



Employer Packet

(keep this folder for your records)

Congratulations on self-directing your supports. We are excited to take part in this process with you. Acumen Fiscal Agent, LLC (Acumen) is one of the oldest and most experienced Fiscal Employer Agents in the nation. We have been helping people self-direct since 1995.

Becoming an Employer: Inside this folder you will find the necessary forms and instructions which will authorize Acumen to act on your behalf. These forms relate to the withholding and filing of employer and employee related taxes. This folder cover provides you with reference information to assist you in being an employer.

The following forms are needed to authorize Acumen to act as your Fiscal Employer Agent. Please complete them and return to Acumen. Examples of these completed forms can be found in the back of the packet. Please check and note the date you emailed, mailed or faxed to Acumen. ****If you currently have or have had an Employer Identification Number (EIN), do not complete any further employer enrollment forms. Please call Acumen for additional steps****

Who can be the Employer?

In this SD-VISA Program the person receiving services or a representative can be the employer. This is a decision that is made before submitting the forms to Acumen.

☐ Acumen Authorization Form

Date Sent

☐ Employer Appointment of Agent - IRS Form 2678

Date Sent

☐ Application for Employer Identification Number - IRS Form SS4

Date Sent

☐ Tax Information Authorization - IRS Form 8821

Date Sent

☐ State of California – Power of Attorney

Date Sent

☐ Employer Agreement Form

Date Sent

Email, Fax or Mail Information to Acumen

****PLEASE INCLUDE SD-VISA in
SUBJECT LINE****

Acumen Fiscal Agent, LLC.
5416 E. Baseline Rd., Suite 200
Mesa, AZ 85206
Fax: (888) 715-9391
enrollment-ca@acumen2.net



Authorization Form

Complete each item and email enrollment-ca@acumen2.net fax (888) 715-9391 or mail 5416 E. Baseline Rd., Suite 200, Mesa, AZ 85206 to Acumen. Please call (888) 516-2432 for English or (800) 611-4936 for Spanish if you have any questions.

I hereby authorize Acumen Fiscal Agent (Acumen) to:

1. File Form SS-4 on my behalf to obtain an Employer Identification Number (EIN), if I do not already have one, and allow the IRS to mail EIN information to Acumen once obtained. Note: If you currently have or have had an EIN, please contact the above phone number before proceeding with the employer enrollment paperwork.
2. Represent you, as the Veteran-Employer/Authorized Representative-Employer, for employer-related tax reporting purposes, by signing IRS Form 2678.
3. Handle all correspondence regarding employer tax reporting issues.
4. Serve as my Employer Agent for unemployment and withholding tax purposes. As such, Acumen shall provide all services for me, the employer, (tax, benefits, and appeals) and shall receive all documents related to my, the employer's, California unemployment and withholding tax account that would otherwise have been sent to me.
5. Receive confidential information and perform any and all acts the employer can perform relating to matters pertaining to California's Unemployment Insurance Program and state tax withholding regulations effective signature date forward; subject to revocation.
6. Electronically send me (e.g. e-mail) information including, but not limited to: employer and/or employee enrollment information, account statement reports, good-to-go information, and new products or services.

Any limitations to this authorization must be specifically stated and attached. This authorization revokes all earlier authorizations and powers of attorney on file, and shall remain in effect until receipt of a written notice of revocation or a subsequent authorization or power of attorney by the California Franchise Tax Board (FTB) and/or the California Employment Development Department.

What am I really authorizing?

- Your appointment grants Acumen Fiscal Agent a limited power of attorney to act as your employer agent for acts required under Section 3504 and Chapters 21, 22, 24, and/or 25 of Subchapter C of the Internal Revenue Code, and for taxes required under 3301.
- You are appointing Acumen Fiscal Agent to act as your agent for the California Franchise Tax Board and the California Employment Development Department in the fulfilling of domestic employer responsibilities relative to the employing of persons through initiatives funded by the State of California.

Employer (Responsible for managing staff)

| |
|-------------------------|
| Name: |
| Social Security Number: |
| Date of Birth: |
| Physical Address: |
| City/State/Zip: |
| Mailing Address: |
| City/State/Zip: |
| Phone Number: |
| E-mail Address: |

Veteran (The person receiving services)

| |
|-------------------------|
| Name: |
| Social Security Number: |
| Date of Birth: |
| Physical Address: |
| City/State/Zip: |

Options Counselor

| |
|-----------------|
| Name: |
| E-mail Address: |
| Phone Number: |

Your signature means that you have read and understand the above information.

Participant or Employer Signature

Date

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

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

OMB No. 1545-0748

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

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

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

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

For IRS use:**Part 1: Why you're filing this form.**

(Check one)

- ☒ You want to **appoint** an agent for tax reporting, depositing, and paying.
- ☐ You want to **revoke** an existing appointment.

Part 2: Employer or Payer Information: Complete this part if you want to appoint an agent or revoke an appointment.**1 Employer identification number (EIN)**

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

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

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

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)



Form 941, Employer's QUARTERLY Federal Tax Return (all 941 series)



Form 943, Employer's Annual Federal Tax Return for Agricultural Employees (all 943 series)



Form 944, Employer's ANNUAL Federal Tax Return (all 944 series)



Form 945, Annual Return of Withheld Federal Income Tax



Form CT-1, Employer's Annual Railroad Retirement Tax Return



Form CT-2, Employee Representative's Quarterly Railroad Tax Return



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

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

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

Sign your name here

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

Print your name here

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

Print your title here

| |
|---------------|
| HCSR EMPLOYER |
|---------------|

Date

| | |
|---|---|
| / | / |
|---|---|

Best daytime phone

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

Now give this form to the agent to complete.

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

| | | | |
|---|---|---|--|
| Employer's Name Here | 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) 5416 E BASELINE RD STE 200 | | 5a Street address (if different) (Don't enter a P.O. box.) |
| | 4b City, state, and ZIP code (if foreign, see instructions) MESA, AZ 85206-4704 | | 5b City, state, and ZIP code (if foreign, see instructions) |
| Employer's County & State Here | 6 County and state where principal business is located | | |
| Employer's Name Here | 7a Name of responsible party | | 7b SSN, ITIN, or EIN |
| | 8a Is this application for a limited liability company (LLC) (or a foreign equivalent)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 9a Type of entity (check only one box). Caution: If 8a is "Yes," see the instructions for the correct box to check. | | | |
| <input type="checkbox"/> Sole proprietor (SSN) <input type="checkbox"/> Estate (SSN of decedent) | | | |
| <input type="checkbox"/> Partnership <input type="checkbox"/> Plan administrator (TIN) | | | |
| <input type="checkbox"/> Corporation (enter form number to be filed) <input type="checkbox"/> Trust (TIN of grantor) | | | |
| <input type="checkbox"/> Personal service corporation <input type="checkbox"/> Military/National Guard <input type="checkbox"/> State/local government | | | |
| <input type="checkbox"/> Church or church-controlled organization <input type="checkbox"/> Farmers' cooperative <input type="checkbox"/> Federal government | | | |
| <input type="checkbox"/> Other nonprofit organization (specify) <input type="checkbox"/> REMIC <input type="checkbox"/> Indian tribal governments/enterprises | | | |
| <input checked="" type="checkbox"/> Other (specify) HCSR EMPLOYER 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) | | | |
| <input type="checkbox"/> Started new business (specify type) | | | |
| <input type="checkbox"/> Banking purpose (specify purpose) | | | |
| <input type="checkbox"/> Changed type of organization (specify new type) | | | |
| <input type="checkbox"/> Purchased going business | | | |
| <input type="checkbox"/> Hired employees (Check the box and see line 13.) | | | |
| <input type="checkbox"/> Created a trust (specify type) | | | |
| <input type="checkbox"/> Compliance with IRS withholding regulations | | | |
| <input type="checkbox"/> Created a pension plan (specify type) | | | |
| <input checked="" type="checkbox"/> Other (specify) HCSR EMPLOYER | | | |
| 11 Date business started or acquired (month, day, year). See instructions. | | 12 Closing month of accounting year DECEMBER | |
| 13 Highest number of employees expected in the next 12 months (enter -0- if none). | | 14 Reserved for future use | |
| Agricultural | | Household | |
| | | 0 | |
| Other | | | |
| 15 First date wages or annuities were paid (month, day, year). Note: If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year) | | | |
| 16 Check one box that best describes the principal activity of your business. | | | |
| <input type="checkbox"/> Construction <input type="checkbox"/> Rental & leasing <input type="checkbox"/> Transportation & warehousing <input type="checkbox"/> Health care & social assistance <input type="checkbox"/> Wholesale-agent/broker | | | |
| <input type="checkbox"/> Real estate <input type="checkbox"/> Manufacturing <input type="checkbox"/> Finance & insurance <input type="checkbox"/> Accommodation & food service <input type="checkbox"/> Wholesale-other <input type="checkbox"/> Retail | | | |
| <input checked="" type="checkbox"/> Other (specify) HCSR EMPLOYER | | | |
| 17 Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided. HCSR EMPLOYER | | | |
| 18 Has the applicant entity shown on line 1 ever applied for and received an EIN? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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 JARED ENDERS, SUNNY HUDSON | | Designee's telephone number (include area code) (623) 792-6100 |
| | Address and ZIP code 5416 E BASELINE RD STE 200, MESA, AZ 85206-4704 | | Designee's fax number (include area code) (480) 371-2241 |
| Employer's Name Here | 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) |
| Employer Sign Here | Name and title (type or print clearly) HCSR EMPLOYER | | Applicant's fax number (include area code) |
| Signature | | Date | |

Do I Need an EIN?

File Form SS-4 if the applicant entity doesn't already have an EIN but is required to show an EIN on any return, statement, or other document.¹ See also the separate instructions for each line on Form SS-4.

| IF the applicant... | AND... | THEN... |
|--|--|--|
| started a new business | doesn't currently have (nor expect to have) employees | complete lines 1, 2, 4a-8a, 8b-c (if applicable), 9a, 9b (if applicable), 10-13, and 16-18. |
| hired (or will hire) employees, including household employees | doesn't already have an EIN | complete lines 1, 2, 4a-6, 7a-b, 8a, 8b-c (if applicable), 9a, 9b (if applicable), and 10-18. |
| opened a bank account | needs an EIN for banking purposes only | complete lines 1-5b, 7a-b, 8a, 8b-c (if applicable), 9a, 9b (if applicable), 10, and 18. |
| changed type of organization | either the legal character of the organization or its ownership changed (for example, you incorporate a sole proprietorship or form a partnership) ² | complete lines 1-18 (as applicable). |
| purchased a going business ³ | doesn't already have an EIN | complete lines 1-18 (as applicable). |
| created a trust | the trust is other than a grantor trust or an IRA trust ⁴ | complete lines 1-18 (as applicable). |
| created a pension plan as a plan administrator ⁵ | needs an EIN for reporting purposes | complete lines 1, 3, 4a-5b, 7a-b, 9a, 10, and 18. |
| is a foreign person needing an EIN to comply with IRS withholding regulations | needs an EIN to complete a Form W-8 (other than Form W-8ECI), avoid withholding on portfolio assets, or claim tax treaty benefits ⁶ | complete lines 1-5b, 7a-b (SSN or ITIN as applicable), 8a, 8b-c (if applicable), 9a, 9b (if applicable), 10, and 18. |
| is administering an estate | needs an EIN to report estate income on Form 1041 | complete lines 1-7b, 9a, 10-12, 13-17 (if applicable), and 18. |
| is a withholding agent for taxes on nonwage income paid to an alien (that is, individual, corporation, or partnership, etc.) | is an agent, broker, fiduciary, manager, tenant, or spouse who is required to file Form 1042, Annual Withholding Tax Return for U.S. Source Income of Foreign Persons | complete lines 1, 2, 3 (if applicable), 4a-5b, 7a-b, 8a, 8b-c (if applicable), 9a, 9b (if applicable), 10, and 18. |
| is a state or local agency | serves as a tax reporting agent for public assistance recipients under Rev. Proc. 80-4, 1980-1 C.B. 581 ⁷ | complete lines 1, 2, 4a-5b, 7a-b, 9a, 10, and 18. |
| is a single-member LLC (or similar single-member entity) | needs an EIN to file Form 8832, Entity Classification Election, for filing employment tax returns and excise tax returns, or for state reporting purposes ⁸ , or is a foreign-owned U.S. disregarded entity and needs an EIN to file Form 5472, Information Return of a 25% Foreign-Owned U.S. Corporation or a Foreign Corporation Engaged in a U.S. Trade or Business | complete lines 1-18 (as applicable). |
| is an S corporation | needs an EIN to file Form 2553, Election by a Small Business Corporation ⁹ | complete lines 1-18 (as applicable). |

¹ For example, a sole proprietorship or self-employed farmer who establishes a qualified retirement plan, or is required to file excise, employment, alcohol, tobacco, or firearms returns, must have an EIN. A partnership, corporation, REMIC (real estate mortgage investment conduit), nonprofit organization (church, club, etc.), or farmers' cooperative must use an EIN for any tax-related purpose even if the entity doesn't have employees.

² However, don't apply for a new EIN if the existing entity only (a) changed its business name, (b) elected on Form 8832 to change the way it is taxed (or is covered by the default rules), or (c) terminated its partnership status because at least 50% of the total interests in partnership capital and profits were sold or exchanged within a 12-month period. The EIN of the terminated partnership should continue to be used. See Regulations section 301.6109-1(d)(2)(iii).

³ Don't use the EIN of the prior business unless you became the "owner" of a corporation by acquiring its stock.

⁴ However, grantor trusts that don't file using Optional Method 1 and IRA trusts that are required to file Form 990-T, Exempt Organization Business Income Tax Return, must have an EIN. For more information on grantor trusts, see the Instructions for Form 1041.

⁵ A plan administrator is the person or group of persons specified as the administrator by the instrument under which the plan is operated.

⁶ Entities applying to be a Qualified Intermediary (QI) need a QI-EIN even if they already have an EIN. See Rev. Proc. 2000-12.

⁷ See also *Household employer agent* in the instructions. **Note:** State or local agencies may need an EIN for other reasons, for example, hired employees.

⁸ See *Disregarded entities* in the instructions for details on completing Form SS-4 for an LLC.

⁹ An existing corporation that is electing or revoking S corporation status should use its previously assigned EIN.

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 _____

Please fill in your name and address

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

Taxpayer name and address

You must list a physical address. A PO box will not be accepted.

Taxpayer identification number(s)

Daytime telephone number

Plan number (if applicable)

Please fill in your phone number here.

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. _____

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 TAXES | 940 AND 941 | Q1 2025 THRU Q4 2027 | NOT APPLICABLE |
| EMPLOYMENT TAXES | W2 AND W3 | 2025 THRU 2027 | NOT APPLICABLE |
| INCOME TAXES | 1099 | 2025 THRU 2027 | NOT APPLICABLE |

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.

Please sign your name here.

Please print your name here.

Signature

Date

Enter date here.

Print Name

HCSR EMPLOYER

Title (if applicable)

Power of Attorney Declaration

This *Power of Attorney (POA) Declaration* (DE 48) is your written authorization for an individual or other entity to act on your behalf in tax and/or benefit reporting matters with us. A POA remains in effect until it is revoked or a new one is received.

If you would like to only authorize a POA for a set period, you must specify the date your new POA will expire.

For more information, see the [Information Sheet: Counseling Service Agent](#) (DE 231CSA) and [Information Sheet: Payroll Reporting Agent](#) (DE 231PRA).

Complete the DE 48

Online

Complete and send us your POA online with [e-Services for Business](http://eddservices.edd.ca.gov/tap/secure/eservices) (eddservices.edd.ca.gov/tap/secure/eservices).

For more information, visit [e-Services for Business FAQs](http://edd.ca.gov/en/payroll_taxes/faq_-_e-services_for_business) (edd.ca.gov/en/payroll_taxes/faq_-_e-services_for_business).

By Mail

You can also send a POA by mailing the completed DE 48 with the following required information:

Employer and taxpayer information

Enter your:

- California employer payroll tax account number (if applicable)
- Federal employer identification number
- Owner or legal name of organization
- Secretary of State identification number
- Business name or doing business (DBA)
- Mailing address
- Business phone and fax numbers
- Business location if different than the mailing address

Representative designation

Enter your representative's business, name, phone number, fax numbers and address.

Authorized acts

If you want to authorize your representative to perform all acts on your behalf, select the **General Authorization** box.

- If you want to limit this authorization, select the boxes that apply under the "Specific Declaration" header. Enter the beginning and ending dates of each interval or period you are making the declaration.

Signature authorizing power of attorney

In order for your new POA to be recognized, it must be signed and dated by an authorized signator.

An authorized signator can be the business:

- Owner
- Partners
- Members
- Managing members
- Corporate officers including the President, Vice President, Chief Executive Officer, or Chief Financial Officer

Please send an updated list of corporate officers or owners with this document.

Note: If your declaration is sent without a date, signature, or with an unauthorized signature, it will be returned.

The signature date must be within 30 days of the submission of the POA.

Mail the completed DE 48 to:

Employment Development Department
Account Services Group, MIC 28
PO Box 826880
Sacramento, CA 94280-0001
Fax 1-916-654-9211

Questions or need assistance completing this form? Call the Account Services Group Agent Line at 1-916-654-7263.

Power of Attorney Declaration

To send a Power of Attorney Declaration (POA) online, use [e-Services for Business](http://eddservices.edd.ca.gov/tap/secure/eservices) (eddservices.edd.ca.gov/tap/secure/eservices).

I. Employer and Taxpayer Information

| | | | |
|--|--|--------------|--------------------|
| California Employer Payroll Tax Account Number: <i>(if applicable)</i> | Federal Employer Identification Number: | | |
| Owner (Limited Liability Company, Limited Partnership, Corporation Name) | Corporate (Limited Liability Company, Limited Partnership Identification Number) | | |
| Business Name (Or Doing Business As): | | | |
| Business Mailing Address: 5416 E Baseline Rd STE 200 | City: Mesa | State: AZ | ZIP Code: 85206 |
| Business Phone Number: (623) 792-6100 | Business Fax Number: (480) 371-2241 | | |
| Business Location <i>(if different from above)</i> : | City: | State: | ZIP Code: |

II. Representative Designation

I hereby appoint the following person to represent the employer or taxpayer for specified matters arising under the California Unemployment Insurance Code.

| | | | |
|---|---------------------------------|-------------------------------|--------------------|
| Representative Business: Acumen Fiscal Agent LLC | | | |
| Representative Name: April Meador | Phone Number: (623) 792-6100 | Fax Number: (480) 371-2241 | |
| Business Mailing Address: 5416 E Baseline Rd STE 200 | City: Mesa | State: AZ | ZIP Code: 85206 |

III. Authorized Act

☐ **All Authorization:** To represent the employer or taxpayer and receive mailings for all state tax matters.

☒ **Specific Declaration:** The representative will have limited authority to your state tax matters.

Indicate the specific dates and acts you are authorizing from _____ To _____

☐ To represent the employer or taxpayer for any or all:

☐ Tax reporting ☐ Benefit reporting ☐ Both matters relating to the reporting period indicated above

☒ To represent the employer or taxpayer and receive mailings for any and all:

☒ Tax reporting ☐ Benefit reporting ☐ Both matters relating to the reporting period indicated above

☐ Other acts: _____

IV. Signature Authorizing Power of Attorney

Signature of the employer or taxpayer, owner, managing member, officer, receiver, administrator, or trustee for the

employer or taxpayer: If you are a corporate officer, partner, guardian, tax matter person, executor, receiver, administrator, or trustee on behalf of the employer or taxpayer, you are certifying that you have the authority to execute this form on behalf of the employer or taxpayer by signing this Power of Attorney Declaration.

If this Power of Attorney Declaration is not signed and dated, it will be returned as invalid.

I certify under penalty of perjury that the above information is true, correct, and complete, and that these actions are not to be taken to receive a more favorable Unemployment Insurance rate. I further certify that I have the authority to sign on behalf of the above business.

| | |
|---------------------|-------------------------------------|
| _____ Signature | _____ Domestic Employer Title |
| _____ Print Name | _____ Date |



San Diego Veterans Independence Services at Any Age (SD-VISA) Employer/Acumen Agreement Form

This Agreement is between Acumen Fiscal Agent and the Employer as stated below.

General understanding and conditions of the San Diego Veterans Independence Services at Any Age (SD-VISA) Program

- Participation in the San Diego Veterans Independence Services at Any Age (SD-VISA) is a decision made after consultation with the Options Counselor.
- I have received from the Options Counselor any/all program related information about the service delivery options and the rules and regulations regarding participation in the (SD-VISA) option. I understand it is my responsibility as the Employer to abide by all the rules and regulations of this program.
- I understand that I am the Employer of Record for this program. The employer is not Acumen Fiscal Agent, nor is the SD-VISA Program.
- I understand that as the Employer of Record I am responsible to comply with paying all of my employees in accordance with the Department of Labor Regulations including the Fair Labor Standards Act and the Final Rule effective December 1, 2016. Furthermore, I understand that this employer responsibility may extend beyond what the program funds may pay my employee and I accept full responsibility for all debts owed. This includes overtime and any hours that are above what is authorized in the Individual Spending Plan) and/or within program rules. (Federal link: https://www.dol.gov/whd/homecare/homcare_guide.pdf)
- I understand that Acumen is only authorized to represent me in processing payments as it relates to this SD-VISA option. Acumen will only make payments on my behalf in accordance to the authorized amounts as outlined in the Spending Plan.
- I understand it is my responsibility to be aware of any remaining balances and schedule provider(s)/employee(s) and/or request program payments within those available units and funds.
- I understand that if I cause work to happen above and beyond what is authorized in the Spending Plan, I, as the employer, will be personally responsible for those expenses.
- I understand it is my responsibility as the employer to ensure all employees and goods and service providers meet the qualifications and receive required training as required in the SD-VISA Program and in the Spending Plan prior to working or providing services. Acumen provides support and assistance with this.
- I understand Acumen will provide me with enrollment materials and guidance on the requirements to complete each form. It is ultimately my responsibility as the employer to ensure all forms that my employee(s) and/or I complete are correct within required guidelines.
- I will not allow provider(s)/employee(s) to begin performing work until Acumen has notified me that provider(s)/employee(s) are active in their system (Good to Go).
- I understand that if the program requires my employee (job applicant) to pass a background check I will ensure all investigation reports are kept confidential, will not be shared, and will be disposed of properly given that they include sensitive data (e.g., criminal history) and personally identifiable information (e.g., name, DOB, SSN).
- I understand it is my responsibility to review and approve all requests for payment prior to

submitting them to Acumen to ensure accuracy and confirm they are authorized for processing.

- I understand that, on occasion, I may receive automated (general announcement) communication from Acumen regarding important program and/or payroll information as it relates only and specifically to the SD-VISA option.
- I understand that Acumen will provide a Workers' Compensation Claim Reporting Guidelines (included in the packet) for use if my employee is injured on the job. I understand that it is my responsibility to make this information available to my employees.
- I understand that I may face penalties and/or fines if I fail to make the Workers' Compensation Reporting Claims Guidelines available to my employees. I, as the employer, will be personally responsible for paying these penalties and/or fines.
- I understand it is my responsibility to notify the Options Counselor immediately of any significant changes in circumstances that may affect the Veteran Spending Plan and/or safety.
- I understand it is my responsibility to notify Acumen immediately of any changes that effect eligibility for SD-VISA services. I understand I may be responsible for payment of any work performed during the loss of eligibility.
- I understand all requests for payment must have an employer signature and date indicating approval, or must be submitted through Acumen's online time entry system which requires password-protected employer approval. I understand that Acumen will not process a payment request without proper employer approval.
- I understand it is my responsibility to ensure the correct service code is utilized when submitting a payment request or timesheet, and I will work with Acumen to help reconcile any billing discrepancies with my employees and goods and service provider(s). It is the employers' responsibility to ensure their own compliance with all California Department of Labor (DOL) laws.
- I attest that I will submit and/or approve all payment requests in accordance with the Program regulations. I understand that payment and satisfaction of my claims may be from Federal and State funds, and that I may be prosecuted under applicable Federal or State laws, for any false claims, statements or documents or concealment of a material fact. Any misuse of funds may result in being fined or penalized including but not limited to the repayment of claim. Any collection costs or legal fees will be my responsibility to pay.
- I hereby authorize Acumen to electronically send me information (e.g. email) including but not limited to account statement reports. I understand that I have the ability to opt-out of electronic communication upon request, and can receive this through U.S. Mail service.
- I acknowledge information necessary and relevant in providing services for the participant may be released, discussed, or disclosed between authorized business associates (i.e. FMS, the San Diego County HHSA staff, service providers, as well as other government authorities.) I understand that my records are protected under Federal Regulations governing Confidentiality of Protected Health Information (PHI) under HIPAA.

My signature below confirms my understanding and agreement to abide by the terms and conditions as stated above.

Name of Veteran: _____

Name of Employer: _____

Employer Signature: _____ Date: _____



Employer's Previous Business Information

This form must be completed by the individual assuming the role of the Employer. Please provide a response to every question below. If any of the questions *cannot* be answered, check "N/A" or write "Do not know" next to the question.

Please do not provide answers to the below questions based on a Partnership, Corporation, Limited Liability Company (LLC), Trust, Estate, Nonprofit or any other entity not considered a Sole Proprietor. Acumen Fiscal Agent, LLC can only accept an EIN and business information for a Sole Proprietor business. **If you have ever owned a Sole Proprietor (currently or in the past), you must let us know. Failure to do so will also drastically increase the time it takes to enroll and receive services under this program.**

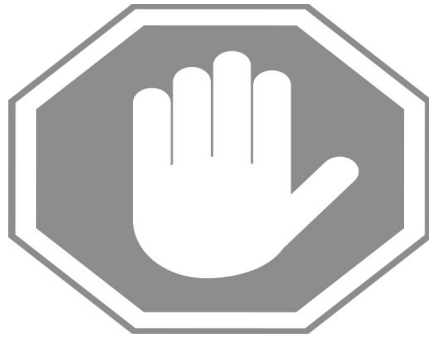
| | |
|--|--|
| Employer Full Name (as shown on Social Security Card) | Employer Social Security Number (SSN) |
| Other Names or Alias Used (please list all): | |

| | | YES | NO | N/A |
|----|--|--------------------------|--------------------------|--------------------------|
| 1. | Have you ever received an Employer Identification Number (EIN) for any Sole Proprietor business you currently or have previously owned? If yes: Please provide the previously assigned Federal EIN: _____ What was the nature of the business: _____ Is the business still active (including any requirements for filing income tax, payroll tax, or information returns): YES _____ NO _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | Have you ever previously been enrolled with another Fiscal/Employer Agent (F/EA), sometimes known as a Financial Management Service Agency? If yes: Please provide the name of the F/EA: _____ Please provide dates of when you were with the F/EA: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. | Was a business account ever established on your behalf for state unemployment insurance (SUTA) by your state's Department of Labor/Employment? If yes: Please provide the account number, if known: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. | Was a business account for state income tax (SIT) withheld on behalf of your employees ever established on your behalf with the state's Department of Revenue? If yes: Please provide the account number, if known: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If you answered yes to question #2, please contact the prior F/EA to obtain the documents received from the Internal Revenue Service (IRS) and state taxing authorities when you were granted your EIN and state tax accounts. Documents should include a Letter 147C or CP575 issued by the IRS, and confirmation of the state tax accounts being created.

Employer Signature

Date



Worker's Compensation Claim Reporting Guidelines for Employees

If there has been a workplace injury or accident, please take the following action:

- If the injury or accident is of a serious nature, seek medical attention immediately.
- Employees must report the injury immediately to their employer.
- Employers must report the injury as soon as possible even if it is a weekend or holiday to the Acumen Workers' Compensation Department.
- To report to Acumen, call 866-472-2297. If you get voicemail when you call, leave a message with your name, call back number, state you are located in, a brief description of the incident and if the injury is of a serious nature (including hospitalization (not ER room & home release), immediate surgery status, critical care or death) .
- Messages of injuries of a serious nature will be returned even on a weekend or holiday. All other messages will be returned the following business day.

Timely reporting of any injury that goes beyond First Aid treatment to Acumen's Workers' Compensation Department is important. When reporting, be prepared with the following information:

- Time & place the incident occurred as well as how it occurred.
- Explain in as much detail as possible what happened to cause the injury.
- Take pictures of the area where the incident occurred, if you are able to do so, and any other photos you are able to obtain that may be helpful to the claim.

Contact Acumen's Workers' Compensation Administrator. Direct line is 866-472-2297.

CHANGE INFORMATION FORM: VETERAN or EMPLOYER



Please complete this form and return to Acumen by one of the following methods:

Mail: 5416 E. Baseline Rd., Suite 200, Mesa, AZ 85206

Fax: (888) 715-9391

Email: enrollment@acumen2.net

Change VETERAN Information

Complete this section when there is a change in veteran information. The veteran is the individual receiving services. If the veteran is also the employer, please complete this section **only**. For a name change, please provide the current and new name. For all other changes, only the new information is required.

| | |
|--|------------------------|
| Change In (select all that apply): Name <input type="checkbox"/> Address <input type="checkbox"/> Phone Number <input type="checkbox"/> E-mail Address <input type="checkbox"/> | |
| Current/Previous Name: | New Name (if changed): |
| Street Address: | |
| City/State/Zip: | |
| Phone Number: | |
| E-mail Address: | |
| Veteran ID Number: | |
| Signature (Employer or Authorized Rep): | |
| Date: | |

Change EMPLOYER Information

Complete this section when there is a change in employer information. The employer is the individual who hires, trains, and manages staff. If the veteran is also the employer, please complete the veteran section only. For a name change, provide the current and new name and please fax or mail a copy of a legal document for name change. For all other changes, only the new information is required.

| | |
|--|------------------------|
| Change In (select all that apply): Name <input type="checkbox"/> Address <input type="checkbox"/> Phone Number <input type="checkbox"/> E-mail Address <input type="checkbox"/> | |
| Current/Previous Name: | New Name (if changed): |
| Street Address (if changed): | |
| City/State/Zip (if changed): | |
| Phone Number (if changed): | |
| E-mail Address: | |
| Client ID Number: | |
| Signature (Employer or Authorized Rep): | |
| Date: | |

Show Me the Money



It costs you, the employer, more to employ someone than just their wages. By law, employers need to pay a portion of an employee's Social Security and Medicare taxes, as well as Federal and State unemployment taxes. Workers' Compensation Insurance are part of your program and are also an employer-related cost. Acumen calls these employer-related costs the "Cost to You."

What this means is that for every \$1.00 you pay in wages, you must add approximately 19 cents to pay for taxes, Workers' Compensation. The "Cost to You" is simply the employee's wage multiplied by **1.1816** (the 19 cents per dollar mentioned above). Acumen calculates and pays these taxes and Workers' Compensation on your behalf. It is important for you to understand how this impacts your authorization/budget.

Simply fill in the blanks below to determine the "Cost to You."

| | | | | |
|----------------------|----------|-------------------------------------|----------|---------------------------------------|
| <input type="text"/> | X | <input type="text" value="1.1816"/> | = | <input type="text"/> |
| Employee Wage | | Taxes & Workers' Comp | | Cost to You (always round <u>up</u>) |

Example:

Jane wants to pay her new employee, Don, \$22.50 per hour. Using the tool described above, Jane calculates her costs:

| | | | | |
|--------------------------------------|----------|-------------------------------------|----------|---|
| <input type="text" value="\$22.50"/> | X | <input type="text" value="1.1816"/> | = | <input type="text" value="\$26.59 (26.586)"/> |
| Employee Wage | | Taxes & Workers' Comp | | Cost to You (always round <u>up</u>) |

It will cost Jane \$26.59 per hour to pay her employee a wage of \$22.50 per hour. Jane determines how this will impact her budget.

Below is a burden break down for your reference:

| No Relationship with Employer | | Spouse, Parent or Child (Under 21) of the Employer | |
|-------------------------------|---------------|--|--------------|
| Social Security | 6.20% | Social Security | 0% |
| Medicare | 1.45% | Medicare | 0% |
| Federal Unemployment | 1.8% | Federal Unemployment | 0% |
| State Unemployment | 3.62% | State Unemployment | 0% |
| Employment Training Tax | .1% | Employment Training Tax | 0% |
| Workers Compensation | 4.99% | Workers Compensation | 4.99% |
| Total | 18.16% | Total | 4.99% |



California Veteran Directed Care Goods and Service Provider (GSP) Payment Request Form

| | |
|-------------------------------------|------------------------------|
| Veteran Name | Acumen ID # |
| Employer Name (if different) | Month/Year of Invoice |

☐ **Employer Reimbursement** ☐ **Direct to Vendor Payment**

Check or Direct Deposit Payment Instructions

| | |
|--|------------------------------------|
| Make Payment To (Vendor/Employer Name): | |
| Vendor/Employer Address | |
| Vendor/Employer City/State/Zip | Vendor/Employer FEIN or SS# |
| If online purchase ship to Name: | Address: |

| Invoice/ Service Date | Spending Plan Description | Description of Service (e.g. Incontinence supplies, Adult Day Service, Home modifications, etc | Total Amount |
|-----------------------|---------------------------|--|--------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | Total Check Amount | |

By signing this form, I attest that services were delivered and received consistent with the Veteran Spending Plan and I have rendered and/or approved this payment request in accordance with the Program regulations. I understand that payment and satisfaction of this claim may be from Federal and State funds, and that I may be prosecuted under applicable Federal or State laws for any false claims, statements or documents or concealment of a material fact. Any misuse of funds may result in being fined or penalized, including but not limited to my repayment of claim.

Veteran or Representative's Signature

Date

Case Manager Signature

Date

This form should be completed and submitted by your Case Manager. To begin the Vendor Payment or Employer Reimbursement process, reach out to your assigned Case Manager.

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

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

OMB No. 1545-0748

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

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

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

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

For IRS use:

Part 1: Why you're filing this form.

(Check one)

- ☒ You want to **appoint** an agent for tax reporting, depositing, and paying.
- ☐ You want to **revoke** an existing appointment.

Part 2: Employer or Payer Information: Complete this part if you want to appoint an agent or revoke an appointment.**1 Employer identification number (EIN)**

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

2 Employer's or payer's name
(not your trade name)**EMPLOYER'S FIRST AND LAST NAME****3 Trade name** (if any)**EMPLOYER'S PHYSICAL STREET ADDRESS****4 Address**

| | | | |
|--------|--|--------|----------------------|
| Number | | Street | Suite or room number |
|--------|--|--------|----------------------|

EMPLOYER'S PHYSICAL CITY**STATE****ZIP CODE**

| | | |
|----------------------|-------------------------|---------------------|
| 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) | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Form 941, Employer's QUARTERLY Federal Tax Return (all 941 series) | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Form 943, Employer's Annual Federal Tax Return for Agricultural Employees (all 943 series) | <input type="checkbox"/> | <input type="checkbox"/> |
| Form 944, Employer's ANNUAL Federal Tax Return (all 944 series) | <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 can't appoint an agent to report, deposit, and pay tax reported on Form 940, unless you're a home care service recipient.

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

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

X Sign your
name here

EMPLOYER'S SIGNATURE

Print your name here

EMPLOYERS FULL NAME

Print your title here

HCSR EMPLOYER

Date

CURRENT DATE

Best daytime phone

ER'S PHONE #**Now give this form to the agent to complete.**

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
EMPLOYER'S FIRST AND LAST NAME

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)
5416 E BASELINE RD STE 200

5a Street address (if different) (Don't enter a P.O. box.)
EMPLOYER'S PHYSICAL STREET ADDRESS

4b City, state, and ZIP code (if foreign, see instructions)
MESA, AZ 85206-4704

5b City, state, and ZIP code (if foreign, see instructions)
EMPLOYER'S PHYSICAL CITY, STATE AND ZIP CODE

6 County and state where principal business is located
EMPLOYER'S PHYSICAL COUNTY AND STATE

7a Name of responsible party
EMPLOYER'S FIRST AND LAST NAME

7b SSN, ITIN, or EIN
EMPLOYER'S SOCIAL SECURITY NUMBER

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 EMPLOYER**

☐ Estate (SSN of decedent)

☐ Plan administrator (TIN)

☐ Trust (TIN of grantor)

☐ Military/National Guard

☐ Farmers' cooperative

☐ REMIC

☐ State/local government

☐ Federal government

☐ Indian tribal governments/enterprises

Group Exemption Number (GEN) if any

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

State

Foreign country

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

☐ Started new business (specify type)

☐ Hired employees (Check the box and see line 13.)

☐ Compliance with IRS withholding regulations

☒ Other (specify) **HCSR EMPLOYER**

☐ Banking purpose (specify purpose)

☐ Changed type of organization (specify new type)

☐ Purchased going business

☐ Created a trust (specify type)

☐ Created a pension plan (specify type)

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

12 Closing month of accounting year **DECEMBER**

14 Reserved for future use

13 Highest number of employees expected in the next 12 months (enter -0- if none).

Agricultural

Household
0

Other

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

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

☐ Construction

☐ Rental & leasing

☐ Transportation & warehousing

☐ Real estate

☐ Manufacturing

☐ Finance & insurance

☒ Other (specify) **HCSR EMPLOYER**

☐ Health care & social assistance

☐ Accommodation & food service

☐ Wholesale-agent/broker

☐ Wholesale-other

☐ Retail

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

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
JARED ENDERS, SUNNY HUDSON

Designee's telephone number (include area code)
(623) 792-6100

Address and ZIP code
5416 E BASELINE RD STE 200, MESA, AZ 85206-4704

Designee's fax number (include area code)
(480) 371-2241

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

Name and title (type or print clearly) **EMPLOYER'S NAME** **HCSR EMPLOYER**

Signature **EMPLOYER'S SIGNATURE** Date **CURRENT DATE**

Applicant's telephone number (include area code) **EMPLOYER'S PHONE NUMBER**

Applicant's fax number (include area code) **EMPLOYER'S FAX NUMBER**

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 16055N Form **SS-4** (Rev. 12-2023)

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 EMPLOYER'S NAME EMPLOYERS PHYSICAL ADDRESS EMPLOYER'S CITY, STATE AND ZIP CODE | Taxpayer identification number(s) Daytime telephone number EMPLOYER'S PHONE # |
|--|--|

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 Check if to be sent copies of notices and communications <input checked="" type="checkbox"/> | CAF No. _____ PTIN _____ Telephone No. _____ Fax No. _____ Check if new: Address <input type="checkbox"/> Telephone No. <input type="checkbox"/> Fax No. <input type="checkbox"/> |
| Name and address Check if to be sent copies of notices and communications <input type="checkbox"/> | CAF No. _____ PTIN _____ Telephone No. _____ Fax No. _____ 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 TAXES | 940 AND 941 | Q1 2025 THRU Q4 2027 | NOT APPLICABLE |
| EMPLOYMENT TAXES | W2 AND W3 | 2025 THRU 2027 | NOT APPLICABLE |
| INCOME TAXES | 1099 | 2025 THRU 2027 | NOT APPLICABLE |

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.

Employer's Signature

Signature

CURRENT DATE

Date

EMPLOYER'S NAME

Print Name

HCSR EMPLOYER

Title (if applicable)