



Financial & Payroll Services for the Nonprofit Sector

Enrollment Information for CO-CPWD

Veteran Directed Program Employers

This packet contains the necessary forms and instructions that will authorize ARIS Solutions to act in your behalf as your Financial Management Service provider.

ALL FORMS MUST BE SIGNED/DATED AND RETURNED TO ARIS SOLUTIONS

- Employer / Veteran Information Form
- Background Check Authorization form- Surrogate employer Only
- Form SS-4 - Application for Employer Identification Number
 - ❖ Form SS-4 allows ARIS to request a Federal Employer Identification Number from the IRS for you.
- Worker's Compensation Application
- Form 2678 - Employer/Payer Appointment of Agent
 - ❖ Allows ARIS to file your employment tax forms.
- Form 8821- Tax Information Authorization
 - ❖ Allows ARIS to receive & review copies of tax filings from the IRS.
- State Tax Forms
 - ❖ Application for Colorado Business Tax Registration (Form CR0100AP)- to setup a Withholding account with the Colorado Department of Revenue on your behalf.
 - Colorado Department of Revenue "Power of Attorney" (Form DR 0145) -this allows ARIS to speak with the Department of Revenue on your behalf about withholding tax.
 - ❖ Application for account with Colorado Department of Labor and Unemployment (Form UITL-100)- to apply for an unemployment insurance account number on your behalf.
 - Employer Power of Attorney Assignment (Form UITL-18) - this allows ARIS to speak with the Department of Labor and Unemployment on your behalf.
- Employer Confirmation of Receipt
- Employer Confirmation of Receipt- Paid Sick Leave
- Fraud & Abuse Statement

If you have questions contact the Veteran Department at 866.970.3301

Return Packet to: ARIS Solutions-Veteran Program

PO Box 4409
White River Jct., VT 05001
Phone: 866.970.3301 (toll free)
Fax: 802.295.9812
Email: veteranpayroll@arissolutions.org



Employer/Veteran Information Form

NAME OF EMPLOYER

Name _____
(Last) (First) (Middle)

Address _____
(Street) (Apt) (City) (State) (Zip)

Phone () _____ Email _____

DOB / / _____ Social Security Number - - _____

FEIN (If previously issued) _____

Relationship to Veteran _____

Veteran IS EMPLOYER YES NO

If yes please skip next section.

NAME OF VETERAN

Name _____

Address _____
(Street) (APT) (City) (State) (Zip)

Phone () _____

Date of Birth _____

Social Security Number _____



Employer Authorization to Perform Background Check(s)

I, _____, have reviewed the list of excluded convictions, substantiations, and findings. I understand that ARIS Solutions will conduct background checks for me on behalf of the Veteran. I understand that the Veteran will be made aware of all findings and that any finding on the list of program background check exclusions will eliminate me from consideration as the Veteran’s employer.

As so, I authorize ARIS Solutions to perform the following background check(s) on behalf of the Veteran

- Criminal Background Check

Signed,

Signature of Employer

Date

Employer Social Security Number:

Alias or Maiden Name(s):



COLORADO Bureau of Investigation

Department of Public Safety

IDENTIFICATION UNIT | 690 Kipling Street, Suite 3000 | Denver, CO 80215 | (303) 239-4208 | www.colorado.gov/cbi

Public Request for Criminal History Record Information

Please type or print clearly | \$13.00 per name (no personal checks) | Reply will be mailed in 3-5 business days

Please call (303) 239-4208 with any inquiries. Discrepancies must be reported within 30 days.

NAME TO BE CHECKED

Last Name:

First Name:

Middle Name:

Date of Birth (required):

/ /

MM/DD/YYYY

Gender (optional):

MALE FEMALE

Social Security Number (optional):

- -

SEND REPLY TO

Name of Business and/or Person

Street Address or P.O. Box

Apt/Unit Number

City

State

ZIP Code

Phone Number

PURPOSE FOR REQUEST

Public Request/General Inquiry

Emergency Medical Technician

Security Guard

Housing

P.O.S.T. Board

Adoption

Visa / International Travel

Immigration

Guardian/Conservator

NOTARIZING

Do you need the response notarized?

YES

NO

Notarizing may add up to three business days to your processing time.

PLEASE READ AND SIGN BELOW

The record you may receive is for lawful use only and summarizes information sent to the Colorado Bureau of Investigation from fingerprint contributors in the state of Colorado. Unless fingerprints accompanied your inquiry, the Colorado Bureau of Investigation cannot guarantee this record relates to the person in whom you have an interest. If the disposition is not shown, or further explanation of an arrest charge or disposition is desired, that information may be obtained from the agency who furnished the arrest information. Only the court of jurisdiction or the respective District Attorney's office wherein the final disposition occurred can provide an official copy to any specific disposition. State law governs access to sealed records. Because additions and deletions to a criminal history record may be made at any given time, a new inquiry should be requested when needed for subsequent use. Any report received from the Colorado Bureau of Investigation as the result of this inquiry shall not be used for the direct solicitation of business for pecuniary (monetary) gain.

X

Signature of Requesting Party (required per State law)

Time sheets are due on Mondays by 11:59pm Eastern Standard Time
 Due dates do not change if they fall on a holiday.

VDC- CO-IL-IN-ME-WI
Time Sheet and Reimbursement Schedule 2024

Pay Period	Pay Period Start Date	Pay Period End Date	Timesheet Submission Due Date	Payment Date
1	12/31/2023	1/13/2024	1/15/2024	1/19/2024
2	1/14/2024	1/27/2024	1/29/2024	2/2/2024
3	1/28/2024	2/10/2024	2/12/2024	2/16/2024
4	2/11/2024	2/24/2024	2/26/2024	3/1/2024
5	2/25/2024	3/9/2024	3/11/2024	3/15/2024
6	3/10/2024	3/23/2024	3/25/2024	3/29/2024
7	3/24/2024	4/6/2024	4/8/2024	4/12/2024
8	4/7/2024	4/20/2024	4/22/2024	4/26/2024
9	4/21/2024	5/4/2024	5/6/2024	5/10/2024
10	5/5/2024	5/18/2024	5/20/2024	5/24/2024
11	5/19/2024	6/1/2024	6/3/2024	6/7/2024
12	6/2/2024	6/15/2024	6/17/2024	6/21/2024
13	6/16/2024	6/29/2024	7/1/2024	7/5/2024
14	6/30/2024	7/13/2024	7/15/2024	7/19/2024
15	7/14/2024	7/27/2024	7/29/2024	8/2/2024
16	7/28/2024	8/10/2024	8/12/2024	8/16/2024
17	8/11/2024	8/24/2024	8/26/2024	8/30/2024
18	8/25/2024	9/7/2024	9/9/2024	9/13/2024
19	9/8/2024	9/21/2024	9/23/2024	9/27/2024
20	9/22/2024	10/5/2024	10/7/2024	10/11/2024
21	10/6/2024	10/19/2024	10/21/2024	10/25/2024
22	10/20/2024	11/2/2024	11/4/2024	11/8/2024
23	11/3/2024	11/16/2024	11/18/2024	11/22/2024
24	11/17/2024	11/30/2024	12/2/2024	12/6/2024
25	12/1/2024	12/14/2024	12/16/2024	12/20/2024
26	12/15/2024	12/28/2024	12/30/2024	1/3/2025
27	12/29/2024	1/11/2025	1/13/2025	1/17/2025
28	1/12/2025	1/25/2025	1/27/2025	1/31/2025

Time sheets, reimbursements, employee paperwork and check requests received by the ARIS Solutions office after the due dates posted above will be processed with the next pay period.

Send to:
 ARIS Solutions
 PO Box 4409
 White River Junction, VT 05001
 FAX: 1.802.295.9812

Questions?
 Veterans Department
 1.866.970.3301
<https://arissolutions.org/submit-timesheet/>

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.

Form (Rev. December 2019) Department of the Treasury Internal Revenue Service

EIN

Main form body containing lines 1 through 18, Third Party Designee section, and signature lines. Includes fields for legal name, address, SSN, and business details.



VDC Colorado Workers' Compensation Form

Employer Legal Name:

Employer Date of Birth:

Veteran name (if different than Employer name):

Relationship to Veteran: Spouse Child Sibling Other (specify):

Employer FEIN # :

Employer Phone:

Street Address (where service is provided):

City, State, ZIP(where service is provided):

Estimated Number of Employees:

Full Time: _____ Part Time: _____

Estimated Annual Payroll:

Effective Date of Coverage (start date):

Employer Signature and Date:

INDIVIDUALS CONCERNED/EXCLUDED

PARTNERS, OFFICERS, RELATIVES TO BE INCLUDED OR EXCLUDED. (Remuneration to be included must be part of rating information section.)								
#	NAME	DATE OF BIRTH	TITLE/RELATIONSHIP	OWNER-SHIP %	DUTIES	INC/EXC	CLASS CODE	REMUNERATION
			Owner	100%	manage budget and employees	Excl		0

PRIOR CARRIER INFORMATION/LOSS HISTORY

PROVIDE INFORMATION FOR THE PAST 5 YEARS AND USE THE REMARKS SECTION FOR LOSS DETAILS							LOSS RUN ATTACHED
YEAR	CARRIER & POLICY NUMBER	ANNUAL PREMIUM	MOD	# CLAIMS	AMOUNT PAID	RESERVE	
	CO: POL #:						
	CO: POL #:						
	CO: POL #:						
	CO: POL #:						
	CO: POL #:						

NATURE OF BUSINESS/DESCRIPTION OF OPERATIONS

GIVE COMMENTS AND DESCRIPTIONS OF BUSINESS, OPERATIONS AND PRODUCTS: MANUFACTURING-- RAW MATERIALS, PROCESSES, PRODUCT, EQUIPMENT, CONTRACTOR-- TYPE OF WORK, SUB-CONTRACTS. MERCANTILE--MERCHANDISE, CUSTOMERS, DELIVERIES. SERVICE--TYPE, LOCATION. FARM--ACREAGE, ANIMALS, MACHINERY, SUB-CONTRACTS.

Colorado Veterans Program

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	YES	NO	EXPLAIN ALL "YES" RESPONSES	YES	NO
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT/WATERCRAFT?			16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?		
2. DO/HAVE PAST, PRESENT OR DISCONTINUED OPERATIONS INVOLVE(D) STORING, TREATING, DISCHARGING, APPLYING, DISPOSING, OR TRANSPORTING OF HAZARDOUS MATERIAL? (e.g. landfills, wastes, fuel tanks, etc)			17. ANY OTHER INSURANCE WITH THIS INSURER?		
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?			18. ANY PRIOR COVERAGE DECLINED/ CANCELLED/NON-RENEWED (Last 3 years)? NOT APPLICABLE IN MO		
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?			19. ARE EMPLOYEE HEALTH PLANS PROVIDED?		
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?			20. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS/SUBSIDIARY?		
6. ARE SUB-CONTRACTORS USED? (IF YES, GIVE % OF WORK SUBCONTRACTED)			21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?		
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INS.?			22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?		
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?			23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST 5 YEARS?		
9. ANY GROUP TRANSPORTATION PROVIDED?			24. ANY UNDISPUTED AND UNPAID WORKERS COMPENSATION PREMIUM DUE FOR YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? IF YES, EXPLAIN INCLUDING ENTITY NAME(S) AND POLICY NUMBERS(S).		
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?			CONTACT INFORMATION		
11. ANY SEASONAL EMPLOYEES?			IN- SPECTION	PHONE:	
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?				NAME:	
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?			ACCTNG RECORD	PHONE:	
14. DO EMPLOYEES TRAVEL OUT OF STATE?				NAME:	
15. ARE ATHLETIC TEAMS SPONSORED?			CLAIMS INFO	PHONE:	
				NAME:	

APPLICABLE IN TENNESSEE: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO ANY PARTY TO A WORKERS COMPENSATION TRANSACTION FOR THE PURPOSE OF COMMITTING FRAUD. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, HI, NE, OH, OK, OR, TN or VT; in DC, LA, ME and VA, insurance benefits may also be denied)

REMARKS

APPLICANT'S SIGNATURE	DATE	PRODUCER'S SIGNATURE	NATIONAL PRODUCER NUMBER
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**COLORADO
WORKERS COMPENSATION**

PREMIUM DISCOUNT AWARENESS FORM

Colorado regulations require us to notify you of the premium discounts available through Cost Containment Certification and Designated Medical Provider Selection.

COST CONTAINMENT CERTIFICATION

Employers who obtain certification of their risk management programs from the Colorado Cost Containment Board, are eligible for up to a 10% reduction of their Workers' Compensation insurance premium. For information or assistance in establishing and implementing a certified risk management program please contact our Loss Control Division at (888) 500-3344.

DESIGNATED MEDICAL PROVIDER

Employers who subscribe to the services of a Designated Medical Provider are eligible for a 2.5% premium discount. For information on selecting a Designated Medical Provider contact Jaclyn Tiger in our Claims Division at (888) 500-3344 ext. 271366.

You are required to provide your employees (at time of injury) with a written list of designated providers from which they can select. This list must be mailed, hand-delivered or furnished in some other verifiable manner to the insured worker within seven (7) business days following the date that you have notice of the injury.

Use the **Notice to Employees – Medical Provider List** included in your policy packet (or available through your agent) for this required notification to injured employees.

YOU ARE REQUIRED TO CONFIRM THAT THESE NOTIFICATIONS HAVE BEEN PROVIDED TO YOU.

PLEASE SIGN AND DATE THE FOLLOWING STATEMENT WHICH WILL BE MAINTAINED IN YOUR POLICY FILE.

I hereby confirm that I am aware of the premium savings that are available through Cost Containment Certification and Designated Medical Provider selection as indicated above.

Signature

Date

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

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

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.

For IRS use:

- 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.

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)

3 Trade name (if any)

4 Address

_____ Suite or room number

Number Street

_____ State ZIP code

City

_____ Foreign postal code

Foreign country name Foreign province/county

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)*	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Form 941, 941-PR, 941-SS (Employer's QUARTERLY Federal Tax Return)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Form 943, 943-PR (Employer's Annual Federal Tax Return for Agricultural Employees)	<input type="checkbox"/>	<input type="checkbox"/>
Form 944, 944(SP) (Employer's ANNUAL Federal Tax Return)	<input type="checkbox"/>	<input type="checkbox"/>
Form 945 (Annual Return of Withheld Federal Income Tax)	<input type="checkbox"/>	<input type="checkbox"/>
Form CT-1 (Employer's Annual Railroad Retirement Tax Return)	<input type="checkbox"/>	<input type="checkbox"/>
Form CT-2 (Employee Representative's Quarterly Railroad Tax Return)	<input type="checkbox"/>	<input type="checkbox"/>

*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

Date

____/____/____

Best daytime phone

Now give this form to the agent to complete. ➡

Tax Information Authorization

► Go to www.irs.gov/Form8821 for instructions and the latest information.
► Don't sign this form unless all applicable lines have been completed.
► Don't use Form 8821 to request copies of your tax returns or to authorize someone to represent you. See instructions.

Received by: _____
Name _____
Telephone _____
Function _____
Date _____

1 Taxpayer information. Taxpayer must sign and date this form on line 6.

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

2 Designee(s). If you wish to name more than two designees, attach a list to this form. **Check here if a list of additional designees is attached** ►

Name and address ARIS Solutions PO Box 4409 White River Jct., VT 05001	CAF No. <u>0313-84964R</u> PTIN _____ Telephone No. <u>866.970.3301</u> Fax No. <u>802.295.9812</u>
Check if to be sent copies of notices and communications <input type="checkbox"/>	Check if new: Address <input type="checkbox"/> Telephone No. <input type="checkbox"/> Fax No. <input type="checkbox"/>

Name and address	CAF No. _____ PTIN _____ Telephone No. _____ Fax No. _____
Check if to be sent copies of notices and communications <input type="checkbox"/>	Check if new: Address <input type="checkbox"/> Telephone No. <input type="checkbox"/> Fax No. <input type="checkbox"/>

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

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

(a) Type of Tax Information (Income, Employment, Payroll, Excise, Estate, Gift, Civil Penalty, Sec. 4980H Payments, etc.)	(b) Tax Form Number (1040, 941, 720, etc.)	(c) Year(s) or Period(s)	(d) Specific Tax Matters
Employment	941, 940, 941R, 941X, W2, W3, W2C, SS4	2022-2025	Tax Liability
Authority to obtain existing FEIN	SS4, 8821	2022-2025	Tax Liability

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

5 Retention/revocation of prior tax information authorizations. If the line 4 box is checked, skip this line. If the line 4 box isn't checked, the IRS will automatically revoke all prior tax information authorizations on file unless you check the line 5 box and **attach a copy** of the tax information authorization(s) that you want to retain ►
To revoke a prior tax information authorization(s) without submitting a new authorization, see the line 5 instructions.

6 Taxpayer signature. If signed by a corporate officer, partner, guardian, partnership representative (or designated individual, if applicable), executor, receiver, administrator, trustee, or individual other than the taxpayer, I certify that I have the legal authority to execute this form with respect to the tax matters and tax periods shown on line 3 above.

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

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

Signature	Date
	HCSR
Print Name	Title (if applicable)

Department Use Only									
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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.			
<input type="checkbox"/> Original application		<input type="checkbox"/> Reinstatement of existing account Account Number _____	
<input type="checkbox"/> 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)			
<input type="checkbox"/> Individual/Sole Proprietor		<input type="checkbox"/> Joint Venture	
<input type="checkbox"/> General Partnership		<input type="checkbox"/> Limited Partnership	
<input type="checkbox"/> Corporation		<input type="checkbox"/> Limited Liability Partnership	
<input type="checkbox"/> "S" Corporation		<input type="checkbox"/> Limited Liability Limited Partnership	
<input type="checkbox"/> Association		<input type="checkbox"/> Limited Liability Company (reported as corporation on Internal Revenue Service Form 8832)	
<input type="checkbox"/> Trust		<input type="checkbox"/> Limited Liability Company (reported as sole proprietor or partnership on Internal Revenue Service Form 8832)	
<input type="checkbox"/> Estate		<input type="checkbox"/> Stock Sale (only complete page 1 of this application and sign on page 4)	
<input type="checkbox"/> Government		<input type="checkbox"/> Other _____	
<input type="checkbox"/> Religious Organization			
<input type="checkbox"/> 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)			
<input type="checkbox"/> 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 _____
Qualifying Date _____	Status Code _____	UITR-1 _____	

□	□	□	□	□	□	□	.	□	□	-	□
---	---	---	---	---	---	---	---	---	---	---	---

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. _____

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 lmi.gateway.coworkforce.com/lmi.gateway.

- 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.

 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
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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

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	.	<input type="checkbox"/>	<input type="checkbox"/>	-	<input type="checkbox"/>
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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
Legal Business Name	UI Account Number	FEIN

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
Legal Business Name	UI Account Number	FEIN

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
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.

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
<input type="checkbox"/> 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.		

INSTRUCTIONS FOR COMPLETING THE POWER OF ATTORNEY

Employer Information

Employer Name: Type or print legibly the entity name or business name.

Trade Name: Type or print legibly the doing-business-as name or trade name.

Employer Account Number: Type the 9-digit Colorado unemployment insurance (UI) premium account number. The power of attorney will not be processed or approved if this account number is not provided.

Business Location Address Only (No PO Boxes): Type the entity's or business's physical location address.

Acceptance of New Power of Attorney

Effective Date of Acceptance: Complete this section if you want to name or change an entity or individual to have power of attorney. If you complete this section, you must provide an effective date.

SIDES: State Information Data Exchange System. By participating in this system, you will receive and respond to the electronic version of form UIB-290, Colorado's Request For Facts About A Former Employee's Employment. To find out more information about SIDES go to <http://info.uisides.org>. It is strongly recommended that you participate in the SIDES system.

For UI premium-related information: Complete this section if you want to accept power of attorney for UI premium-related information only.

For UI benefits-related information: Complete this section if you want to accept power of attorney for UI benefit-related information only.

Power of Attorney Complete Name and Address: Type the name and address of the entity or individual you want to accept as the power of attorney. Do not list an individual's name unless that is the business name.

NOTE: If you have an existing power of attorney and the UI Division approves your acceptance of a new power of attorney, the new power of attorney automatically replaces the existing power of attorney for the purposes you indicate on this form.

Mailing-Address Information

Complete Mailing Address: For UI premium information and/or forms such as the UITR-7, Unemployment Insurance Rate Notice; UITR-1, Your Quarterly Report of Wages Paid and Premiums Owed; UITR-1a, Unemployment Insurance Report of Workers Wages; and UITR-2, Unemployment Insurance Statement of Payment Due; or any other premium forms you must provide the complete mailing address regardless of whether you are adding or changing a power of attorney. This information must be completed to ensure that UI correspondence is sent to the address of the entity or individual who will be responsible for UI correspondence. Provide a second mailing address only if you want the UI benefits-related information sent to a mailing address different from the mailing address used for premium-related information.

NOTE: You are responsible for ensuring that any UI correspondence that is sent to an incorrect mailing address is properly forwarded. You are also responsible for updating your mailing address with us.

Power-of-Attorney Signature

New Power of Attorney Representative Signature: A representative of the entity or the individual who you want to accept as the power of attorney **must** provide his or her name and title and sign and date the form in order to make this a valid document.

Employer Approval

Signature of Employer Official: The employer **must** sign this form to accept an entity or individual as the power of attorney. The employer official's name, title, signature, and date of signature are required to make this a valid document.

Discontinuation of Power of Attorney

If you elect to discontinue a power of attorney without accepting a new power of attorney, submit a written request to the UI Division at the above address.

CR 0100AP (10/31/14)
COLORADO DEPARTMENT OF REVENUE
 Registration Control 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			
	<input type="checkbox"/> Original Application		<input type="checkbox"/> Change of Ownership	<input type="checkbox"/> Additional Location
Do you have a Department of Revenue Account Number?			If Yes, Account Number	
<input type="checkbox"/> Yes <input type="checkbox"/> No				
2. Indicate Type of Organization. If you are not an individual you must have a FEIN number.				
<input type="checkbox"/> Individual		<input type="checkbox"/> Limited Liability Company (LLC)	<input type="checkbox"/> Corporation/'S' Corp.	<input type="checkbox"/> Government
<input type="checkbox"/> General Partnership		<input type="checkbox"/> Limited Liability Partnership (LLP)	<input type="checkbox"/> Association	<input type="checkbox"/> Joint Venture
<input type="checkbox"/> Limited Partnership		<input type="checkbox"/> Limited Liability Limited Partnership (LLLP)	<input type="checkbox"/> Estate/Trust	<input type="checkbox"/> 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
Physical Place of Business				
3a. Principal Address (A Colorado address is required if a location in the state)		City	State	Zip
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 ()
4c. Mailing Address		City	State	Zip
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?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you rent out items for 30 days or less?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you sell tobacco products?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you sell Prepaid Wireless?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your business in a special taxing district?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you sell medical marijuana?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you rent motor vehicles for 30 days or less?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you sell adult usage marijuana?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5a. List specific products and/or services you provide and Explain In Detail				
6a. Owner/Partner/ Corp. Officer Last Name		Owner/Partner/ Corp. Officer First Name		Middle Initial
6b. Title	6c. FEIN	6d. SSN	6e. Phone Number ()	
6f. Address		City	State	Zip
7a. Owner/Partner/ Corp. Officer Last Name		Owner/Partner/ Corp. Officer First Name		Middle Initial
7b. Title	7c. FEIN	7d. SSN	7e. Phone Number ()	
7f. Address		City	State	Zip

(Form continued on page 2)



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)	
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: <input type="checkbox"/> \$15.00/ month or less — Annually <input type="checkbox"/> Under \$300/ month — Quarterly <input type="checkbox"/> Wholesale Only — Annually <input type="checkbox"/> \$300/ month or more — Monthly	2b. First Day of Sales (MM/DD/YY)
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3. Indicate which applies to you: <input type="checkbox"/> Retail-Sales <input type="checkbox"/> Wholesaler <input type="checkbox"/> Charitable <input type="checkbox"/> Retailers-Use	Revenue Registration Account Number (Dept. Use Only)
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D	1. Filing frequency If wage withholding amount is W2 (Withholding of \$50,000 plus see Section D page 6) <input type="checkbox"/> \$1 – \$6,999/Year — Quarterly <input type="checkbox"/> \$7,000 – \$49,999/ Year — Monthly <input type="checkbox"/> \$50,000 +/ Year — Weekly	2. <input type="checkbox"/> W2 Withholding <input type="checkbox"/> 1099 Withholding
	1a. Filing frequency If wage withholding amount is 1099 (Withholding of \$50,000 plus see Section D page 6) <input type="checkbox"/> \$1 – \$6,999/Year — Quarterly <input type="checkbox"/> \$7,000 – \$49,999/ Year — Monthly <input type="checkbox"/> \$50,000 +/ Year — Weekly	2a. <input type="checkbox"/> Oil/Gas Withholding

3a. First Day of Payroll, if applicable (MM/DD/YY)	3b. Payroll Records Phone Number ()
--	--------------------------------------

	Period Covered		Fees (see fees on page 3)			
	From	To				
	MM/YY	MM/YY				
E			(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)

(See fees and additional information on page 3)





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: <input type="checkbox"/>)	City	State	ZIP Code
2. Acts Authorized. Mark either a) or b), required*			
<input checked="" type="checkbox"/> 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: <input type="checkbox"/> I am appointing only the individual(s) listed on line 3.			
OR			
<input type="checkbox"/> 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: <input type="checkbox"/> 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*	
DONKA, EMILIE	TAX	866-970-3301	
Firm or Organization Name, if applicable	Email Address	Fax Number	
ARIS SOLUTIONS - VETERAN DEPT	EMILIE.DONKA@ARISOLUTIONS.ORG	802-295-9812	
Mailing Address	City	State	ZIP Code
PO BOX 4409	WHITE RIV JCT	VT	05001
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
	WITHHOLDING		
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: <input type="checkbox"/> 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.



Employer Confirmation of Receipt

I, _____, have read the “Program Integrity and Fraud Prevention” documents provided by ARIS Solutions.

I understand and accept my role or my designated representative’s role as an employer in the Veteran Directed Program employment model.

I acknowledge that I am the employer of any employee I may choose to hire to provide home health care service in the Veteran Directed Program employment model.

I understand I am responsible for hiring, firing, training, and supervising my employees, as well as, maintaining program integrity by preventing and reporting fraud.

I understand and acknowledge that as a FMS Provider, ARIS Solutions, **will not** act as the employer of any employee I may choose to hire through this program.

Signed,

Signature of Employer

Date



Employer Confirmation of Receipt: Paid Leave Accrual

I, _____, understand that being an employer in Colorado grants access for my employees to **Paid Sick Leave** hours. Included below is information regarding this State mandated accrual and how it works.

- *For every 30 hours worked, employees accrue 1 hour of paid leave.*
- *No waiting period to use paid leave, once accrued employee can use that time.*
 - *Employees are paid their current hourly rate when using time.*
 - *Claiming hours is for absences during **regularly scheduled work shifts**.*
 - *Please refer to the FAQ within these documents for qualifying events to use paid sick leave for.*
- *The maximum amount of paid leave an employee can accrue and take in a year is 48 hours.*
- *Carryover from one year to the next allows employees to take 48 hours from one year to the next year, rules regarding time an employee can take and use within a year stay the same, that being 48 hours. (Calendar year i.e., January – December)*
- *If an employee is separated from employment and rehired within 6 months with the same employer, employee shall be entitled to any previously accrued time.*
- *Upon separation of employment, the employee will not be entitled to be paid out for any remaining accrued leave time.*
- *Employers cannot deny time requested or retaliate against an employee for requesting or using paid leave. Employees have the right to file a complaint or bring civil action if either situation occurs.*
- *ARIS Solutions, as the FMS will manage your paid leave accrual and be available if questions arise.*

I understand and accept my role as an employer in the Veteran Directed Program employment model.

I understand I am responsible for completing the required employer paperwork and will be responsible for managing the employees and budget as part of this participant directed business model.

On my employee(s) first day of employment, this above accrual will begin.

I understand and acknowledge that as an FMS Provider, ARIS Solutions **is not** the employer.

Employer Signature:

Date

Veteran name:



Fraud & Abuse Statement Signature Page

Veteran's Signature

Date

Authorized Representative Signature

Date

FMS Provider Signature

Date

HIPAA NOTICE OF PRIVACY PRACTICES & AGREEMENT

PLEASE SIGN/DATE & RETURN TO ARIS SOLUTIONS

At ARIS Solutions/ VDC Program, we respect the confidentiality of your medical information and will protect information in a responsible manner. We have a privacy program in place that meets the requirements of HIPAA, the government legislation that sets standards for the privacy of medical information.

*This notice will be effective for all medical information that we maintain, including medical information we created or received before _____ (date)
_____(initials)*

HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT AND CONSENT

I acknowledge that I have been provided with a notice of privacy practices and have been advised of how health information about me may be used and disclosed by ARIS Solutions/ VDC Program and how may I obtain access to and control of this information.

Signature of Employer

Date





ARIS SOLUTIONS
White River Junction, VT 05001
Phone 866.970.3301
Fax 802.295.9812

veteranpayroll@arissolutions.org

Financial & Payroll Services for the Nonprofit Sector

Enrollment Information for Co-CPWD

Veteran Directed Program Employers

This packet contains the necessary forms and instructions that will authorize ARIS Solutions to act in your behalf as your Financial Management Service provider.

ALL FORMS MUST BE SIGNED/DATED AND RETURNED TO ARIS SOLUTIONS

- New Employer/Veteran Information
- ARIS Solutions Contact Sheet
- Customer Grievance Policy
- Timesheet and Reimbursement Schedule
- Employer Information Book

If you have questions contact the Veteran Department at 866.970.3301

Return Packet to: ARIS Solutions-Veteran Program

PO Box 4409
White River Jct., VT 05001
Phone: 866.970.3301 (toll free)
Fax: 802.295.9812
Email: veteranpayroll@arissolutions.org

Financial & Payroll Services for the Nonprofit Sector

New Employer/Veteran Information**You are now an Employer!**

Welcome to the Veteran Directed Home and Community Based Services Program employment model. You will now manage and direct the services you receive or the services the Veteran you represent receives. In this employer model you, or a representative who you appoint, are the employer and you direct the work of your employee.

The Role of ARIS Solutions as Your Financial Management Services "FMS" Provider

ARIS Solutions will serve as your FMS Provider to support you and complete many of the administrative employer obligations. This means that ARIS will process your timesheets, conduct criminal background checks on potential employees manage your employer tax responsibilities on the federal and state level, apply for workers compensation insurance, and pay your employees.

Roles and Responsibilities Chart

Your Role (as Employer)	Employee's Role (as Employee)	ARIS Solutions' Role (as FMS Provider)
Select and hire an employee Schedule employees (staying within your authorized budget) Train employees Sign timesheets Review employees job performance	Meet your requirements for hiring Complete required employment paperwork Submit a background check Submit signed timesheets to ARIS	Assist with paperwork, as needed Establish you as an employer Establish your worker as your employee Conduct criminal background checks
Dismiss employees Establish clear boundaries Let your employee know what the rules are and what their responsibilities are Prevent fraud	Respect employer's boundaries, rules and responsibilities Provide home care services to your employer as directed by your employer Prevent fraud	Provide payroll services Prepare and disburse payroll checks Pay employer taxes Prepare year-end tax reports Apply for and secure Workers Compensation insurance on behalf of the employer



Contact Information

You can remove this page from the packet and post it somewhere prominent so you always have the information you need to contact the Veterans Program team.

ARIS Solutions-Veteran Program staff are available for support Monday through Friday from 8:00 am to 4:00pm (EST) and can be reached at **866.970.3301** (toll free), our veteran dedicated email address: veteranpayroll@arissolutions.org or our Website at www.arissolutions.org

ARIS Solutions is not open on state or federal holidays.

CUSTOMER GRIEVANCE POLICY

At ARIS Solutions, we truly believe in providing best in class services to our customers. We aim to understand both our strengths and opportunities for improvement from our customer's point of view and work to continuously improve our services to best meet their needs.

Our Grievance Policy focuses on improving customer satisfaction by collecting feedback from all our customers and by putting action plans in place to address key issues, which are assigned to the relevant key staff for action.

We have a complaint tracking system which assigns each complaint with a number and allows us to track the aging and resolution of each complaint. The status of complaints is systematically reported to our Senior Management. Our goal is to ensure that all customer complaints are resolved within 30 days. The 30-day period will commence after all the necessary information sought from the customer is received.

The various channels through which our customers can contact us for any assistance with their grievances are listed below:

In the event your complaint is not addressed satisfactorily:

If you are not satisfied with the response received at our helpline, you can escalate your grievance to:

Name: Theresa Danforth

Email: theresa.danforth@arissolutions.org

Fax: 802.295.9812

Telephone: 866.970.3301

(Monday to Friday 8:00 am to 4:00 pm EST)

Address: PO Box 4409, White River Jct., VT 05001

For further escalation of grievances, the same can be addressed to:

Name: Elizabeth Lundberg

Email: elizabeth.lundberg@arissolutions.org

Fax: 802.295.9812

Telephone: 802.280.1911

(Monday to Friday 8:00 am to 4:00 pm EST)

Address: PO Box 4409, White River Jct., VT 05001





FRAUD & ABUSE STATEMENT

Fraud is defined as **recklessly or purposefully** making false statements or representations to obtain some benefit or payment that you would not be entitled to without those statements or facts. These acts may be committed either for the person's own benefit or for the benefit of someone else. In other words, fraud includes the obtaining of something of value through misrepresentation or concealment of facts. Fraud is committed when a person or business deceives or distorts facts or information to get something they would not be otherwise entitled to. Fraud can range from a solo act to a broad-based operation by an institution or a group. Anyone can commit fraud.

Examples of Medicaid/Veteran Administration Fraud include, but are not limited to:

- Knowingly and/or purposefully filling out an employee timesheet incorrectly for hours or services that were not provided during the times listed or on the day listed;
- Knowingly and/or purposefully allowing the Vendor ARIS FMS-Support Broker entity to bill Medicaid/Veteran Administration for services that were not provided;
- Knowingly and/or purposefully using the Veteran's budget for any other purpose than what has been approved in the Veteran's service plan.
- Knowingly and/or purposefully allowing an employee to document services or hours that were not provided.
- Knowingly and/or purposefully submitting invoices to the Vendor ARIS FMS-Support Broker entity for goods and services that were not provided.
- Knowingly and/or purposefully having the Vendor ARIS FMS-Support Broker entity pay an employee or vendor for goods and/or services actually provided by someone else. (This is also tax fraud.)
- Knowingly and/or purposefully making a "side deal" with an employee to split their pay check with the Veteran or his/her representative. (This is also tax fraud).
- Knowingly or purposefully withholding information from authorities during an investigation
- Knowingly and/or purposely having the Vendor ARIS FMS-Support Broker entity pay for an approved good included in the Veteran's budget, and then return the approved good to get the cash or use it for something else that has not been approved.

Abuse is defined as practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to Medicaid/Veteran Administration and other programs, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medicaid/Veteran Administration program.

Examples of Medicaid/Veteran Administration Abuse include:

- Making errors when filling out the employee's timesheet and not immediately reporting the error to the Vendor ARIS FMS-Support Broker entity to remedy the situation.
- Being late in handing in Veteran/representative-employer related paperwork to the Vendor ARIS FMS-Support Broker entity.

The difference between Fraud and Abuse

Fraud is anything intentionally, purposefully or recklessly done to get something for your own benefit that you normally would not be entitled to. Abuse is anything that wasn't done intentionally or purposefully but was still completed incorrectly for your own benefit and not immediately reported.

Medicaid/Veteran Administration Fraud and Abuse is a crime against all taxpayers and is both a state and federal offense. All reports or allegations of fraud and abuse within the Veteran Directed Home and Community Based Services Program will be referred to the Veteran's Administration for possible criminal investigation. Veteran's suspected of Medicaid/Veteran Administration Fraud or Abuse also face termination from the Veteran Directed Home and Community Based Services Program.

HIPAA NOTICE OF PRIVACY PRACTICES & AGREEMENT

This notice describes how medical information about you may be used and disclosed and how we may obtain access to this information. Please review it carefully & keep for your records.

DEFINITION OF MEDICAL INFORMATION

When ARIS Solutions/ VDC Program refers to medical information, we mean protected health information (PHI). PHI is information that is individually identifiable health information including demographic information collected.

USES AND DISCLOSURES OF PHI

Health Care Operations- Your medical information may be used and disclosed in connection with our health care operational including:

- *Case management and care coordination.*
- *Quality assessment and improvement activities and protocol assessment.*
- *Reviewing the competence or qualifications of health care professionals, evaluating provider performance, conducting training programs, accreditation, certification activities, and credentialing activities.*
- *Conducting legal services, compliance programs, fraud and abuse detection*
- *Business planning and development.*

Additional disclosures-PHI may be disclosed;

- *To another entity that has relationship with the organization for their health care operations relating to quality improvement and assessment activities, reviewing competence or qualifications of health care professionals.*
- *To other entities that assist us in conducting our health care operations.*

We will not disclose your medical information to those persons or entities unless they agree to keep it protected.



**HIPAA NOTICE OF PRIVACY PRACTICES & AGREEMENT
continued...**

For the Public Benefit- as authorized by law for the following purposes:

- *As required by law*
- *For public health activities, including disease and vital statistic reporting, FDA oversight, and for work related illness or injury*
- *To health oversight agencies*
- *In response to court and administrative orders*
- *To avert a serious threat to health and human safety*

Your written authorization is required for all other uses and disclosures of your PHI. You may revoke your authorization at any time. However, your revocation will not affect any use or disclosure you permitted to your revocation.

YOUR RIGHTS

Access to your information — You have the right to inspect or obtain a copy of the medical information about you that is contained in a “designated record set”. The organization may ask you to submit your request in writing.

Accounting of disclosures – You have the right to receive a list of instances in which we or our associates disclosed your PHI for purposes other than health care operations or those authorized by you.

Confidential Communication – You have the right to request that we communicate with you about your PHI by a different means or at a different location. You make this request in writing.

Amending your PHI – You have the right to request that we amend your PHI contained in the “designated record set” if it is not correct or complete. We may require that this request be in writing.

Complaints – You have the right to file a complaint if you believe your privacy rights have been violated. You may file this complaint with ARIS Solutions/ VDC Program and/or the Secretary of the Department of Health and Human Services. All complaints to ARIS Solutions/ VDC Program must be made in writing. We support your right to protect your PHI.

****PLEASE KEEP THIS FOR YOUR RECORDS****





WHAT EMPLOYERS NEED TO KNOW

Author(s): Lucia Cucu, J.D.

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How to Protect Yourself and Your Worker: A Guide for Employers

Being an employer brings not only rights but also responsibilities. This guide describes a few important issues that every employer should know about.

Maintaining a Safe Workplace

It is important to keep your home safe for your employee. Slips and falls are a common cause of injuries, so you should clean up or warn your employee of spills and wet surfaces, and keep stairs and flooring in good repair. If you have pets in your home, make sure they cannot bite or scratch your employee.

Making Hiring and Firing Decisions

Terminating Employees

Do not hesitate to terminate an employee who does not meet your needs. Most employment relationships are considered employment “at will,” which means you can terminate an employee for any reason or no reason at all, so long as your reason is not discriminatory, retaliatory (see discussion below) or otherwise unlawful.

Avoiding Promises about the Length of Employment

To avoid a claim for breach of contract, do not make any promises to your employee that you will keep him employed for a certain period of time or that you would only fire him for a specific reason. Remember that a contract does not always have to be in writing to be legally binding. Spoken statements and promises can sometimes create legal obligations.

Avoiding Illegal Discrimination and Retaliation

In many states it is illegal to discriminate against employees based on certain factors, which can include race, color, religion, sex, national origin, marital status, sexual orientation. This means that you must not hire, fire, or harass employees based on such factors. While your employee is with you, be careful not to express any personal opinions that could be interpreted as discriminatory. Even if you are in your own home, the home is considered a workplace while your employee is there, and workplace discrimination and harassment are prohibited by law.

Do not allow friends or family to behave in ways that could be considered discriminatory or harassing towards your employee. As the employer, you could be held responsible for their behavior if you allow it to continue.

Sexual harassment is also illegal. It includes unwelcome sexual advances that can be physical or verbal, such as offensive comments or gestures that create a hostile environment. Remember that the harasser can be someone other than the employer, such as a guest visiting your home or someone who lives with you.

It is also illegal to fire employees in retaliation for reporting a crime or irregularity. For example, if an employee believes that an employer is misusing Medicaid funds and reports it to the authorities, it would be illegal to fire the employee in retaliation.

Providing References for Former Employees

Be careful when talking about your reasons for terminating employees, because you could risk a claim of discrimination or defamation (saying things about the employee who harms them). If you are asked for a reference about a former employee and cannot provide a positive one, it is safest not to provide a reference at all.

What Family Members and Authorized Representatives Need to Know

Your Duty as Representative

In participant-directed programs, usually the participant (the person receiving services) is the employer. It is not unusual, however, for the participant to be unable or unwilling to serve as the employer. In those cases, the participant will designate a “representative” to serve as the employer. If you are designated as an authorized representative, you have a *fiduciary* duty to the participant. “Fiduciary” means you must always act in the best interest of the participant and not in your own interest. Program funds must always be spent for the participant’s benefit, not your own benefit.

Hiring and Training Employees

If the participant is likely to injure himself or others, you have a duty to warn employees of the risk and instruct them how to best handle it. Make sure to hire only employees who can deal with situations that arise. Ask them to confirm that they understand the risks and are willing and able to handle them.

If you are a parent, you must exercise reasonable care to control your minor child as best as you can, even if you are not listed as an authorized representative for the child. It is important to hire employees who are able to deal with any risks they may encounter when caring for your child. You should warn employees ahead of time of risks, and explain how to best handle situations that may come up.

Mandatory Reporter Duty

As an authorized representative, you may have a legal duty to report to the authorities if you suspect or notice that the participant is being abused by a family member, an employee, or some other person. Many states have “mandatory reporter” laws that could require you to report abuse of a child, an elderly adult or a person with a disability. You may have a duty to report the abuse even if the abuser is a member of your own family or the participant’s family.

Worker's Compensation Insurance

It is important to maintain a worker's compensation insurance policy, because such insurance will pay for claims if an employee is injured on the job.

If an employee is injured while at work, the employer is liable even if the injury is not the employer's fault. For example, if your employee drives to the grocery store on your behalf and is injured when a careless driver hits her car, the employee could ask you for compensation even though you could not have prevented the accident. This is because employers have to compensate employees for injuries sustained on the job. A worker's compensation insurance policy will pay for such claims.

Liability Insurance

Worker's compensation will pay when your employee is injured, but what happens when someone else is injured? As an employer you may be liable when your employee injures someone else, even if the injury is not your fault. For example, if your employee causes a car accident while driving you to an appointment and injures a third party, the third party could sue you because your employee caused the accident while on the job.

Employment-related claims like wrongful termination, discrimination, or defamation are another source of liability that is not covered by worker's compensation insurance.

Some homeowner's, renter's, or liability insurance policies will cover such claims. However the terms of insurance policies vary, so you should read the terms and consult with an insurance agent before you start your participant direction program. You may consider an addition to your homeowner's or renter's policy, or a separate liability insurance policy, to be covered for liability risks related to domestic employees.



FREQUENTLY ASKED QUESTIONS

REGARDING COLORADO FAML I 1/1/2024

Colorado – Family and Medical Leave Insurance Program (FAML I)

▪ What is this?

- FAML I is specific to the state of Colorado and is a paid family and medical leave insurance program, this ensures all Colorado workers have access to paid leave to take care of themselves or their family during life circumstances that pull them away from work.
- Employees working within the state of Colorado have been contributing .45% from their pay since January 2023, employers with a total of **ten or more** employees must also contribute an additional .45% of wages.

▪ What can employees use this time for?

- Qualifying conditions for paid family and medical leave are:
 - Caring for a new child during the first year after the birth, adoption, or foster care placement of that child.
 - Caring for a family member with a serious health condition.
 - Caring for your own serious health condition.
 - Planning for a family member’s military deployment.
 - Obtaining safe housing, care, and/or legal assistance in response to domestic violence, stalking, sexual assault, or sexual abuse.

▪ When can employees start claiming FAML I leave?

- January 1, 2024 – benefits will be available.

▪ What makes you eligible to take FAML I leave?

- Most Colorado employees become eligible to take paid leave after they have earned at least \$2,500 in wages within the State of Colorado within the last 4 calendar quarters.

▪ How long and how often can an employee take FAML I leave?

- Covered employees are entitled to up to 12 weeks of paid family and medical leave unless it is needed for pregnancy and childbirth complications, and it can then be extended to 16 weeks. FAML I leave can only be taken once a year across a rolling calendar year. A rolling annual calendar example is: an employee takes leave on February 11th, 2024, for

the full 12 weeks, they would not be eligible for any other FAMLI again until February 11th, 2025.

- **Am I responsible for paying my employees while on FAMLI leave?**
 - No, the program is a social insurance, and the State of Colorado pays your employee a portion of their weekly wages directly through a debit card or direct deposit.
- **How much will the employee receive while on FAMLI leave?**
 - Employees will only be receiving a portion of their paycheck dependent on their average weekly wage and not the full amount, the benefit pay for this leave is capped at \$1,100 a week.
- **How does an employee submit a claim for FAMLI?**
 - Employees will need to create an account online at famli.colorado.gov
 - Employees will be asked for documentation to provide to take FAMLI leave, the website or someone from the FAMLI division will be able to assist with those types of questions.



FREQUENTLY ASKED QUESTIONS

REGARDING PAID SICK LEAVE

Colorado – Healthy Families and Workplaces Act (HFWA)

▪ What is this?

- Colorado's sick leave Act, HFWA begins January 1, 2024. This new Act provides paid leave for the following reasons:
 - Mental or physical illness or injury, including diagnosis and treatment
 - Preventive medical care
 - Reasons related to domestic abuse, sexual assault, or harassment
 - Deal with a workplace closure or the closure of a child's school or place of care during a public health emergency
 - Take bereavement or deal with financial or legal needs after the death of a family member
 - Evacuate their residence or care for a family member whose school or place of care was closed in the event of inclement weather; power, heat, or water loss; or another unexpected event.

▪ What makes you eligible as an Employer?

- The Paid Sick Leave Act applies to all Colorado employers.

▪ Does the Act apply to part-time employees, or just full-time employees?

- The act doesn't distinguish between part-time, full-time, or seasonal employees. Both full-time and part-time employees are covered by this Act. Employees who work fewer hours may accrue less leave time compared to full-time employees.

▪ What can employees use this time for?

- Employees can use their paid leave for the above reasons without providing documentation. If an employee is out for 4 or more consecutive days, they can require reasonable documentation upon return.

▪ How does an employee earn time?

- The accrual rate is one hour of paid leave for every 30 hours worked. With a maximum of 48 hours accrued per year and can only use 48 hours in a year.

▪ Does time carry from one year to the next?

- Employees can carry over up to 48 hours from year to year, but the maximum they can have will remain 48 hours and they cannot earn over that or use over that in a year.
- **When does an employee start earning time?**
 - Current employees as of 1/1/2024, start earning time as of that date. New employees start earning as of their date of hire.
- **When can an employee use leave time?**
 - Employees can use leave time as soon as it has been earned (example: after working 30 hours, you can use the one hour you earned next payroll).
- **Who pays for leave time when used?**
 - Employees who use leave time are paid through the Veterans budget, due to this being an expense of being an employer within the State of Colorado.
 - Employees will submit a timesheet to ARIS when claiming time, it is not the standard timesheet for hours worked. Allowing it to stand out when processing.
- **Are employees required to sign anything agreeing to hours they will earn?**
 - Yes, current employees will be mailed a confirmation of receipt regarding the paid leave accrual which will be stored with their employee documents at ARIS.
 - New employees will sign this form when completing the employee enrollment forms for ARIS.
- **How would an employee know how many hours they have in leave time?**
 - Earned leave time will be included in the pay stub the employee receives from ARIS.
 - Or they can call ARIS and ask.
- **If an employee leaves employment or is terminated, do they receive pay for earned time?**
 - No, upon leaving employment an employee will not be paid for unused leave time.
- **What if an employee leaves and is rehired?**
 - If the employee is rehired within 6 months of separation by the same employer, any previously earned leave time that was not used is reinstated to the employee.

- **What hourly rate are employees paid when using leave time?**
 - Employees must be paid at their current hourly rate when using leave time.
- **Do Employers need anything posted?**
 - Yes, employers must post the Colorado “PAID LEAVE, WHISTLEBLOWING, & PROTECTIVE EQUIPMENT” poster in a conspicuous place on site. (ARIS will mail this to all Colorado based employers, or they can be printed from <https://cdle.colorado.gov/sites/cdle/files>)
- **Can employers deny leave?**
 - No, an employer cannot deny leave time.
 - An employer can have a written policy that contains reasonable procedures for the employee to provide notice when the use of leave is a foreseeable circumstance.
 - Employers cannot retaliate against an employee for requesting or using paid leave and the employee has the right to file a complaint or bring civil action against an employer in the event this occurs.
- **Can an employer require an employee to find coverage during leave?**
 - No, employers cannot require employees to find coverage upon taking leave time.

FAMLI & Other Types of Leave

Employers: Here's what you need to know about how FAMLI works with other types of leave you may offer your staff:

- **Paid Time Off (PTO):** Employees can't be required to use PTO before FAMLI leave, but they may choose to do so. Employers and employees must have a mutual signed written agreement to use accrued PTO to top-off the FAMLI benefit. The total amount from PTO and FAMLI may not exceed the employee's average weekly wage.
- **FMLA:** FMLA is designed to run concurrently with FAMLI. If FAMLI leave is used for a reason that also qualifies as leave under FMLA, then the leave also counts as FMLA leave. An employer can't require an employee to exhaust available FAMLI leave as a condition to access FMLA leave.
- **Unemployment:** No one getting unemployment insurance payments can receive FAMLI benefits for the same job and same period of time.
- **Workers' comp:** No one getting workers' compensation indemnity benefits payments can receive FAMLI benefits to recover from the same workplace-related injury.
- **Healthy Families and Workplaces Act (HFWA):** HFWA and FAMLI are two separate Colorado laws that provide employees with paid leave for a range of health and safety needs. For more information and specifics on the differences and overlap of the two leave types, please see INFO #6C on cdle.colorado.gov/infos.
- **Other leave benefits:** Employers can require employees to use FAMLI leave as a condition for benefits that the employer is not legally required to provide, like short-term disability, long-term disability, or paid parental leave. Additionally, employers can require FAMLI leave to run concurrently with those employer-provided short-term disability, long-term disability or paid parental leave benefits. Otherwise, employers and benefit administrators can't require an employee to exhaust available FAMLI leave.

If an employee is improperly paid PTO or sick leave, employers may recoup the overpayment.

Life happens. FAMLI has you covered.
Learn more at famli.colorado.gov.



COLORADO
Family and Medical Leave
Insurance Program (FAMLI)
Department of Labor and Employment



THE HEALTHY FAMILIES & WORKPLACES ACT (“HFWA”): Paid Leave Rights

Coverage: All Colorado employers, of any size, must provide paid leave

- All employees earn 1 hour of paid leave per 30 hours worked (“accrued leave”), up to 48 hours a year.
- Employees are required to be paid their regular pay rate during leave, and the employer must continue their benefits.
- Up to 48 hours of unused accrued leave carries over for use during the next year.
- For details on specific situations (irregular hours, non-hourly pay, etc.), see Wage Protection Rule 3.5, 7 CCR 1103-7.
- Up to 80 hours of supplemental leave applies in a public health emergency (PHE), until 4 weeks after the PHE ends.*

Employees can use accrued leave for the following safety or health needs:

- (1) a mental or physical illness, injury, or health condition that prevents work, including diagnosis or preventive care;
- (2) domestic abuse, sexual assault, or criminal harassment leading to health, relocation, legal, or other services needs;
- (3) caring for a family member experiencing a condition described in category (1) or (2);
- (4) grieving, funeral/memorial attendance, or financial/legal needs after a death of a family member;
- (5) due to inclement weather, power/heat/water loss, or other unexpected occurrence, the employees needs to either (a) evacuate their residence, or (b) care for a family member whose school or place of care was closed; *or*
- (6) in a PHE, a public official closed the workplace, or the school or place of care of the employee’s child.

Employer Policies (Notice; Documentation; Incremental Use; Privacy; and Paid Leave Records)

- **Written notice and posters.** Employers must (1) provide notice to new employees no later than other onboarding documents/policies; and (2) display updated posters, and provide updated notices to current employees, by end of year.
- **Notice for “foreseeable” leave.** Employers may adopt “reasonable procedures” in writing as to how employees should provide notice if they require “foreseeable” leave, but **cannot deny paid leave** for noncompliance with such a policy.
- **An employer can require documentation to show that accrued leave was for a qualifying reason only if leave was for four or more consecutive work days** (*i.e.* days when an employee would have worked, not calendar days).
- **Documentation is not required to take accrued leave**, but can be required as soon as an employee returns to work or separates from work (whichever is sooner). **No documentation can be required for PHE leave.**
- **To document leave for an employee’s (or an employee’s family member’s) health-related need**, an employee may provide: (1) a document from a health or social services provider *if* services were received and a document can be obtained in reasonable time and without added expense; *otherwise* (2) the employee’s own writing.
- **Documentation as to domestic abuse, sexual assault, or criminal harassment** can be a document or writing under (1) above (*e.g.* legal or shelter services provider) or (2) above, or legal document (restraining order, police report, etc.).
- **If an employer reasonably deems an employee’s documentation deficient**, the employer must: (A) notify the employee within seven days of either receiving the documentation or the employee’s return to work or separation (whichever is sooner), and (B) give the employee at least seven days to cure the deficiency.
- **Incremental Use.** Depending on employer policy, employees can use leave in either hourly or six-minute increments.

- **Employee Privacy.** Employers cannot require employees to disclose “details” about an employee’s (or their family’s) HFWA-related health or safety information; such information must be treated as a confidential medical record.
- **Records must be retained and provided upon request.** Employers must provide documentation of the current amount of paid leave employees have (1) available for use, and (2) already used during the current benefit year, including any supplemental PHE leave. Information may be requested once per month or when the need for HFWA leave arises.

Retaliation or Interference with HFWA Rights

- **Paid leave cannot be counted as an “absence”** that may result in firing or another kind of adverse action.
- **An employee can’t be required to find a “replacement worker” or job coverage when taking paid leave.**
- **An employer cannot fire, threaten, or otherwise retaliate against, or interfere with use of leave by**, an employee who: (1) requests or takes HFWA leave; (2) informs or assists another person in exercising HFWA rights; (3) files a HFWA complaint; or (4) cooperates/assists in investigation of a HFWA violation.
- **If an employee’s reasonable, good-faith HFWA complaint, request, or other activity is incorrect**, an employer need not agree or grant it, but cannot *act against* the employee for it. Employees *can* face consequences for misusing leave.

PROTECTED HEALTH/SAFETY EXPRESSION & WHISTLEBLOWING (“PHEW”): Worker Rights to Express Workplace Health/Safety Concerns & Use Protective Equipment

Coverage: All Employers and Employees, Plus Certain Independent Contractors

- PHEW covers not just “employers” and “employees,” but all “principals” (an employer or a business with at least 5 independent contractors) and “workers” (employees or independent contractors working for a “principal”).

Worker Rights to Oppose Workplace Health/Safety Violations:

- It is unlawful to **retaliate against, or interfere with**, the following acts:
 - (1) **raising reasonable concerns**, including informally, to the principal, other workers, the government, or the public, about workplace violations of government health or safety rules, or a significant workplace health or safety threat;
 - (2) **opposing or testifying, assisting, or participating** in an investigation or proceeding about retaliation for, or interference with, the above-listed conduct.
- A principal need not address a worker’s PHEW-related concern, but it still cannot fire or take other *action against* the worker for raising such a concern, as long as the concern was reasonable and in good-faith.

Workers’ Rights to Use Their Own Personal Protective Equipment (“PPE”):

- A worker must be allowed to **voluntarily wear their own PPE** (mask, faceguard, gloves, etc.) if the PPE (1) provides **more protection** than equipment provided at the workplace, (2) is **recommended** by a government health agency (federal, state, or local), and (3) does not make the worker **unable to do the job**.

COMPLAINT RIGHTS (under both HFWA & PHEW)

- Report violations to the Division as complaints or anonymous tips, or file in court after exhausting pre-lawsuit remedies.

This Poster summarizes two Colorado workplace public health laws: C.R.S. § 8-13.3-401 et seq., (paid leave), and C.R.S. § 8-14.4-101 et seq. (healthy and safety whistleblowing) including amendments current as of the date of this poster. It does not cover other health or safety laws, rules, and orders, including under the federal Occupational Safety and Health Act (OSHA), from the Colorado Department of Public Health and Environment (CDPHE), or from local public health agencies. Contact those agencies for such health and safety information.

*In a PHE, employees gain additional hours of leave for inability to work, testing, quarantining, caring for family in such situations, and related needs. No PHE is now in effect; this poster will be updated if one is declared.

This poster must be displayed where easily accessible to workers, shared with remote workers, provided in other languages as needed, and replaced with any annually updated versions.

This Poster is a summary and cannot be relied on as complete labor law information. For all rules, fact sheets, translations, questions, or complaints, contact:

DIVISION OF LABOR STANDARDS & STATISTICS, ColoradoLaborLaw.gov, cdle_labor_standards@state.co.us, 303-318-8441 / 888-390-7936.