**Now give this form to the agent to complete.**

220100AP19999

CR 0100 (05/02/22)
**COLORADO DEPARTMENT OF REVENUE**
Taxpayer Service Center
PO Box 17087
Denver CO 80217-0087


# Colorado Sales Tax and Withholding Account Application

## A

**● 1. Reason for Filing This Application**

- [x] 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.**

- [x] 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) | ● First Name |
|---|---|
| | |

Check the applicable box and write your SSN or ITIN in box 1b: [x] SSN [ ] ITIN

● 1b. TIN (Required)

| ● 2a. Business Name (If registering as FEIN) | ● 2b. Trade Name / DBA (If applicable) | ● 2c. FEIN (Required) |
|---|---|---|
| | **N/A** | |

3. Proof of Identification

- [ ] State DL/ID _____
- [ ] Passport _____
- [ ] Other _____

### Principal Place of Business (Do not use PO Box)

| ● 4a. Principal Address | ● City | ● State | ● ZIP |
|---|---|---|---|
| | | **CO** | |

| ● 4b. County | ● 5. Phone Number | ● 6. Email Address |
|---|---|---|
| | **406-532-8502 ext. 8** | **taxdept@consumerdirectcare.com** |

Email Opt In For

- [x] Return Filing
- [x] Tax Updates
- [ ] Revenue Online Instructions
- [x] Tax Rate Changes (2x/Year)
- [ ] Marketplace Information

### Mailing Address (If different from the principal address)

| ● 7a. Business Name | ● 7b. Attention to (First, Last Name) |
|---|---|
| **Consumer Direct Care Network** | **FMS Agent** |

| ● 7c. Mailing Address | ● City | ● State | ● ZIP |
|---|---|---|---|
| **100 Consumer Direct Way, Suite 303** | **Missoula** | **MT** | **59808** |

220100AP29999



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

| 8a. Last Name | First Name | Job Title |
|---|---|---|
| | | **Household Employer** |

| 8b. SSN | 8c. Phone Number | Is this person responsible for tax compliance? (Required) |
|---|---|---|
| | | ☐ Yes ☑ No |

| 8d. Home Address | City | State | ZIP |
|---|---|---|---|
| | | **CO** | |

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 |
|---|---|---|---|---|
| | | | | |

**C**

## 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
**624120**

## D — Withholding Account (No Fees Apply)

**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 — Fees for Licenses (See Instructions)

| Period Covered (Dept Use Only) 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) |
|---|---|---|
| | **Household Employer** | |

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DR 0145 (05/26/21)
**COLORADO DEPARTMENT OF REVENUE**
*Tax.Colorado.gov*


# 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 |
|---|---|---|---|
| **100 Consumer Direct Way, Suite 303** | **Missoula** | **MT** | **59808** |

**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* | |
|---|---|---|---|
| **Haynes, Madison** | **FEA Supervisor** | **406-532-8502 ext. 8** | |
| Firm or Organization Name, if applicable | Email Address | Fax Number | |
| **CDCN-CO - Consumer Direct for Colorado as Fiscal Agent, LLC** | **taxdept@consumerdirectcare.com** | **406-532-8588** | |
| Mailing Address | City | State | ZIP Code |
| **100 Consumer Direct Way, Suite 304** | **Missoula** | **MT** | **59808** |
| Individual Appointee or Contact Name (Last, First), if applicable | Title or Relationship to Taxpayer | Phone Number | |
| **Arlint, Susan** | **Payroll Tax Manager** | **406-532-8515** | |
| Firm or Organization Name, if applicable | Email Address | Fax Number | |
| **CDCN-CO - Consumer Direct for Colorado as Fiscal Agent, LLC** | **taxdept@consumerdirectcare.com** | **406-532-8588** | |
| Mailing Address | City | State | ZIP Code |
| **100 Consumer Direct Way, Suite 304** | **Missoula** | **MT** | **59808** |

**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 |
|---|---|---|---|
| | **Withholding Tax** | | |

**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.

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