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

- ❑ Employer / Veteran Information Form
- ❑ 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/Authorized Representative Background Check Release Form
- ❑ 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 _____

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

ARIS Solutions
Name of Business and/or Person

PO Box 4409
Street Address or P.O. Box

Apt/Unit Number

White River Jct (City) | VT (State) | 05001 (ZIP Code) | (802) 280-1911 (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 2025

Pay Period	Pay Period Start Date	Pay Period End Date	Timesheet Submission Due Date	Payment Date
1	**1/12/2025**	**1/25/2025**	**1/27/2025**	**1/31/2025**
2	1/26/2025	2/8/2025	2/10/2025	2/14/2025
3	**2/9/2025**	**2/22/2025**	**2/24/2025**	**2/28/2025**
4	2/23/2025	3/8/2025	3/10/2025	3/14/2025
5	**3/9/2025**	**3/22/2025**	**3/24/2025**	**3/28/2025**
6	3/23/2025	4/5/2025	4/7/2025	4/11/2025
7	**4/6/2025**	**4/19/2025**	**4/21/2025**	**4/25/2025**
8	4/20/2025	5/3/2025	5/5/2025	5/9/2025
9	**5/4/2025**	**5/17/2025**	**5/19/2025**	**5/23/2025**
10	5/18/2025	5/31/2025	6/2/2025	6/6/2025
11	**6/1/2025**	**6/14/2025**	**6/16/2025**	**6/20/2025**
12	6/15/2025	6/28/2025	6/30/2025	7/4/2025
13	**6/29/2025**	**7/12/2025**	**7/14/2025**	**7/18/2025**
14	7/13/2025	7/26/2025	7/28/2025	8/1/2025
15	**7/27/2025**	**8/9/2025**	**8/11/2025**	**8/15/2025**
16	8/10/2025	8/23/2025	8/25/2025	8/29/2025
17	**8/24/2025**	**9/6/2025**	**9/8/2025**	**9/12/2025**
18	9/7/2025	9/20/2025	9/22/2025	9/26/2025
19	**9/21/2025**	**10/4/2025**	**10/6/2025**	**10/10/2025**
20	10/5/2025	10/18/2025	10/20/2025	10/24/2025
21	**10/19/2025**	**11/1/2025**	**11/3/2025**	**11/7/2025**
22	11/2/2025	11/15/2025	11/17/2025	11/21/2025
23	**11/16/2025**	**11/29/2025**	**12/1/2025**	**12/5/2025**
24	11/30/2025	12/13/2025	12/15/2025	12/19/2025
25	**12/14/2025**	**12/27/2025**	**12/29/2025**	**1/2/2026**
26	12/28/2025	1/10/2026	1/12/2026	1/16/2026
27	**1/11/2026**	**1/24/2026**	**1/26/2026**	**1/30/2026**
28	1/25/2026	2/7/2026	2/9/2026	2/13/2026

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/

CO- CPWD

Form **SS-4**
(Rev. December 2023)
Department of the Treasury
Internal Revenue Service

Application for Employer Identification Number

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

OMB No. 1545-0003

EIN

Type or print clearly.

1 Legal name of entity (or individual) for whom the EIN is being requested

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

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

4a Mailing address (room, apt., suite no. and street, or P.O. box)
C/O ARIS Solutions PO Box 4409

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

4b City, state, and ZIP code (if foreign, see instructions)
White River Jct., VT 05001

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

6 County and state where principal business is located

7a Name of responsible party

7b SSN, ITIN, or EIN

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

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

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

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

- ☐ Sole proprietor (SSN) _____
- ☐ Partnership
- ☐ Corporation (enter form number to be filed) _____
- ☐ Personal service corporation
- ☐ Church or church-controlled organization
- ☐ Other nonprofit organization (specify) Other _____
- ☒ (specify) HCSR

- ☐ Estate (SSN of decedent) _____
- ☐ Plan administrator (TIN) _____
- ☐ Trust (TIN of grantor) _____
- ☐ Military/National Guard ☐ State/local government
- ☐ Farmers' cooperative ☐ Federal government
- ☐ REMIC ☐ Indian tribal governments/enterprises

Group Exemption Number (GEN) if any

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

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

- ☒ Started new business (specify type) _____
  Home Care Service Recipient
- ☐ Hired employees (Check the box and see line 13.)
- ☐ Compliance with IRS withholding regulations
- ☐ Other (specify)

- ☐ Banking purpose (specify purpose) _____
- ☐ Changed type of organization (specify new type) _____
- ☐ Purchased going business
- ☐ Created a trust (specify type) _____
- ☐ Created a pension plan (specify type) _____

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

12 Closing month of accounting year

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

Agricultural	Household	Other

14 If you expect your employment tax liability to be $1,000 or less in a full calendar year **and** want to file Form 944 annually instead of Forms 941 quarterly, check here. (Your employment tax liability will generally be $1,000 or less if you expect to pay $5,000 or less, $6,536 or less if you're in a U.S. territory, in total wages.) If you don't check this box, you must file Form 941 for every quarter. ☐

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

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

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

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

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

Third Party Designee

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

Designee's name
ARIS Solutions Fiscal Agent

Designee's telephone number (include area code)
866.970.3301

Address and ZIP code
PO Box 4409 White River Jct., VT 05001

Designee's fax number (include area code)
802.295.9812

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

Applicant's telephone number (include area code)

Name and title (type or print clearly)

Applicant's fax number (include area code)

Signature — Date

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:

CO CPWD

INDIVIDUALS INCLUDED/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
1. DOES APPLICANT OWN, OPERATE OR LEASE AIRCRAFT/WATERCRAFT?		✔
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)		✔
3. ANY WORK PERFORMED UNDERGROUND OR ABOVE 15 FEET?		✔
4. ANY WORK PERFORMED ON BARGES, VESSELS, DOCKS, BRIDGE OVER WATER?		✔
5. IS APPLICANT ENGAGED IN ANY OTHER TYPE OF BUSINESS?		✔
6. ARE SUB-CONTRACTORS USED? (IF YES, GIVE % OF WORK SUBCONTRACTED)		✔
7. ANY WORK SUBLET WITHOUT CERTIFICATES OF INS.?		✔
8. IS A WRITTEN SAFETY PROGRAM IN OPERATION?		✔
9. ANY GROUP TRANSPORTATION PROVIDED?		✔
10. ANY EMPLOYEES UNDER 16 OR OVER 60 YEARS OF AGE?		✔
11. ANY SEASONAL EMPLOYEES?		✔
12. IS THERE ANY VOLUNTEER OR DONATED LABOR?		✔
13. ANY EMPLOYEES WITH PHYSICAL HANDICAPS?		✔
14. DO EMPLOYEES TRAVEL OUT OF STATE?		✔
15. ARE ATHLETIC TEAMS SPONSORED?		✔

EXPLAIN ALL "YES" RESPONSES	YES	NO
16. ARE PHYSICALS REQUIRED AFTER OFFERS OF EMPLOYMENT ARE MADE?		✔
17. ANY OTHER INSURANCE WITH THIS INSURER?		✔
18. ANY PRIOR COVERAGE DECLINED/ CANCELLED/NON-RENEWED (Last 3 years)? NOT APPLICABLE IN MO		✔
19. ARE EMPLOYEE HEALTH PLANS PROVIDED?		✔
20. IS THERE A LABOR INTERCHANGE WITH ANY OTHER BUSINESS/SUBSIDIARY?		✔
21. DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS?		✔
22. DO ANY EMPLOYEES PREDOMINANTLY WORK AT HOME?		✔
23. ANY TAX LIENS OR BANKRUPTCY WITHIN THE LAST 5 YEARS?		✔
24. ANY UNDISPUTED AND UNPAID WORKERS COMPENSATION PREMIUM DUE FROM YOU OR ANY COMMONLY MANAGED OR OWNED ENTERPRISES? IF YES, EXPLAIN INCLUDING ENTITIY NAME(S) AND POLICY NUMBERS(S).		✔

CONTACT INFORMATION

IN-SPECTION	PHONE:
	NAME:
ACCTNG RECORD	PHONE: 802-280-1191
	NAME:
CLAIMS INFO	PHONE: 802-280-1191
	NAME: Theresa Danforth

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

		Are cancer treatments provided?	No
		Do they give immunizations or shots?	No
Does insured have any locations outside of this state?	No	Do they take safety precautions with pregnant employees?	No
Is travel radius greater than 200 miles?	No	Do they have procedures for reporting unsafe conditions?	No
Are operations 24 hours?	No	Are all clients/patients ambulatory (ie: able to walk on their own)?	No

APPLICANT'S SIGNATURE	DATE	PRODUCER'S SIGNATURE	NATIONAL PRODUCER NUMBER

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

MPWC 1004 (11/15)

COLORADO
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_____ _____

Signature Date

MPWC 1004 (11/15)

CO- CPWD

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

(Rev. December 2023) Department of the Treasury — Internal Revenue Service

OMB No. 1545-0748

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

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

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

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

For IRS use:

Part 1: Why you're filing this form.

(Check one)

[x] 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**

Number Street Suite or room number

City State ZIP code

Foreign country name Foreign province/county Foreign postal code

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

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

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

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

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

Sign your name here

Print your name here

Print your title here

Date / /

Best daytime phone

Now give this form to the agent to complete.

Form **8821**

(Rev. January 2021)

Department of the Treasury
Internal Revenue Service

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.**

OMB No. 1545-1165

For IRS Use Only
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	CAF No. / PTIN / Telephone No. / Fax No.
ARIS Solutions PO Box 4409 White River Jct., VT 05001	CAF No. 0313-84964R PTIN Telephone No. 866-970-3301 Fax No. 802-295-1912
Check if to be sent copies of notices and communications ☐	Check if new: Address ☐ Telephone No. ☐ Fax No. ☐
Name and address	CAF No. PTIN Telephone No. Fax No.
Check if to be sent copies of notices and communications ☐	Check if new: Address ☐ Telephone No. ☐ Fax No. ☐

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	940, 941x, 941 R, 940, 940x, SS4, W2, W2c, W3, 1099	2025-2028	Tax Liability
Authority to obtain FEIN	SS4, 8821	2025-2028	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)

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

Department Use Only
☐☐☐☐☐☐.☐☐-☐

APPLICATION FOR UNEMPLOYMENT INSURANCE ACCOUNT AND DETERMINATION OF EMPLOYER LIABILITY

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

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

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

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

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) C/O ARIS Solutions PO Box 4409 White River Jct., VT 05001	Telephone Number 802.280.1911

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) C/O ARIS Solutions PO Box 4409 White River Jct., VT 05001	Payroll-Records Telephone Number 802.280.1911

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

Department Use Only

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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 lmigateway.coworkforce.com/lmigateway.

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

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

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

Provide specific detail regarding the business's activity in Colorado. If more than one service is provided, indicate which is predominant.

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

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.

Department Use Only

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

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

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

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

16. Provide the following information regarding the prior employer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

☐ Political Subdivision/Government

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

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

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

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

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

Type of services provided _____

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

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

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

CO- CPWD

Department Use Only

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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 Domestic Employer (HCSR)	
Telephone Number 802.280.1911	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.

Clear Form Save Form

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

POWER OF ATTORNEY

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

Employer Information

Employer Name	Trade Name	Employer Account Number (Required)	
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
ARIS Solutions 72 South Main Street White River Jct., VT 05001	802.280.1911 tax@arissolutions.org

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
ARIS Solutions 72 South Main Street, White River Jct., VT 05001	802.280.1911 tax@arissolutions.org

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
Janet Couture	Veterans Payroll Specialist
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
	Domestic Employer (HHCSR)
Signature of Employer Official (Required) ☐ SIDES (To add employer account information to SIDES), or go to: http://info.uisides.org	*Date

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

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

Clear Form Save Form

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.

240100CR19999

CR 0100 (11/22/24)
COLORADO DEPARTMENT OF REVENUE
Taxpayer Service Center
PO Box 17087
Denver CO 80217-0087

Colorado Sales Tax and Withholding Account Application

A

● 1. Reason for Filing This Application

- [X] Original Application for a New Business
- [ ] Add a New Physical Location to an Existing Account
- [ ] Change in Managing Partners, Members, or Officer of an Existing Business
- [ ] Change of Ownership for an Existing Business

Enter the existing Colorado Account Number

Complete line 9 to report existing business sold to a new owner or change in entity structure of an existing business

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

- [X] Individual/Sole Proprietor
- [ ] Limited Liability Company (LLC)
- [ ] Corporation/S Corp
- [ ] Government
- [ ] General Partnership
- [ ] Limited Liability Partnership (LLP)
- [ ] Association
- [ ] Joint Venture
- [ ] Limited Partnership
- [ ] Limited Liability Limited Partnership (LLLP)
- [ ] Estate/Trust
- [ ] Nonprofit (Charitable)

B

Business Information

● 1a. Last Name (If registering as TIN)	● First Name

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

● 1b. TIN (Required)

● 2a. Business Name (If registering as FEIN)	● 2b. Trade Name / DBA (If applicable)	● 2c. FEIN (Required)

3. Proof of Identification

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

Principal Place of Business (Do not use PO Box)

● 4a. Principal Address	● City	● State	● ZIP

● 4b. County	● 5. Phone Number	● 6. Email Address

Email Opt In For

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

Mailing Address (If different from the principal address)

● 7a. Business Name	● 7b. Attention to (First, Last Name)
C/O ARIS Solutions	

● 7c. Mailing Address	● City	● State	● ZIP
PO Box 4409	White River Jct	VT	05001

240100CR29999

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

8a. Last Name	First Name	Job Title
		Domestic Employer

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

8d. Home Address	City	State	ZIP

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

Business acquisition or purchase, complete the following

9a. Prior Business Name	Prior Owner's Last Name, First Name	9b. Date of Acquisition (MM/YYYY)

9c. Address	City	State	ZIP	9d. Prior Owner's FEIN

C

Sales Tax Account (Fees Apply)

● **1. Indicate Type of Sale**

☐ Wholesaler ☐ Retail-Sales ☐ Charitable

● 2a. License Start Date or First Day of Sale **Required** (MM/YYYY)	CO Account Number - Site **(Dept Use Only)**

● **2b. Filing Frequency:** If **SALES TAX** collected is:

☐ Wholesale Only - Annually ☐ Under $600/month - Quarterly ☐ Seasonal, write in months below

☐ $15/month or less - Annually ☐ $600/month or more - Monthly

● **3. Complete the questionnaires below**

Do you sell alcohol?	☐ Yes	☒ No	Do you sell **EXCLUSIVELY** through the marketplace?	☐ Yes	☒ No
Do you sell tobacco?	☐ Yes	☒ No	Are you a Marketplace Facilitator?	☐ Yes	☒ No
Do you sell Prepaid Wireless?	☐ Yes	☒ No	If you are a Marketplace Facilitator, do you also sell products?	☐ Yes	☒ No
Do you rent out rooms for 30 days or less?	☐ Yes	☒ No	Do you sell firearms/guns, firearm/gun precursor parts, or ammunition?	☐ Yes	☒ No
Do you rent motor vehicles for 30 days or less?	☐ Yes	☒ No			

**If you sell both medical and recreational marijuana, a separate application must be filled out for each

Do you sell Medical Marijuana?	☐ Yes	☒ No	Do you sell Recreational Marijuana?	☐ Yes	☒ No

4. List the specific products you sell and/or services you provide (Required) or indicate the NAICS code. To look up the code, go to *www.naics.com/search*

● NAICS Code

240100CR39999

D — Withholding Account (No Fees Apply)

1. Indicate Type of Withholding:

☒ W2 Withholding	● **2. Filing Frequency:** If W2 wage withholding tax amount is ☒ $1 - $6,999/Year - Quarterly ☐ $7,000 - $49,999/Year - Monthly ☐ $50,000+/Year-Weekly
☐ 1099 Withholding	● **3. Filing Frequency:** If 1099 withholding tax amount is ☐ $1 - $6,999/Year - Quarterly ☐ $7,000 - $49,999/Year - Monthly ☐ $50,000+/Year-Weekly

● ☐ W-2G (Gaming Withholding)

● ☐ Oil/Gas Withholding

Filing Frequency is monthly

● 4. First Day of Payroll **Required** (MM/YYYY)

E — Fees for Licenses (See Instructions)

Period Covered (Dept Use Only) From	To				
MM/YY		● (0020-810)	State Sales Tax Deposit	● (355)	● $
MM/YY	MM/YY	● (0100-750)	Wholesale License	● (999)	● $
MM/YY	MM/YY	● (0080-750)	Retail-Sales Tax License	● (999)	● $
MM/YY	MM/YY	● (0160-750)	Charitable License	● (999)	● $

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

Amount Owed ● $

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

F

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

Signature of Owner, Partner, Member, or Officer **(Required)**	Job Title	Date (MM/DD/YYYY)
	Domestic Employer (HHCSR)	

Employer/Authorized Representative Background Checks

Effective February 1, 2024 any new Employer of Record or Authorized Representative whom is other than the Veteran, are required to undergo and pass a background check in accordance with the Veterans Administration (VA) and state polices as specified by the VDC provided to be designated as a Veteran's representative.

Per VA policy, any representative candidate who has a felony for fraud, abuse or exploitation for an individual may be not authorized as a representative for a Veteran.

Examples of Disqualifying Events as a Result of a Background Check would include:

1. A misdemeanor conviction against any individual that involves:

   a. Physical or sexual assault;
   b. Violence or exploitation;
   c. Child pornography;
   d. Threatening or reckless conduct;
   e. Theft;
   f. Fraud;
   g. Driving under the influence of drugs or alcohol;
   h. Any other conduct that represents evidence of behavior that could endanger the safety or well-being of an individual.

2. A conviction of a felony against an individual.

3. Additional factors considered in determining suitability may include, but not limited to:

   a. Relevance of the crime to the position sought;
   b. The nature of the work and/or activity to be performed;
   c. Time elapsed since the conviction;
   d. Age of the candidate at the time of the offense;
   e. The number of offenses;
   f. Whether the individual has pending charges;
   g. Any relevant evidence of rehabilitation or lack thereof;
   h. Any other relevant information, including information submitted by the individual or requested by the hiring authority.

Employer/Authorized Representative Background Check Release Form

Veteran Directed Care Program

Care Coordinator _____AAA_____

Veteran Demographic Information		
Last Name:	First Name:	
Home Phone:	Cell Phone:	ID # (Last 4 SS#):
Is Veteran using a Representative? Yes____ No____ **(If no, skip Authorized Representative Information)**		

Authorized Representative Demographic Information		
Full Name (**If also a POA please attach documentation**):		
Alias/Maiden Name (if more than one):		
Home Phone Number:	Cell Phone:	Work Phone:
Address:		
Address outside of state within 5 years:		
Date of Birth:	Full Social Security Number:	

By signing below, I am consenting to reviewing the list of excluded convictions, substantiations, and findings. I understand that ARIS Solutions will conduct background checks 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 or Authorized Representative.

As so, I authorize ARIS Solutions to perform the following background check(s) on behalf of the Veteran. The cost of these background check(s) will be an expense to the Veterans budget.

*Criminal History Information Check *Office of Inspector General Check

Signatures:

Employer/Authorized Representative: _____ Date: _____

Veteran: _____ Date: _____

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*

e-Timesheets Registration and Agreement Form

Each Employer and Employee must complete a separate form. If you are filling out this form as an Employee, you (and your Employer) must sign up for e_Timesheets with each Employer that you work for.

Please remember that each Employer and Employee must have individual email addresses (**cannot** share one with any other employer or employee).

Name: _____
Required (Please print clearly)

E-mail Address: _____
Required (Please print clearly)

Phone Number: _____ Last 4 digits of Social Security Number: _____
Required

Registering as: **Employer** ____

Employee ____ **My Employer's** name is: _____
Required if enrolling as employee

You are also agreeing that:

- You understand that ARIS Solutions reports suspected fraud to the Office of Attorney General and will automatically do that, even if the timesheet is sent through e_Timesheets,

- You will not share your User Name or Password with anyone,
- You will notify ARIS Solutions immediately if you change your email address,
- You will notify ARIS Solutions immediately if there is a change in employment status of any employee who uses e_Timesheets,
- You will notify ARIS Solutions immediately if there is a change in the employer of record for anyone who uses e_Timesheets, and
- Submitting hours or services that were not worked may be considered fraud.

Signature _____
Required

Print Name _____
Required

Date _____
Required

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

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.

Financial & Payroll Services for the Nonprofit Sector

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

FREQUENTLY ASKED QUESTIONS

REGARDING COLORADO FAMLI 1/1/2024

Colorado – Family and Medical Leave Insurance Program (FAMLI)

- **What is this?**
  - FAMLI 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 FAMLI leave?**
  - January 1, 2024 – benefits will be available.
- **What makes you eligible to take FAMLI 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 FAMLI 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. FAMLI 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

COLORADO
Department of
Labor and Employment

CO - CPWD

Colorado Workplace Public Health Rights Poster: PAID LEAVE, WHISTLEBLOWING, & PROTECTIVE EQUIPMENT

Updated July 14, 2023
may be updated periodically

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.