Premier
FINANCIAL MANAGEMENT SERVICES
Part of the AssuranceSD family

CADDO VETERAN DIRECTED HCBS
LOUISIANA
VETERAN PAPERWORK CHECKLIST

DOCUMENT NAME	REQUIRED / OPTIONAL
Authorized Representative Form	Required
Form SS-4: Application for Employer Identification Number	Required
Form 2678: Employer/Payer Appointment of Agent	Required
Form 8821: Tax Information Authorization	Required
CADDO VDHCBS Employer of Record Form	Required
Employer Authorization of Designated Representative/Power of Attorney	Required
Form R-7006: Power of Attorney & Declaration of Representative	Required
Background Check Disclosure	Required

NOTE:

Please ensure all REQUIRED documents are filled out accurately before submitting them for processing.

Premier
Financial Management Services

CADDO VDHCBS AUTHORIZED REPRESENTATIVE FORM

Instructions: *Please fill out any information in Sections 1 and 2, where applicable. Veterans are required to sign and date at the bottom of the form. If a Veteran has an Authorized Representative, the AR must also sign and date the form. Please submit the completed form to* ***Premier Financial Management Services*** *(Premier FMS) via one of the following options:*

Mail:
10425 W North Ave.
Suite 345
Milwaukee, WI 53226

Email:
PremierEnrollment@Premier-FMS.com

VETERAN'S INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Email Address: _____ Gender:

Date of Birth: ____/____/_____ Social Security Number: _____-_____-_____

AUTHORIZED REPRESENTATIVE'S INFORMATION *(If applicable)*

First Name: _____ Middle Initial: _____ Last Name: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Email Address: _____

Date of Birth: ____/____/_____ Social Security Number: _____-_____-_____

By signing below, you certify that the information on this form is accurate and that you have all supporting documentation that may be needed to verify your selection. For any questions or concerns, please contact our office at (855) 387-1377.

Veteran Signature: _____ Date: ____/____/_____

Authorized Representative Signature: _____ Date: ____/____/_____

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

Application for Employer Identification Number

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

OMB No. 1545-0003

EIN

Type or print clearly.

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

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

3 Executor, administrator, trustee, "care of" name
Premier Financial Management Services

4a Mailing address (room, apt., suite no. and street, or P.O. box)
10425 W North Ave 345

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

4b City, state, and ZIP code (if foreign, see instructions)
Milwaukee, WI 53226

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

Group Exemption Number (GEN) if any

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

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

- ☐ Started new business (specify type)
- ☐ Hired employees (Check the box and see line 13.)
- ☐ Compliance with IRS withholding regulations
- ☑ Other (specify) HHCSR
- ☐ 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	Other
0	0	0

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) HHCSR

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

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
Jonathan Claflin

Designee's telephone number (include area code)
855-275-3948

Address and ZIP code
10425 W North Ave. Ste 345 Milwaukee, WI 53226

Designee's fax number (include area code)
855-71-1731

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

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.

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

(Rev. August 2014) 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 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.

For IRS use:

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

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, 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.

X Sign your name here

Date / /

Print your name here

Print your title here HHCSR

Best daytime phone

Now give this form to the agent to complete.

Form **8821**

(Rev. January 2021)

Department of the Treasury
Internal Revenue Service

Tax Information Authorization

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

OMB No. 1545-1165

For IRS Use Only
Received by:
Name
Telephone
Function
Date

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

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

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

Name and address	
PremierFMS: Jonathan Claflin **10425 W North Ave Ste 345** **Milwaukee, WI 53226**	CAF No. **0316-07105R** PTIN Telephone No. **(855) 224-5810** Fax No. **(855) 471-1731**
Check if to be sent copies of notices and communications ☐	Check if new: Address ☐ Telephone No. ☐ Fax No. ☐
Name and address	CAF No. **0316-07108R**
PremierFMS: Taja Jackson 10425 W North Ave Ste 345 Milwaukee, WI 53226	PTIN Telephone No. **(855) 224-5810** Fax No. **(855) 471-1731**
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
Income Tax Withholding and Employment Taxes	**940, 940R, 940EZ, 941, 941R, 941X, 941 (c), 843, W-2, W-2(c), W-3, W-3(c), SS4**	**2024-2027**	**Tax Liability**

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

5 Retention/revocation of prior tax information authorizations. If the line 4 box is checked, skip this line. If the line 4 box isn't checked, the IRS will automatically revoke all prior tax information authorizations on file unless you check the line 5 box and **attach a copy** of the tax information authorization(s) that you want to retain . . . . . ► ☐

To revoke a prior tax information authorization(s) without submitting a new authorization, see the line 5 instructions.

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

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

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

Signature | Date

Print Name | Title (if applicable)

Premier
FINANCIAL MANAGEMENT SERVICES
Part of the AssuranceSD family

CADDO VETERAN DIRECTED HCBS
LOUISIANA
EMPLOYER OF RECORD FORM

Veteran Name: _____ Date of Birth: _____ / _____ / _____

Email Address: _____ Gender: _____

EMPLOYER OF RECORD DESIGNATION *(check ONLY one box):*

☐ I designate _____ to serve as my Employer of Record for the Veteran's Directed (VDHCBS) Program.

☐ My legal guardian, _____ (legal guardian), designates _____ to serve as Employer of Record for the Veterans Directed (VDHCBS) Program.

☐ The person granted power of attorney of me, _____ (Power of Attorney), designates: _____ to serve as Employer of Record for the Veteran's Directed (VDHCBS) Program.

EMPLOYER OF RECORD INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Mobile #: _____

Email Address: _____

Relationship to Veteran: _____ Social Security Number: _____ / _____ / _____

EMPLOYER OF RECORD AGREEMENT

I, _____ (full name) agree to serve as the Employer of Record on behalf of _____ who is a participant in the Veteran's Directed (VDHCBS) Program.

Tasks completed in partnership with VDHCBS participants:

1. Find, interview, and hire employees to provide care.
2. Define employees' job duties.
3. Develop a job description for employees.
4. Train employees to deliver care based on the participant's needs and preferences.
5. Set the schedule at which employees will give care.
6. Make sure employees work only as many hours as stated on the Veterans Services Plan.
7. Supervise and evaluate employees' performance.
8. Address problems or concerns with employees' performance.
9. Terminate an employee when needed.
10. Decide how much employees will be paid (within limits set by the State)
11. Review the time employees report to be sure it is correct.
12. Develop a back-up plan to address times that a scheduled employee doesn't report for their shift (the veteran's health and safety must be assured).
13. Activate the back-up plan when needed to be sure the veteran doesn't go without needed care.

By signing below, I affirm that I have read and understood my responsibilities and agree to perform all of the responsibilities of a representative as defined above. I also, affirm that any questions or concerns that I have with the Employer of Record form have been answered to my satisfaction by PremierFMS.

Print Name (Veteran): _____

Veteran Signature: _____ Date: _____ / _____ / _____

Print Name (Legal Guardian/POA, *if applicable*): _____

Legal Guardian/POA Signature (*if applicable*): _____ Date: _____ / _____ / _____

Print Name (Employer of Record): _____

Employer of Record Signature: _____ Date: _____ / _____ / _____

For any questions or concerns, please contact our office at **855.387.1377**. Please submit the completed form to PremierFMS via one of the following options:

Mail
10425 W North Ave
Suite 345
Milwaukee, WI 53226

Email
PremierEnrollment@Premier-FMS.com

REQUIRED ONLY IF VETERAN RESIDES IN LOUISIANA.

Louisiana Workforce Commission
UI Tax Liability and Adjudication
Employer Authorization of Designated Representative/ Power of Attorney
Please Fax completed form to (225) 346-6073

EMPLOYER NAME	STATE UI NO.		FEDERAL ID NO.
DBA NAME			TELEPHONE
ADDRESS	CITY	STATE	ZIP CODE

This written authorization shall serve to notify the Louisiana Workforce Commission that the above named employer hereby appoints and designates the following named individual or entity as its representative. If no agent is designated, all correspondence will be sent to the employer.

☐ **Add agent account**

Agent Name	Contact Person		
Address			
City		State	Zip

This written authorization shall serve to notify the Louisiana Workforce Commission that the above named employer hereby revokes the following named individual or entity as its representative. If no agent is designated above, all correspondence will be sent to the employer.

☐ **Revoke existing employer**

Agent Name	Contact Person		
Address			
City		State	Zip

Employer designated agent to specifically transact any and all business between this named employer and LWC and to do any and all acts necessary in connection with the below matters of the unemployment in the state of Louisiana as follows:

☐ Tax matters (all automated forms and notices)

☐ Benefit matters (all automated forms and notices)

This authorization further authorizes the above named representative to submit the request to LWC for information on behalf of the named employer to the extent to which such employer has a right to access in regard to the designated above matters.

The designated representative agrees to restrict access to any unemployment compensation information provided by LWC to specifically authorize personnel and to instruct such personnel as to the confidentiality of such data. The provided information shall be used and safeguarded by the representative solely for the specific purpose authorized by the agent contact, and shall not be stored for resale. All employees or personnel of the representative shall be subject to the same sanctions and penalties for violation of confidential requirements as would employees of the state agency. The representative agrees to bear all the costs arising from any claims for any unauthorized use of such employer information.

This authorization additionally servers to revoke any prior authorization in regard to the same matters designated above and shall remain in full force and effect until and unless written notice is provided by the above named employer or agent to LWC. This authorization shall be executed in triplicate original one of which shall be retained by the above named employer, one by the representative, and one by LWC and shall become effective within five (5) working days of the date of receipt by LWC.

Signature of Owner/Partner/Corporate Officer	Print or Type Name and Title	Date

Revised 09/14/2016

R-7006 (1/11)

REQUIRED ONLY IF VETERAN RESIDES IN LOUISIANA.

LOUISIANA
DEPARTMENT *of* REVENUE

Power of Attorney and Declaration of Representative

PART I. POWER OF ATTORNEY

Taxpayer(s) must sign and date this form on page 2. **PLEASE TYPE OR PRINT.**

Your Name or Name of Entity	Spouse's Name, if a joint return *(or corporate officer, partner or fiduciary, if a business)*		
Street Address	City	State	ZIP
Social Security/Louisiana or Federal ID Number	Spouse's Social Security Number *(if a joint return)*		

I/we appoint the following representative as my/our true and lawful agent and attorney-in-fact to represent me/us before the Louisiana Department of Revenue. The representative is authorized to receive and inspect confidential information concerning my/our tax matters, and to perform any and all acts that I/we can perform with respect to my/our tax matters, unless noted below. **Modes of communication for requesting and receiving information may include telephone, e-mail, or fax. The authority does not include the power to receive refund checks, the power to substitute another representative, the power to add additional representatives, or the power to execute a request for disclosure of tax returns or return information to a third party.**

Representative must sign and date this form on page 2, Part II.

Name		
Firm Premier Financial Management Services		
Street Address 10425 W North Ave, Ste 345		
City Milwaukee	State WI	ZIP 53226
Telephone Number ( )		
Fax number ( )		
E-mail Address caddo@premier-fms.com		

Acts Authorized. Mark only the boxes that apply. By marking the boxes, you authorize the representative to perform any and all acts on your behalf, including the authority to sign tax returns, with respect only to the indicated tax matters:

Tax Type	Year(s) or Period(s)	Tax Type	Year(s) or Period(s)
☐ Individual income tax		☐ Sales and use tax	
☐ Corporate income/franchise tax		☑ Withholding tax	
☐ Special Fuels tax		☐ Gasoline tax	
☐ Tobacco tax		☐ Other *(Please specify.)*	

DELETIONS. Mark or list any specific deletions to the acts otherwise authorized in this power of attorney.

☐ Sign the return(s) for the above tax matters.

☐ Execute an agreement to suspend prescription of tax.

☐ File a protest to a proposed assessment.

☐ Execute offers in compromise or settlements of tax liability.

☐ Represent the taxpayer before the department in any proceeding, including protest hearings.

☐ Obtain a private letter ruling on behalf of the taxpayer.

☐ Other prohibited acts. *(List prohibited acts.)* _____

NOTICES AND COMMUNICATIONS. Original notices and other written communications will be sent only to you, the taxpayer. Your representative may request and receive information by telephone, e-mail or fax. Upon request, the representative may be provided with a copy of a notice or communication sent to you. If you want the representative to request and receive a copy of notices and communications sent to you, **check this box.** ☑

REVOCATION OF PRIOR POWER(S) OF ATTORNEY. Except for *Power(s) of Attorney and Declaration of Representative(s)* filed on Form R-7006 (1/11), the filing of this Power of Attorney automatically revokes all earlier Power(s) of Attorney on file with the Louisiana Department of Revenue for the same tax matters and years or periods covered by this document.

Signature of Taxpayer(s). If a tax matter concerns a joint return, both husband and wife must sign if joint representation is requested. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, or trustee on behalf of the taxpayer, I certify that I have the authority to execute this form on behalf of the taxpayer.

IF THIS POWER OF ATTORNEY IS NOT SIGNED AND DATED, IT WILL BE RETURNED.

Taxpayer signature _____ Date *(mm/dd/yyyy)* _____

Spouse signature _____ Date *(mm/dd/yyyy)* _____

Signature of duly authorized representative, if the taxpayer is a corporation, partnership, executor or administrator _____ Title _____ Date *(mm/dd/yyyy)* _____

Part II. DECLARATION OF REPRESENTATIVE

Under penalties of perjury, I declare that:

- I am not currently under suspension or disbarment from practice before the Internal Revenue Service.
- I am authorized to represent the taxpayer(s) identified in Part I for the tax matters specified there; and
- I am one of the following: *(insert applicable letter in table below)*

a. Attorney—a member in good standing of the highest court of the jurisdiction shown below.

b. Certified Public Accountant—duly qualified to practice as a certified public accountant in the jurisdiction shown below.

c. Enrolled Agent—a person enrolled to practice before the Internal Revenue Service.

d. Officer—a bona fide officer of the taxpayer organization.

e. Employee—an employee of the taxpayer.

f. Family Member—a member of the taxpayer's immediate family *(state the relationship, i.e., spouse, parent, child, brother, or sister)*.

_____

_____

g. Other *(state the relationship, i.e., bookkeeper or friend)* Fiscal Employer Agent

h. Former Louisiana Department of Revenue Employee. As a representative, I cannot accept representation in a matter with which I had direct involvement while I was a public employee.

IF THIS DECLARATION OF REPRESENTATIVE IS NOT SIGNED AND DATED, THE POWER OF ATTORNEY WILL BE RETURNED.

Designation-Insert Above Letter (a-h)	State Issuing License	State License Number	Signature	Date *(mm/dd/yyyy)*
g				

Premier
Financial Management Services

CADDO VDHCBS
WORKERS' COMPENSATION FORM

WHO NEEDS WORKERS' COMPENSATION INSURANCE?

In almost every state, there are laws requiring certain types of businesses to carry workers compensation insurance. Since it can be expensive and time-consuming to determine whether an injured employee or the employer is "at fault" in a workplace accident, workers' compensation laws provide a consistent and fair way to handle the costs and compensation of work-place injuries and occupational diseases.

This document is specifically for employers who operate in the states of Arkansas, Louisiana, and Texas. **For employers within the state of Louisiana, Workers' Compensation insurance is required and you may not opt-out.** For employers operating within Arkansas and Texas, you must make an election and submit this form. You may choose to opt-in to provide Workers' Compensation insurance or simply opt-out.

Workers' compensation insurance, sometimes referred to as workman's comp or workers comp, helps protect both employees and employers if someone is injured on the job or develops a work-related illness.

A worker's compensation policy provides benefits for:

- Lost wages and benefits
- Medical care and rehabilitation services
- Legal representation and compliance services

Examples of workplace injuries that could be covered by workers comp insurance include injuries from lifting heavy objects, slipping and falling, or exposure to chemicals or fires. The injury or illness must have occurred due to a work-related event for workers compensation benefits to apply.

Would you like to opt-in to provide Workers' Compensation Insurance? ☐ Yes ☐ No
This only applies to Employers in Arkansas and Texas.

Veteran: _____

Employer of Record: _____
This only applies if the Veteran is not the employer.

Please note that if you choose to opt-out and would like to opt-in at a later time, it is your responsibility to let Premier Financial Management Services (Premier FMS) know of any changes by submitting this form with a new election.

Veteran/Employer of Record Signature: _____ Date: ____/____/_____

Please submit the completed form to Premier FMS via one of the following options:

Mail:
10425 W North Ave.
Suite 345
Milwaukee, WI 53226

Email:
PremierEnrollment@Premier-FMS.com

CADDO - LOUISIANA
BACKGROUND CHECK DISCLOSURE

Premier Financial Management Services (PremierFMS) is required, as part of the CADDO Veteran Directed Home and Community Bases Services program, to conduct a background check before authorized representatives are eligible to begin serving as an authorized representative/employer for a Veteran. PremierFMS will be running a background check. Successfully passing the background check is a condition of representing the Veteran.

First Name: _____ Middle Initial: _____ Last Name: _____

Maiden Name or Alias *(if applicable)*: _____ Date of Birth: _____ / _____ / _____

AUTHORIZATION

By signing below, I certify that the information provided above is accurate. I authorize PremierFMS to conduct a background check. Furthermore, I understand that the results of the background checks will be shared with the Louisiana State Veteran Directed Care Program Coordinator and Veteran/ Authorized Representative.

Signature: _____ Date: _____ / _____ / _____

For any questions or concerns, please contact our office at 855.287.6638. Please submit the completed form to PremierFMS via one of the following options:

Mail
10425 W North Ave
Suite 345
Milwaukee, WI 53226

Email
PremierEnrollment@Premier-FMS.com