PALCO

PO Box 242930
Little Rock, AR 72223
Toll Free 866.710.0456
Online: PalcoFirst.com

Employer Enrollment Packet

Thank you for choosing Palco to direct your care. This packet contains all the forms you need to enroll as an employer in self-direction and begin paying your worker. Please make sure to follow all directions in this packet.

You must complete and return:

- ☐ Participant Referral & Intake Form
- ☐ Designation of Surrogate Employer (optional)
- ☐ Authorized User Designation (optional)
- ☐ Employer Responsibilities & Attestation
- ☐ Authorization Agreement
- ☐ NUCS-4556
- ☐ IRS Form SS-4
- ☐ IRS Form 2678
- ☐ IRS Form 8821

Failure to return these forms will delay enrollment. We encourage you to use the checklist above as a final review before you return the forms to Palco. The other documents, including information on how to complete forms and timesheets, the payment schedule, Palco's Notice of Privacy Practices, and similar instructional forms, are for informational purposes only and do not need to be sent back to Palco. Send completed paper forms by fax, email or mail to Palco at the address below.

Fax: 501-821-0045
Email: enrollment@palcofirst.com
Palco, Inc.
Attn: Enrollment
P.O. Box 242930
Little Rock, AR 72223

Should you need any assistance during this process, please contact a friendly customer support representative at 1.866.710.0456 or at info@palcofirst.com. Visit our website at www.palcofirst.com for more information on forms and frequently asked questions.

We look forward to serving you!

Sincerely,
The Palco Team

Notice of Privacy Practices

Palco may receive and create records concerning your medical and individually identifiable information ("PHI") and is required to maintain the privacy and security of your PHI. Please read this notice carefully. If you have questions or concerns, contact the Palco Privacy Officer at privacy@palcofirst.com. Palco will only use and disclose your information as allowed by law and as described below:

- **Help manage the health care treatment you receive.** We may disclose your information to provide treatment and administer services, including performing assessments, issuing workers' compensation and administering similar programs, and recommending services in some situations. We may disclose information to others who implement your health services. We may correspond with you and/or your designated representative (e.g., surrogate employer or authorized user). All emailed correspondence from Palco is encrypted and secure. By emailing Palco with your personal email account, you accept the risk that your correspondence may not be encrypted, nor secure.
- **Run our business, including payment for and administration of your health services.** We may use and disclose your information to receive and issue payment on your behalf and bill Medicaid, Medicare, Managed Care Organizations, the Veterans Administration, or other bodies, as required by your program.
- **Comply with federal and state law, including investigations by the United States Department of Health and Human Services (U.S. DHHS) and law enforcement.** Palco is required by law to comply with investigations by regulatory bodies and issues involving national security. Palco may be required to disclose your information to coroners and other officials at your death.
- **Respond to legal actions and health oversight, such as lawsuits or quality assurance reviews.** Palco may be required to respond to requests, including discovery, subpoenas, audits, and other legal or regulatory matters.

You have the right to:

- **Authorize the use and disclosure of your PHI for reasons not authorized by federal or state law.** Palco will seek your approval to disclose PHI for reasons not required at law, and you may reject disclosure.
- **Receive this notice of privacy practices**. You can request a copy of this notice or view the posting at palcofirst.com, in enrollment packets, and in program manuals, as applicable. Palco can change the terms of this notice at any time. Changes will apply to all of your medical records. Direct complaints to the Privacy Officer or the U.S. DHHS.
- **Review and receive copies of your records and a list of disclosures.** Requests must be on a Request for Sensitive Records. We will provide you with a copy or summary within 10 days of receiving your request. We may charge a reasonable, cost-based fee for collection of the records, including postage and labor. Palco may reject some requests if required by law.
- **Request amendments to your records.** Requests must be on a Request to Amend Sensitive Information. We will provide you with a copy or summary or a rejection within 15 days of receiving your request.
- **Request information in an alternate format or restrict access on your records**. Requests must be in writing on a Request for Additional Privacy. We will provide you with a copy or summary within 15 days of receiving your request. We may reject or terminate the request in certain limited cases and will notify you of rejections and terminations.
- **Be notified in case of a breach of your sensitive information.** You will be notified within 60 days by the Privacy Officer.
- **Choose someone to act on your behalf with regard to your records.** You must complete the appropriate forms and information to designate Authorized Users in order for those individuals to communicate with Palco on your behalf.

PALCO SEMI-MONTHLY PAYMENT SCHEDULE - 2024

Nevada Veterans-Directed HCBS Program

Service Period		Timesheets Due to Palco By 12 PM	Payment Date
Start Date	**End Date**	**Deadline**	**Paid On**
December 16, 2023	December 31, 2023	January 2, 2024	January 8, 2024
January 1, 2024	January 15, 2024	January 17, 2024	January 23, 2024
January 16, 2024	January 31, 2024	February 2, 2024	February 8, 2024
February 1, 2024	February 15, 2024	February 17, 2024	February 23, 2024
February 16, 2024	February 29, 2024	March 1, 2024	March 8, 2024
March 1, 2024	March 15, 2024	March 17, 2024	March 25, 2024
March 16, 2024	March 31, 2024	April 2, 2024	April 8, 2024
April 1, 2024	April 15, 2024	April 17, 2024	April 23, 2024
April 16, 2024	April 30, 2024	May 2, 2024	May 8, 2024
May 1, 2024	May 15, 2024	May 17, 2024	May 23, 2024
May 16, 2024	May 31, 2024	June 2, 2024	June 10 2024
June 1, 2024	June 15, 2024	June 17, 2024	June 24, 2024
June 16, 2024	June 30, 2024	July 2, 2024	July 8, 2024
July 1, 2024	July 15, 2024	July 17, 2024	July 23, 2024
July 16, 2024	July 31, 2024	August 2, 2024	August 8, 2024
August 1, 2024	August 15, 2024	August 17, 2024	August 23, 2024
August 16, 2024	August 31, 2024	September 2, 2024	September 9, 2024
September 1, 2024	September 15, 2024	September 17, 2024	September 23, 2024
September 16, 2024	September 30, 2024	October 2, 2024	October 8, 2024
October 1, 2024	October 15, 2024	October 17, 2024	October 23, 2024
October 16, 2024	October 31, 2024	November 2, 2024	November 8, 2024
November 1, 2024	November 15, 2024	November 17, 2024	November 25, 2024
November 16, 2024	November 30, 2024	December 2, 2024	December 9, 2024
December 1, 2024	December 15, 2024	December 17, 2024	December 23, 2024
December 16, 2024	December 31, 2024	January 2, 2025	January 8, 2025

Late time submissions and mistakes may result in late payment!

2024 Bank & Palco Office Holidays

New Year's Day - Monday, January 1*
Martin Luther King, Jr. Day - Monday, January 15
President's Day - Monday, February 19
Memorial Day - Monday, May 27*
Juneteenth Day – Wednesday, June 19
Independence Day - Thursday, July 4*
Labor Day - Monday, September 2*
Columbus Day - Monday, October 14
Veterans Day - Monday, November 11
Thanksgiving - Thursday-Friday, November 28-29*
Christmas - Tuesday-Wednesday, December 24-25*

*** Palco Office Closures**

EN-280019-MPS-1.0

Instructions for Employer Forms

Please use the instructions below to complete the attached Palco forms in order to become an employer through the self-directed program.

- The **Participant Referral and Intake** is used to enroll the participant in the program and establish the employer of record. Complete the entire form. Sign and date the highlighted fields on page 2.

- The **Designation of Surrogate Employer** is used to establish a surrogate Employer of Record on behalf of the participant. Complete the entire form. Sign and date the highlighted fields on page 2. *This form is optional and applicable only when the participant is not the employer.*

- The **Authorized User Designation** allows Palco to use or disclose the participant's health information only to the appointed individual listed on the form. Complete the entire form. Sign and date the highlighted fields on page 2. *This form is applicable if the family would like to appoint someone other than the surrogate employer to speak with Palco about the child's protected health information and other program-related activities.*

- The **Employer Responsibilities & Attestation** outlines the responsibilities of the employer. Complete, sign, and date the four highlighted fields at the bottom of the page.

- The **Authorization Agreement** outlines Palco's responsibilities as the fiscal/employer-agent and authorizes Palco to ensure compliance with the IRS and other federal and state tax authorities on the employer's behalf. Complete, sign, and date the four highlighted fields at the bottom of the page.

- The **NUCS 4556** gives Palco the authority to provide and receive information and to perform any and all acts that Palco can perform on your behalf as the employer with respect to any Nevada unemployment compensation matters. Complete, sign and date the highlighted fields on the page.

*If the employer has already been setup with their state for State Unemployment Tax Act (SUTA), then a separate document must be provided with log-in credentials (including account number, current rate, user ID password, security questions, etc.) and state ID.

PALCO
PO Box 242930
Little Rock, AR 72223
Toll Free 866.710.0456
Online: PalcoFirst.com

Participant Referral & Intake

Complete this form entirely to enroll the participant, provide important information to continue the enrollment process, and establish the employer of record.

PARTICIPANT INFORMATION			
First Name	Middle Name		Last Name
Social Security Number	Email		Date of Birth (mm/dd/yyyy)
Program NV VDHCBS			Gender ☐ Male ☐ Female
Physical Address (Street Address, Including Apt. #)			
City	State	Zip	County
Mailing Address (Street Address, Including Apt. #) – *if different than the physical address*			
City	State	Zip	County
Phone1	Phone2		Preferred Method of Communication ☐ Email ☐Mail ☐ Phone / Voicemail

By participating in the self-directed model, the participant or someone over the age of 18 who the participant elects (the "surrogate") will recruit, hire, train, and terminate workers who provide support to the participant. This includes overseeing worker tasks and schedules, completing enrollment forms, and submitting timesheets. This responsibility is known as the employer of record. Who will serve as the employer of record? (Select one.)

☐ A surrogate individual. **Please complete a Designation of Surrogate Employer Form.**

☐ The participant.

The participant has provided an email address that belongs to him/her and understands that Palco is not responsible for providing information to an incorrect email address supplied by him/her. The participant has read and agrees to Palco's Notice of Privacy Practices and the Terms and Conditions of Palco's enrollment system and agrees to receive information, notifications, and other correspondence electronically to the email address provided in this document. Such correspondence may contain Personal Health Information as defined at 45 CFR 160.103 and other personally identifiable information. The participant accepts all risks associated with the transmission of such information via those channels. The participant understands that his or her consent is in effect until Palco is notified in writing that the participant withdraws such consent.

PO Box 242930
Little Rock, AR 72223
Toll Free 866.710.0456
Online: PalcoFirst.com

Participant Printed Name

Participant Signature

Date

If the participant is unable to sign, please witness:

Witness Printed Name

Witness Signature

Date

Designation of Surrogate Employer

☐ Check this box if this form is being used to change the Employer of Record on an existing participant's account. Effective date of change: ____/_____/______. This change will be effective starting the next scheduled service period after paperwork is processed.

PARTICIPANT INFORMATION		
Full Name	ID / Last 4 of SSN	Program NV VDHCBS

The employer of record must recruit, hire, train, supervise, and terminate workers who provide support to the participant. This includes overseeing worker tasks and schedules, completing enrollment forms, and submitting timesheets. The employer of record functioning, must be over the age of 18, demonstrate a strong commitment to the participant, display knowledge about and respect for the participant's preferences, and use sound judgment to act on the participant's behalf.

EMPLOYER INFORMATION			
First Name	Middle Name	Last Name	
Social Security Number	Email	Date of Birth (mm/dd/yyyy)	
Relationship to Participant ☐ Parent ☐ Spouse ☐ Child ☐ Legal Guardian ☐ Power of Attorney ☐ Other Non-relative ☐ Other: ________________________________		Gender ☐ Male ☐ Female	
Physical Address (Street Address, Including Apt. #)			
City	State	Zip	County
Mailing Address (Street Address, Including Apt. #) – *if different than the physical address*			
City	State	Zip	County
Phone1	Phone2	Preferred Method of Communication ☐ Email ☐ Mail ☐ Phone / Voicemail	

The employer does not receive monetary compensation for directing care on the participant's behalf in the course of the self-directed program. Employers cannot provide direct support services to the participant. Employees must have no convictions involving exploitation, abuse, or assault on another person and must be fully capable of the responsibilities associated with managing support staff and handling financial aspects of the self-directed program, including proper utilization of the budget and verifying the accuracy of reports provided by Palco.

By completing this form and signing below, all parties agree that the individual named herein shall accept the responsibilities of the employer of record. The employer consents to complete enrollment electronically and has provided an email address and Social Security Number that belongs to him and her. The employer understands that Palco is not responsible for providing information to an incorrect email address supplied by him or her. The employer has read and agrees to Palco's Notice of Privacy Practices and the Terms and Conditions of Palco's online enrollment system and agrees to receive information, notifications, and other correspondence electronically to the email address provided in this document. Such correspondence may contain Personal Health Information as defined at 45 CFR 160.103 and other personally identifiable information. The employer accepts all risks associated with the transmission of such information via those channels. The employer understands that his or her consent is in effect until Palco is notified in writing that the employer withdraws such consent.

____
Employer Printed Name

____
Employer Signature

____
Date

____
Participant Printed Name

____
Participant Signature

____
Date

If the participant is unable to sign, please witness:

____
Witness Printed Name

____
Witness Signature

____
Date

Please return this form to Palco
via email: enrollment@palcofirst.com
or via fax to 1.877.859.8757.

PALCO

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Little Rock, AR 72223
Toll Free 866.710.0456
Online: PalcoFirst.com

Authorized User Designation

PARTICIPANT INFORMATION		
Full Name	ID/Last 4 of SSN	Program/Plan

I voluntarily consent and authorize Palco, Inc. to use or disclose my health information itemized below during the term, to the recipient, and for the purposes identified herein.

AUTHORIZED USER INFORMATION			
First Name	Middle Name	Last Name	
Social Security Number	Date of Birth (mm/dd/yyyy)	Gender Male ☐ Female ☐	
Physical Address (Street Address, Including Apt. #)			
City	State	Zip	County
Mailing Address (Street Address, Including Apt. #) – *if different than the physical address*			
City	State	Zip	County
Phone1	Phone2	Email	
Preferred Method of Communication ☐ Email ☐ Mail ☐ Phone / Voicemail			
Relationship to Participant:	Reason for Disclosure:		
Term of Disclosure (if applicable): Start date of this Authorization: __ __/__ __/__ __ __ __ End date of this Authorization: __ __/__ __/__ __ __ __ *If no end date, leave blank*			
Information to be Disclosed: *(please select one)* ☐ All of my health information that Palco has in its possession, including information relating to any medical history, mental, or physical condition and any treatment received by me. ☐ Only the following limited information: __________ __________			

PALCO

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The participant understands that Palco cannot guarantee that the recipient will not re-disclose his/her health information to a third party who may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of the participant's information and that disclosure may render the Privacy Rule inapplicable to his/her information. The participant holds Palco harmless for any harm resulting to him/her from disclosure of this information. The participant understands that he/she may revoke this authorization at any time in writing to Palco. The revocation will be effective immediately to all disclosures made after receipt of the revocation.

____
Participant Printed Name

____
Participant Signature

____
Date

If the participant is unable to sign, please witness:

____
Witness Printed Name

____
Witness Signature

____
Date

Please return this form to Palco via email: enrollment@palcofirst.com **or via fax to 1.877.859.8757.**

For Palco Privacy Officer Use Only:	*Date:*	*Reason/Action:*
☐ Authorization revoked		

PALCO

Employer Responsibilities & Attestation

As the employer of record, I understand that I am the sole employer for all support workers providing services to the participant. The employer controls the training and management, evaluation, scheduling, and termination of the worker. The worker is not employed or retained by Palco, program/state administrators, or any other state or federal governmental agency. The worker is not an independent contractor.

As the employer, I must adhere to all federal, state, local, program, and employment-related (including all Department of Labor, United States Citizenship and Immigration Services, Internal Revenue Service, and state law and unemployment agency) laws, regulations, and requirements, as well as program rules and policy. This includes providing necessary training and orientation to workers, reporting critical incidents, and reporting suspected fraud, waste, abuse, neglect, or exploitation.

The employer must assume responsibility for managing the risk and liability of any incidence(s) of work-related injuries or illnesses and for any negligent acts or omissions in the work place. Neither Palco, nor program/state administrators, are responsible or liable for any negligent acts, work-related injuries, or omissions by the employer, participant, worker, service providers, or other authorized parties.

Funds to pay for services provided by the worker are from public sources, and financial accountability and liability applies to the use of the funds. Both the employer and worker have individual and joint responsibilities to be accountable for the funds spent through the program and understand that submitting false or fraudulent timesheets or submitting requests for payment of goods or services provided, other than those approved on the authorized service budget, will be reported to the appropriate authorities for investigation and possible prosecution as fraud. In the case of insufficient funds to cover program expenses, as the employer, you are responsible for payment to the worker or service provider under state and federal laws. The employer must maintain accurate records and provide such records to authorized parties as requested, as well as adhere to all program rules and regulations, including Palco's Privacy Policies.

By signing below, I attest that I have read, understand, agree and attest to the above and have directed my worker accordingly.

______________________________ ______________________________

Printed Employer Name **ID# / Last Four of SSN**

______________________________ ______________________________

Employer Signature **Date**

Employer Authorization Agreement

As the employer of record, I understand that I have certain responsibilities, such as filing and paying employment taxes for my workers and other employment-related responsibilities falling under Internal Revenue Service (IRS) guidance, Department of Labor (DOL), and agency/programmatic guidelines and regulations. Palco, Inc. will act as my agent in a limited scope and on my behalf for only the tasks related to this program and as listed below, notwithstanding approval by the IRS or other state agencies.

- To perform all duties as the Fiscal/Employer Agent as required by contract, policy regulation, federal and state statues, and other applicable rules and regulations.
- To obtain a Federal Employer Identification Number (FEIN), file IRS Form 2678 to represent me for program-related and employer-related tax purposes, file tax reports, and correspond with the IRS regarding FEINs or employer tax information.
- To establish and register me as an employer in the state in which business is conducted.
- To be my agent for the limited purposes of state and/or local income tax withholding and state unemployment tax purposes, including applying for state and/or local income tax withholding and state unemployment identification number(s), establishing online account(s) to file and pay taxes on my behalf, and receiving correspondence related to my program-related state and/or local income tax withholding and state unemployment tax account(s).
- To receive confidential information about me and receive and disburse public funds, as directed by me, the program, and the budget and/or spending plan.
- To apply for and establish workers' compensation policies and accounts, pay workers' compensation premiums, and comply with annual audit requirements, when permissible by state law and program policies.
- To provide limited information on my behalf with regards to benefits, appeals, and as required by law to fulfill tax, labor, and other disputes.
- To complete federal and state tax and labor forms as required and as related to the employer duties enumerated above.

This Authorization revokes all earlier authorizations and powers of attorney on file and shall remain in full force and effect until revoked by either party in writing. By signing below, I hereby authorize Palco, Inc. to act on my behalf for the items listed herein and attest that I understand these responsibilities and agree to the terms of this Employer Authorization Agreement.

______________________________	______________________________
Printed Employer Name	**ID# / Last Four of SSN**
______________________________	______________________________
Employer Signature	**Date**

EMPLOYER: You must complete this form if anyone other than yourself will be acting on your behalf.

State of Nevada
Department of Employment, Training & Rehabilitation
Employment Security Division, Contributions Section
500 East Third Street, Carson City, NV 89713-0030
Telephone (775) 684-6310
https://uitax.nvdetr.org

POWER OF ATTORNEY

Employer Account Number ______________________ **Federal ID Number** ______________

Owner Name ______________________

Doing Business As ______________________

Address ______________________

Telephone Number (____) ______________________ **Fax** (____) ______________

The following agent is authorized to provide and receive information and to perform any and all acts that I can perform as the employer/taxpayer with respect to any Nevada unemployment compensation matters. In order to access employer account information online, the FEIN of the authorized agent is required. **Begin Authority As Of:** ______________

Authorized Agent Palco, Inc. **Federal ID Number** 05-0578399

Address PO Box 242930, Little Rock, AR 72223

Telephone Number (866) 710-0457 **Fax** (501) 821-0045

This Power of Attorney Authorizes the Above Agent to:

1. Sign for and file quarterly state unemployment insurance tax forms by mail, magnetic media, or electronic filing.
2. Provide, receive, and discuss information, including but not limited to, experience rates, adjustments to your employer account, reimbursement in lieu of contributions, and employer's protest of benefit claims.

Mail Notices to:

TAX NOTICES: (This includes the Employer's Quarterly Contribution and Wage Reports AND Tax Rate Statements)
Send To: (Choose ONE) ☐ Employer/taxpayer address **OR** ☑ Authorized agent named above

BENEFITS NOTICES: (This includes claim notices of former employees AND Benefits Charge Statements)
Send To: (Choose ONE) ☐ Employer/taxpayer address **OR** ☑ Authorized agent named above

Signature of Employer/Taxpayer

I hereby certify that the Nevada Department of Employment, Training and Rehabilitation, Employment Security Division, Contributions Section is authorized to release to the above named authorized agent any and all information in their files with respect to any unemployment compensation matters. I relieve the Department and their representatives of any liability related to release of such information to the above named authorized agent. I understand that this authorization does not absolve me, as the employer/taxpayer, of the responsibility to ensure that all tax returns are filed and all taxes paid on time. Any authorization granted remains in effect until revoked, in writing, by the taxpayer or reporting agent.

The person signing must have actual legal authority to bind the business. Persons may include officer of a corporation, partner, managing member, owner, Chief Financial Officer, Chief Executive Officer, or a fiduciary of a trust or estate.

I certify I have the authority to execute this form and authorize disclosure of otherwise confidential information on behalf of the employer.

Signature (Required) ______________________

Title (Required) HCSR Household Employer Date (Required) ______________

Employer IRS Forms Instructions

Please complete the attached IRS forms to become an employer through the self-directed program. Use the instructions and checklist below to guide you through this process. All areas highlighted in yellow on the forms must be signed.

- **IRS Form SS-4** gives Palco the ability to file for a FEIN (Federal Employer Identification Number) with the IRS on your behalf. This is required of all employers in the United States.

  - ☐ Print your full name on Line 1.
  - ☐ List your county and state on Line 6.
  - ☐ Print your full name on Line 7a.
  - ☐ Print your Social Security Number (SSN) on Line 7b.
    - *This must match the SSN on your official Social Security Card.*
    - *If you already have a FEIN under your SSN, print your FEIN on Line 7b, instead of your SSN, <u>send Palco a copy FEIN assignment letter from the IRS.</u>*
  - ☐ Print your name, sign and date at the bottom of the form.

  If you already have an FEIN under your SSN, please send Palco a copy FEIN assignment letter from the IRS.

- **IRS Form 2678** appoints Palco as your agent only for the limited purposes of payment employment payroll taxes for the participant's worker.

  - ☐ Print your full name on Line 2.
  - ☐ Print your address in the appropriate spaces on Line 4. Be sure to complete all three rows as applicable.
  - ☐ Print your name, sign, and date at the bottom of the form.

- **IRS Form 8821** allows Palco to correspond with the IRS on your behalf for the limited purpose of the self-directed program.

  - ☐ Print your full name and address in the appropriate space in Box 1.
  - ☐ Print your name, sign, and date at the bottom of the form.

Form **SS-4**
(Rev. December 2019)
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.)

▶ Go to *www.irs.gov/FormSS4* for instructions and the latest information.

▶ See separate instructions for each line. ▶ Keep a copy for your records.

OMB No. 1545-0003

EIN

Type or print clearly.

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

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

3 Executor, administrator, trustee, "care of" name
Palco, Inc. as 3504 Fiscal Employer Agent

4a Mailing address (room, apt., suite no. and street, or P.O. box)
PO Box 242930

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

4b City, state, and ZIP code (if foreign, see instructions)
Little Rock, AR 72223

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) ▶ **Household Employer (HCSR)**
- ☐ 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) ▶ **Household Employer (HCSR)**
- ☐ Banking purpose (specify purpose) ▶ ______
- ☐ Changed type of organization (specify new type) ▶ ______
- ☐ Purchased going business
- Created a trust (specify type) ▶ ______
- ☐ Created a pension plan (specify type) ▶ ______

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

12 Closing month of accounting year

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 generally will be $1,000 or less if you expect to pay $5,000 or less in total wages.) If you don't chec 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.

- ☐ Health care & social assistance
- ☐ Wholesale-agent/broker
- ☐ Construction
- ☐ Rental & leasing
- ☐ Transportation & warehousing
- ☐ Accommodation & food service
- ☐ Wholesale-other
- ☐ Retail
- ☐ Real estate
- ☐ Manufacturing
- ☐ Finance & insurance
- ☒ Other (specify) ▶ **Household Employer (HCSR)**

17 Indicate principal line of merchndise 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
Alicia Paladino

Designee's telephone number (include area code)
(501)604.9936

Address and ZIP code
PO Box 242930, Little Rock, AR 72223

Designee's fax number (include area code)
(501) 821.0045

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

Applicant's telephone number (include area code)

Name and title (type or print clearly) ▶

Applicant's fax number (include area code)

Signature ▶ Date ▶

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

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

OMB No. 1545-0748

For IRS use:

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

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

  Note. This appointment is not effective until we approve your request. See the instructions for filing Form 2678 on page 3.

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

Part 1: Why you are filing this form...

(Check one)

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

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

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

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

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

3 Trade name (if any)

4 Address PO BOX 242930

Number Street Suite or room number

LITTLE ROCK | AR | 72223

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, 940-PR (Employer's Annual Federal Unemployment (FUTA) Tax Return)*	☑	☐
Form 941, 941-PR, 941-SS (Employer's QUARTERLY Federal Tax Return)	☑	☐
Form 943, 943-PR (Employer's Annual Federal Tax Return for Agricultural Employees)	☐	☐
Form 944, 944(SP) (Employer's ANNUAL Federal Tax Return)	☐	☐
Form 945 (Annual Return of Withheld Federal Income Tax)	☐	☐
Form CT-1 (Employer's Annual Railroad Retirement Tax Return)	☐	☐
Form CT-2 (Employee Representative's Quarterly Railroad Tax Return)	☐	☐

*Generally you cannot appoint an agent to report, deposit, and pay tax reported on Form 940, Employer's Annual Federal Unemployment (FUTA) Tax Return, unless you are a home care service recipient.

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

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

✗ **Sign your name here**

Date / /

Print your name here

Print your title here HCSR Household Employer

Best daytime phone 501-604-9936

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 (501) 604.9936

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
Palco
Alicia Paladino
PO Box 242930
Little Rock, AR 72223

CAF No. 5005-46467R
PTIN P000142099
Telephone No. (501) 604.9936
Fax No. (501) 821.0045

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	SS-4, 2678, 8821		
Employment	W-4, W-5		
Employment	940, 941, W-2,W-3		

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

Print Name | Household Employer (HCSR)
Title (if applicable)