

Public Partnerships LLC  
8000 Avalon Blvd,  
Suite 300  
Alpharetta, GA 30009  
Phone: 888-752-8250

[Date]

Dear Attendant,

A member in the Colorado Consumer-Directed Attendant Support Services (CO CDASS) program selected you to provide their services. This packet has the paperwork you need to complete.

Colorado CDASS members have a Financial Management Services (FMS) provider. The member who wants to hire you selected Public Partnerships LLC (PPL) to be their FMS provider. PPL is not your employer. The CDASS member or their authorized representative is your employer. PPL will help your employer with some employer tasks.

Before you can start working, PPL must receive all your employer's and your attendant paperwork. Work with your employer to read, sign, and complete all the required paperwork for the CDASS program. Then, send all the completed forms to PPL.

As you work on the paperwork in this packet, avoid using correction tape or fluid. If you need a new form, download it from our website (<https://pplfirst.com/programs/colorado>) or call PPL to request one. You must complete a full packet of forms for each employer who wants to hire you as an attendant even if you are all living in the same household.

The CDASS program, through PPL, will pay you for the services you provide to the member. You cannot be paid for any services you provide before the date you are approved to begin working. PPL will tell you and your employer the date when you are approved to start working in CDASS.

Below is a list of the forms included in this packet.

- |                                                                                                               |                                              |
|---------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Attendant Enrollment and Agreement Form                                              | <input type="checkbox"/> Direct Deposit Form |
| <input type="checkbox"/> Attendant Services and Rates Form                                                    | <input type="checkbox"/> Tax Exemptions Form |
| <input type="checkbox"/> Electronic Visit Verification Attestation of Exemption Form (State of Colorado form) | <input type="checkbox"/> Form W-4            |
|                                                                                                               | <input type="checkbox"/> USCIS Form I-9      |

If you have questions, call PPL Customer Service toll-free at 888-752-8250. Customer Service is available Monday through Friday from 8am until 5pm MST.

Sincerely,

Public Partnerships LLC

# Attendant Enrollment and Agreement Form

This form is required for Health First Colorado (Colorado's Medicaid program) members in the Colorado Consumer-Directed Attendant Support Services (CDASS) program to hire an attendant with Public Partnerships LLC (PPL). This form is used to tell PPL who is applying to be the member's attendant and that they agree to fulfill their duties.

**Instructions:** Attendant and employer, complete the form and sign the last page.

**Employer Name (first and last):** \_\_\_\_\_

**Member Name (first and last):** \_\_\_\_\_ **PPL ID:** \_\_\_\_\_

## Attendant Information

Name (first, middle and last): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Maiden or Previous Last Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Relationship to the member (check one):  Spouse  Parent  Other Relative  Non-Relative

## Physical Address (where you live)

Address (not PO Box): \_\_\_\_\_ Address 2 (Apt., Ste., or other): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Check the box if the address where you live is the same as your mailing address. If it is not, complete the Mailing Address section below.

## Mailing Address

Address (not PO Box): \_\_\_\_\_ Address 2 (Apt., Ste., or other): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

## Contact Details (an email and phone number are required)

Email: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Home or other phone: \_\_\_\_\_ Primary language: \_\_\_\_\_

Preferred Contact Method:  Email  Cell Phone  Home Phone  Mail

Best Contact Times: \_\_\_\_\_

Do you want PPL to text you? Carrier charges may apply.  Yes  No

## **Qualifying as an Attendant**

A CDASS attendant must meet certain qualifications before they can be hired. An attendant must:

- Be at least 16 years of age,
- Pass a background check,
- Be allowed to work in the United States,
- Have a valid U.S. Social Security Number,
- Be able to care for the member to their or their Authorized Representative's (AR) satisfaction,
- Not serve as the member's AR at the same time that they are an attendant, and
- Fulfill all CDASS program requirements.

## **Role of Public Partnerships LLC**

PPL is a Financial Management Service (FMS) provider using a Fiscal/Employer Agent model. As such, PPL is not the attendant's employer. The CDASS member or their AR is the legal Employer of Record. However, PPL completes tasks on behalf of the employer, such as:

- Managing the attendant enrollment process,
  - PPL helps the employer collect attendant information needed to complete employment forms required by Federal and state law, and the rules of the CDASS program,
- Ensuring that attendants are qualified to work in the CDASS program,
- Processing attendant timesheets,
- Applying attendant payroll garnishments,
- Paying attendants,
  - PPL uses attendant bank account numbers only to process paychecks and garnishments (if applicable) on behalf of the CDASS employer,
  - PPL will process my paychecks only after my employer approves my timesheets,
- Collecting and sending payroll taxes to the federal and state government, and
- Contacting attendants regarding employment or program issues, as needed, using the contact information provided by phone, text message (if opted-in), email, and/or regular mail.

## **CDASS Employer Role**

To self-direct care in CDASS, the member or their AR must be the legal employer of each attendant hired to provide services to the member. A CDASS employer ensures their attendant understands:

- They are the employee of the member or the AR, not Public Partnerships LLC (PPL) or the State of Colorado,
- They cannot be the member's AR and attendant at the same time, and
- They are expected to perform services following CDASS and Medicaid rules and regulations.

## **CDASS Attendant Duties**

### **Background Check and Enrollment with PPL**

A CDASS attendant must undergo and pass a background check administered by PPL to be hired. Attendant background checks involve:

- Colorado criminal background check,
- Colorado Board of Nursing check, and
- Office of Inspector General List of Excluded Individuals and Entities database check.

To pass the background check, an attendant **must not have**:

- Been convicted of a high-risk crime according to the CDASS Background Check Crimes of High Risk program policy,
- Had a license or certification issued by the Colorado Board of Nursing revoked, suspended, or denied,
- Been placed on the Office of Inspection General List of Excluded Individuals and Entities, and
- Failed any additional background checks required by the CDASS employer.

An attendant **is not allowed** to start working and get paid until they have passed the background check process and completed all enrollment paperwork required in PPL's hiring process. By accepting an offer of employment, they agree to:

- Promptly and accurately complete all attendant paperwork,
- Cooperate with their employer to complete employer or member paperwork, as needed, and
- Sign all forms electronically, when possible, as requested by PPL.

Attendants must understand that their CDASS employer will:

- Confirm when they are hired,
- Communicate the official start date/"Good-to-Go date" when the attendant can begin working, as they are informed by PPL,
- Set all terms of the attendant's work and schedule, before their start date, and
- Explain what services the attendant will be providing to the member, before their start date.

## Providing Services

CDASS attendants provide services to the member following the directions they receive from their CDASS employer. To provide quality care, the attendant must:

- Understand that their CDASS employer:
  - Sets the rate(s) of pay equal to or greater than the highest legally required minimum wage,
  - Sets and communicates the work schedule, including the number of hours per week the attendant will work,
  - Provides all job training, and
  - Supervises the attendant,
- Complete the duties and jobs assigned by their employer, as allowed by CDASS regulations,
- Comply with hourly work limits based on their relationship to the employer,
- Comply with work limits if they are under the age of 18, specifically:
  - Not working more than 8 hours a day,
  - Not working more than 30 hours in a week, and
  - Not operating any patient lift devices on the member,
- Not provide services to the member at any time they are in a care facility, such as a hospital or a nursing home,

- Understand that this agreement does not promise they will work:
  - A certain number of hours each week, or
  - The same number of hours they previously worked each week.
- Understand that the attendant's job depends on the member remaining in the CDASS program; if the member is disenrolled from CDASS the attendant can no longer work for them.

## **Timesheets**

A CDASS attendant is required to document their work shifts in PPL's timesheet system. They must:

- Use PPL's timesheet system to document their work shifts,
- Ensure their timesheets are always correct,
- Submit timesheets to only their employer, meeting PPL's timesheet deadlines,
- Understand that only their employer can approve timesheets, including daily timesheets,
- Submit timesheets with only the work that was authorized by their employer,
- Make sure the work they do is authorized by the member's CDASS program budget,
- Not start working before their employer gives them their official start date, and
- Not work if they are no longer qualified under the CDASS program rules to provide services.

A CDASS attendant cannot be paid in the CDASS program unless their employer approves their timesheet. They cannot work more hours than their employer approves.

## **Electronic Visit Verification**

Attendants in CDASS who must complete Electronic Visit Verification (EVV) log their work shifts using PPL's EVV technologies. EVV collects data about a member's services such as when, where, and how long care is provided. An attendant must:

- Have reliable access to:
  - A mobile phone,
  - A tablet,
  - A computer, or
  - The member's land line,
- Clock-in and out of work shifts using PPL's EVV mobile application and/or telephone reporting,
- Not use PPL's online portal to log work shifts as the primary method of completing EVV,
- Report to their employer any changes in their access to the internet or internet connectivity, and
- Cooperate with their employer to comply with the State's EVV requirements.

## **Payroll Garnishments**

PPL will help a CDASS employer comply with garnishment orders against an attendant. If PPL gets a court order for garnishment, the attendant must understand and comply with PPL:

- Withholding money from their paycheck, as required by the court order,
- PPL possibly charging a processing fee for setting up the garnishment, and
- Withholding money from their paycheck until:
  - The entire amount of the garnishment has been satisfied, or
  - The court order no longer applies.

## **Employer Communication and Reporting Changes**

A CDASS attendant is expected to communicate with their employer, and when necessary, directly with PPL. It is the attendant's responsibility to:

- Work directly with their employer for all job-related needs,
- Report to their employer:
  - Changes to their information, including contact information,
  - Changes to their work availability,
  - Need for sick leave or family and medical leave,
  - Plans to not work for more than six months, attendants must also report this to PPL,
  - Any payment issues, or
  - If they no longer want to work for the employer and choose to quit.
- Contact PPL only if they:
  - Need to update their name, address, or phone number,
  - Receive error messages on PPL's web portal or phone app,
  - Need to report a major decline, improvement, or change in the member's health status,
  - Have stopped working for the employer, or
  - Cannot contact the employer or CDASS member.
- They must keep private all personal information about the member.

## **Fraud, Waste, and Abuse**

It is a critical duty of the CDASS attendant to responsibly and lawfully provide services to the member. The attendant must:

- Understand that the CDASS program is part of Health First Colorado (Colorado's Medicaid program),
- Understand that committing fraud, waste or abuse of Medicaid funds is a crime,
- Understand that following activities could qualify as Medicaid fraud, waste, or abuse:
  - Being paid for work they did not do, or
  - Being paid for work that is not permitted in the CDASS program,
- Understand that when Medicaid fraud, waste, or abuse occurs:
  - They, the attendant, will need to pay back the money they did not earn,
  - The State or the Federal Government may take legal action to get the money back, and
  - Both the employer and attendant may be subject to criminal penalties, and
- Report to PPL and/or the State any fraud, waste, or abuse of the member's Medicaid funds (CDASS budget) they suspect.

## **Mistreatment, Abuse, Neglect, and Exploitation**

It is critical that a CDASS member is safe when receiving services. As a service provider, the CDASS attendant agrees to:

- Never:
  - Mistreat or abuse the member,
  - Neglect the member when they are responsible for caring for the member,
  - Misuse the funds or property of the member, and

- Coerce the member to make decisions or take action that risks their wellbeing,
- Report anyone who has committed the actions above to PPL and the appropriate authorities.

**Termination**

When a CDASS attendant is no longer fulfilling their duties and meeting the expectations of the employer, they may be terminated. The attendant must understand:

- Their employer can terminate them at any time and for any lawful reason,
- Their employer may choose, or be required by the State, to fire them if:
  - They commit abuse or neglect of the member,
  - They commit fraud, waste or abuse of the member’s Medicaid funds, or
  - If they misuse funds or property of the member, and

**CDASS Attendant Agreement and Signature**

By signing below, I understand and agree to the following:

- I have read this Attendant Enrollment and Agreement Form completely,
- All the information I have provided is accurate and complete,
  - I understand that if I have given false information to my employer, PPL or the State of Colorado that I may be:
    - Terminated by my employer,
    - Excluded from working in the CDASS program, and/or
    - Subject to administrative and/or legal penalties,
- This document is not an employment contract between me and PPL or the State of Colorado,
- I can only be employed in the CDASS program if I have the right to work in the US, and have passed all required background checks requirements,
- To be hired as an attendant for the above-named CDASS member,
- I will fulfill all my CDASS attendant duties listed in this document,
  - I understand that I may be terminated if I do not follow CDASS rules or the requirements of this Attendant Agreement,
- If this attendant quits or is terminated, I will complete and submit PPL’s Notice of Attendant No Longer Working Form,
- To follow all CDASS program rules set by the State of Colorado,
- Agree to not bring any claims or legal actions against PPL that relate to me not following CDASS rules or the requirements of this Attendant Agreement.

**Attendant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Attendant Printed Name (first and last):** \_\_\_\_\_

**Employer Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Employer Printed Name (first and last):** \_\_\_\_\_

# Direct Deposit Form

This form directs Public Partnerships LLC (PPL) to set up an attendant's payment method as direct deposit. Attendants are paid by paper check until their payment method is set up because it takes one to two pay periods for payment methods to become active.

**Employer Name (first and last):** \_\_\_\_\_

**Member Name (first and last):** \_\_\_\_\_ **PPL ID:** \_\_\_\_\_

**Instructions:** Attendant, complete Parts 1, 2 and 3. If you work for multiple CDASS employers, you must submit this form for each one. Submit a new form to change your bank or third-party money app details.

**Part 1:** Check the box next to the method of payment you want.

Direct Deposit to Bank Account or Third-Party Money App

Account type (select one):  Checking Account  Savings Account  Money app

Bank or money app name: \_\_\_\_\_

Routing number: \_\_\_\_\_

Account number: \_\_\_\_\_

PPL will deposit my payment directly into my bank account or money app.

Deposit to Debit Card

If you select Debit Card as your payment method, you must provide PPL with your mailing address in the section below. If you work for more than one employer, all payments will be on one card.

Payment by Paper Check

## Mailing Address

Address (not PO Box): \_\_\_\_\_

Address 2 (Apt., Ste., or other): \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

County: \_\_\_\_\_

**Part 2:** Pay stubs are available through the PPL web portal and the PPL mobile app. Select the checkbox below if you require or prefer to have your pay stubs sent to you in the mail.

Send my pay stub in the mail. Your paystub will be received at the address you provided above.

### Part 3 - Agree and Sign

By signing below, I confirm that I have read this form and that:

- All the information I have given on this form is correct and complete,
- I understand that PPL is the Financial Management Service (FMS) for my employer. PPL is not my employer. My employer is:
  - The person receiving services (member), or
  - An authorized representative for the member.
- PPL, as a Financial Management Service (FMS), will support my CDASS employer in:
  - Processing paychecks,
  - Managing taxes, and
  - Performing other payroll tasks.
- PPL will use my account numbers only to process my paychecks and garnishments (if applicable) on behalf of my CDASS employer.
- I understand errors on this form may make my payments delayed and/or incorrect,
- If my direct deposit to bank, money app, or debit card payment is made in error, I understand PPL:
  - Will withdraw the incorrect deposited amount from my account,
  - Can only withdraw the incorrect amount if my account is open and has enough money, and
  - Will withhold future payments owed to me until my account can be debited the incorrect deposited amounts, and
- I will provide PPL the account details in Part 1 if want to change my payment method.

**Attendant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Attendant Printed Name (first and last):** \_\_\_\_\_ **PPL ID:** \_\_\_\_\_

# Attendant Services and Rates Form

This form informs Public Partnerships LLC (PPL) of the hourly rate of pay for a Colorado Consumer-Directed Attendant Support Services (CDASS) attendant. Hourly rates of pay are based on the member’s CDASS budget. PPL will change the rate at the beginning of the next pay period.

**Employer Name (first and last):** \_\_\_\_\_

**Member Name (first and last):** \_\_\_\_\_ **PPL ID:** \_\_\_\_\_

**Attendant Name (first and last):** \_\_\_\_\_ **PPL ID:** \_\_\_\_\_

**Instructions:** Employer, select the request type and write in the standard rate for your attendant in the appropriate chart below. Setting an Emergency and Other rate is optional. The attendant and employer will both sign. **Important:** PPL needs the attendant’s hourly wage only—not the wage plus taxes or other costs. For example, the Colorado minimum wage for direct care workers is \$17.00 per hour. If you will pay your attendant this hourly rate, write \$17.00 in the chart below. Submit the form to PPL: email [cocdassadmin@pplfirst.com](mailto:cocdassadmin@pplfirst.com), fax 1-866-947-4813, or mail Public Partnerships, 8000 Avalon Blvd, Suite 300, Alpharetta, GA 30009.

**Request Type:**  New Service  Change Hourly Rate (**only** mark if the attendant is already working)

**Table 1 - Attendant Hourly Rate of Pay:**

Service Name:	Standard Rate:	Emergency Rate:	Other Rate:
CDASS			

**Table 2 - Members on the Supported Living Services (SLS) Waiver only:**

Service Name:	Standard Rate:	Emergency Rate:	Other Rate:
Health Maintenance			
CDASS			

**Table 3 - Members in Community First Choice (CFC) only:**

Service Name:	Standard Rate:	Emergency Rate:	Other Rate:
CDASS			
Legally Responsible Person Homemaker			

## Agree and Sign

By signing below, I confirm that I have read this form and that:

- All the information I have given on this form is correct and complete, and
- I have discussed the above-listed service details and/or hourly wage details with my attendant.

**Attendant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Employer Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Tax Exemptions Form

This form identifies for Public Partnerships LLC (PPL) whether an attendant's employer is required to withhold and pay taxes on the wages they pay their attendant. If the employer is required to withhold and pay these taxes, PPL will do so on their behalf as their Financial Management Services provider.

**Employer Name (first and last):** \_\_\_\_\_

**Member Name (first and last):** \_\_\_\_\_ **PPL ID:** \_\_\_\_\_

**Instructions:** Attendant, complete Parts 1 and 2 read the form and sign the last page.

**Part 1:** Of the four statements below, check the box for **the one that is true for you**, the attendant.

1.  I am the spouse of the employer.
2.  I am the parent of the employer (adult child including legally adopted children). Select any of the following statements a. through c. that apply to you:
  - a.  My adult child, the employer, is one of the following:
    - Divorced and not remarried,
    - A widow or widower,
    - Married and living with their spouse. Their spouse has a mental or physical condition that makes them unable to care for my grandchild/step-grandchild for at least four weeks in a row during the calendar quarter. During this time, I am working for my child, the employer.
  - b.  I provide care for my grandchild/step-grandchild in the home of my child (employer).
  - c.  The grandchild/step-grandchild I care for is under 18 or has a physical/mental condition that requires them to receive personal care from an adult at least four weeks in a row during the calendar quarter. During this time, I also work for my adult child.
3.  I am the biological or legally adopted child of the employer, and I am under the age of 21.
4.  I am not the spouse, parent, or child of the employer.

**Part 2:** Check the box for one of the two statements below, if it applies to you. Check only one box.

- I am under 18 years old and I am a full-time student.
- I am under 18 years old and this job of performing household services (respite) is my primary job.

### Part 3 - Agree and Sign

By signing below, I confirm that I have read this form and that:

- All the information I have given on this form is correct and complete,
- I understand that any false statement on this form may result in my termination,
- I understand my right to work in the U.S. must be confirmed before I am hired, and
- I understand this document is not a contract between me (attendant), PPL, and/or the State.
- If my information changes after submitting this form, I will report those changes to PPL.

**Attendant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Attendant Printed Name (first and last):** \_\_\_\_\_ **PPL ID:** \_\_\_\_\_

**Employer Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## Electronic Visit Verification Attestation of Exemption Form

The Department of Health Care Policy and Financing (HCPF) allows exemption from Electronic Visit Verification (EVV) in these situations:

- Caregivers that permanently live with the Health First Colorado (Colorado’s Medicaid Program) member receiving services; the most common exemption type, and it expires in 365 days.
- Caregivers with extenuating circumstances or do not permanently live with a member; a less common exemption type that must be pre-approved by HCPF and expires in 365 days or less.
- Caregivers or members asking for reasonable modifications under the protection of the Americans with Disabilities Act (ADA); the least common exemption type that must be pre-approved by HCPF and does not expire.

An EVV Exemption must be requested using this EVV Attestation of Exemption Form and include supporting documentation. If you are approved for an EVV Exemption, you are not required to collect EVV data for the approved timeframe. However, you may still be required to document services electronically according to your provider agency’s policy. If the EVV Exemption is approved, the billing provider is responsible for billing of the EVV Exemption using the correct billing methodology.

For updates about the EVV Exemption, form, or request process, [visit our EVV webpage](#).

### Quick Start Guide

A member or caregiver completes this form and submits it with the supporting documentation to the billing provider or Financial Management Services (FMS) Vendor to ask for a live-in caregiver EVV Exemption. If asking for an EVV Exemption for extenuating circumstances or ADA reasonable modifications, then submit this form to HCPF for pre-approval.

Complete the sections of this form that apply to the EVV Exemption type you are asking for. Keep a copy of the submitted form for your records.

For more detailed instructions, questions about this form, information on who can ask for an EVV Exemption, or when to use an EVV Exemption, see the Terms and Definitions section (page 5).

When you have identified the EVV Exemption type you are asking for then complete the specific required sections of the form.

- **Live-in Caregiver:** Sections 1, 2, 3, 4, and 7.
- **Extenuating Circumstances for a Caregiver:** Sections 1, 2, 3, 4, 6, 7 and 8.
- **ADA Reasonable Modifications for a Caregiver:** Sections 1, 2, 3, 4, 6, 7 and 8.
- **ADA Reasonable Modifications for a Member:** Sections 1, 2\*, 3, 5, 6, 7, and 8 of this form.  
\*Section 2 is optional under this EVV Exemption type.



## Electronic Visit Verification Attestation of Exemption Form

<b>1. Member Information</b>			
Complete this section with the Health First Colorado member's information. Go to section 2.			
First Name:	MI:	Last Name:	Medicaid ID:
<b>2. Caregiver Information</b>			
Complete this section with the caregiver's information. Go to section 3.			
This information is optional when a member is asking for the EVV Exemption due to ADA reasonable modifications.			
First Name:	Last Name:	ID (Last 5 of SSN):	
Is the caregiver legally responsible for the member? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, describe their relationship (parent, spouse, sibling, etc.):			
<b>3. Billing Provider or FMS Vendor Information</b>			
Complete this section with the billing provider's information, this is the same for FMS Vendors. Then, if you are asking for an EVV Exemption for a caregiver go to section 4.			
If you are asking for the EVV Exemption for a member due to ADA reasonable modifications, skip to section 5.			
Billing Provider or FMS Vendor name:			
Billing Provider or FMS Vendor Medicaid ID (Not NPI):			
Billing Provider or FMS Vendor representative name:			
<b>4. Caregiver Exemption</b>			
If you are a caregiver asking for an EVV Exemption, fill out this section. Select ONLY one EVV Exemption type.			
If you select the Live-in Caregiver box, then enter the residential address shared by the member and caregiver and skip to section 7.			
If you select the Extenuating Circumstances or ADA Reasonable Modifications, then skip to section 6.			
See Terms and Definitions (page 5) for more information on the EVV Exemption.			
<input type="checkbox"/> Live-in Caregiver (Enter the shared residential address, then skip to section 7.)			
Street Address:			
City or Town:	State:	ZIP Code:	
<input type="checkbox"/> Extenuating Circumstances (If checked, then skip to section 6.)			
<input type="checkbox"/> ADA Reasonable Modifications (If checked, then skip to section 6.)			



## Electronic Visit Verification Attestation of Exemption Form

### 5. Member Exemption

If you are a member asking for the EVV Exemption due to ADA reasonable modifications, fill out this section and go to section 6.

See Terms and Definitions (page 5) for more information on the member EVV Exemption.

ADA Reasonable Modifications (If checked, then go to section 6.)

### 6. Explanation for Request Extenuating Circumstances or ADA Reasonable Modifications

If you are asking for an EVV Exemption for extenuating circumstances or due to ADA reasonable modifications, explain below why you are asking for an EVV Exemption and go to section 7. HCPF may request other documentation before approving.

See Terms and Definitions (page 5) for more information on the EVV Exemption.

### 7. Attestation Sign and Date (Effective Date)

Complete this section with signatures and dates by the member or authorized representative, billing provider or FMS representative, and caregiver\*.

If asking for the Live-in Caregiver EVV Exemption, then send this form and supporting documentation to the billing provider or FMS Vendor.

If asking for an EVV Exemption for extenuating circumstance or due to ADA reasonable modifications, go to section 8.

Billing providers or FMS Vendors must submit this form and supporting documentation through the Provider Web Portal within 30 days of the member’s attestation date.

\*A caregiver signature is optional when a member is asking for the EVV Exemption due to ADA Reasonable Modifications.

I declare that this form, to the best of my knowledge, is true, correct, and complete. I understand that falsification or misrepresentation of information may result in HCPF revocation of the EVV Exemption, program integrity investigation, and/or recoupment of paid claims. If the EVV Exemption is revoked, EVV must be collected for required services.

Member or Authorized Representative Signature:	Date: (Effective Date)
Provider or FMS Vendor Representative Signature:	Date:
Caregiver Signature: (Optional if a member is asking for an EVV Exemption due to ADA reasonable modifications)	Date:



## Electronic Visit Verification Attestation of Exemption Form

### 8. HCPF Pre-approval for Extenuating Circumstances & ADA Reasonable Modification

If you are asking for an EVV Exemption for extenuating circumstance or due to ADA reasonable modifications, send this form to [evv@state.co.us](mailto:evv@state.co.us) for HCPF pre-approval before you send it to the billing provider or FMS Vendor. Once pre-approved then send this form, signed by HCPF EVV staff, with the HCPF pre-approval letter to the billing provider or FMS Vendor.

See Terms and Definitions (page 5) for additional information on the HCPF pre-approval letter.

HCPF EVV Staff Signature:

Date:

### Provider Maintenance - EVV Exemption Request via Provider Web Portal

Complete this form and submit it via the Provider Web Portal using the following steps (do not mail it to Gainwell Technologies):

1. Log in to the Provider Web Portal
2. Click “Provider Maintenance”
3. Click “Exemptions”
4. Complete the EVV Exemption Request
5. Click “Attachments and Submit” on the left-hand side of the page
6. Add the completed EVV Attestation of Exemption form and supporting documentation
7. Select the Attachment Type “Other” with the document labeled “EVV Attestation of Exemption Form” and supporting documentation
8. Submit the provider maintenance request

Once the provider maintenance request has been approved, a provider maintenance approval letter will be received, and the billing provider may begin billing for the EVV exemption. EVV Exemption requests and approvals can be viewed in Provider Maintenance on the Exemptions page.

### Provider Revalidation - EVV Exemption Request via Provider Web Portal

Complete this form and submit it via the Provider Web Portal using the following steps (do not mail it to Gainwell Technologies):

1. Log in to the Provider Web Portal
2. Click “Revalidation”
3. Progress through the revalidation application until the “Exemptions” page is reached
4. Complete the EVV Exemption Request
5. Progress through the remaining revalidation pages until the “Attachments and Fees” page is reached
6. Add the completed EVV Attestation of Exemption form and supporting documentation
7. Select the Attachment Type “Other” with the document labeled “EVV Attestation of Exemption Form” and supporting documentation
8. Submit the revalidation application

Once the revalidation application has been approved, a revalidation approval letter will be received, and the billing provider may begin billing for the EVV exemption. EVV Exemption requests and approvals can be viewed in Provider Maintenance on the Exemptions page.



# Electronic Visit Verification Attestation of Exemption Form

## Terms and Definitions

**EVV Exemption** is a general term used to describe exemptions from EVV requirements based on live-in caregiver status including extenuating circumstances; as well as caregivers and members exempted from EVV based on reasonable modification under the Americans with Disabilities Act (ADA).

**Live-in caregiver** is a caregiver who permanently resides in the same residence as the member receiving services. Live-in caregiver status is determined by meeting requirements established by the U.S. Department of Labor, Internal Revenue Service, or HCPF-approved extenuating circumstances. Documentation of live-in caregiver status shall be collected and maintained by the billing provider or FMS Vendor then submitted through the Provider Web Portal.

**Extenuating circumstance** is a live-in caregiver status beyond the standard definitions and granted by HCPF. It allows for situations like joint custody, foster care, members transitioning from residential services, caregivers residing with a member for extended periods of time<sup>1</sup> and other less common situations. This type of EVV Exemption requires HCPF pre-approval and may be approved for less than one year.

**Reasonable modifications under the Americans with Disabilities Act (ADA)** is a federally mandated accommodation that ensures individuals with disabilities have an equal opportunity to participate in programs, services, and activities when modifications are necessary to avoid discrimination on the basis of disability. This type of EVV Exemption requires HCPF pre-approval and does not expire. It is most commonly used to support members who perform employer of record responsibilities in the CDASS program.

**Attestation date** is the day this form is signed by the member or Authorized Representative and used as the “effective” date when submitting an application through the Provider Web Portal.

**Billing Provider** submits claims for and receives reimbursement for Medicaid services; submits EVV Exemption documentation through the Provider Web Portal. Both provider agencies and Financial Management Service (FMS) Vendors must have a billing provider identification number in order to perform these activities.

**Provider Web Portal** is an online portal provided by HCPF. It is used by billing providers and FMS Vendors to manage various administrative tasks related to Health First Colorado services.

**Legally responsible person** is any person who has a duty under state law to care for another person, such as the parent of a minor child or a spouse.

**Permissible Supporting Documentation** are HCPF-allowed documents required to verify the EVV Attestation of Exemption Form. Records must contain current information relevant to the EVV

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<sup>1</sup> Department of Labor Application of the Fair Labor Standards Act to Domestic Service, Final Rule; Fact Sheet #79B: Live-in Domestic Service Workers Under the Fair Labor Standards Act (FLSA)



## Electronic Visit Verification Attestation of Exemption Form

Exemption requested. A minimum of one document is required. An example of this is a bank statement with **both** the member and caregiver's name on it **and** their shared address.

- Permissible documents for a live-in caregiver EVV Exemption must include the shared address and be current.
  - These documents may be used if dated **within 90 days** of a member's attestation date. These include at least one of the following: bank statements; copies of bills (utility, credit card, etc.); pre-printed pay stubs; and United States Postal Service (USPS) Change of Address Form (CNL107).
  - **These documents may be used if they are not expired.** These include copies of state identification (ID) cards, driver's licenses, motor vehicle registrations, homeowner's insurance policy, renter's insurance policy, or motor vehicle insurance policy.
  - These documents may be used if they are dated **within 365 days or 12 months** of the member's attestation date. These include tax returns, voter registrations (screenshot of the webpage must include website and the date it was checked), mortgage contract, lease contract, rental contract, transcript or report cards from accredited schools, State or Federal benefits documents, correspondence regarding benefits like SNAP or Medicaid, school correspondence such as letters from a child's school, and school enrollment forms from the child's school. Documents must be within these specified types to be permitted.
- Permissible supporting documents for EVV Exemptions for extenuating circumstances and ADA reasonable modifications is the HCPF Pre-approval Letter.
  - **The HCPF Pre-approval Letter** is the supporting document or decision letter that is obtained from HCPF and required before submitting an EVV Exemption for extenuating circumstance or ADA reasonable modifications through the Provider Web Portal.

## Difficulty of Care Federal Income Exclusion Form

This form helps a Colorado Consumer-Directed Attendant Support Services (CDASS) attendant determine if they qualify for the Difficulty of Care Federal Income Exclusion. Completing this form will tell Public Partnerships LLC (PPL) whether the attendant qualifies for the exclusion or they request PPL remove it because they no longer qualify. As a Financial Management Services (FMS), PPL will appropriately apply the exclusion on the CDASS employer's behalf.

**Member Name (first and last):** \_\_\_\_\_ **PPL ID:** \_\_\_\_\_

**Employer Name (first and last, this is required):** \_\_\_\_\_

**Instructions:** Attendant, complete Part 1 or Part 2, then complete Part 3. If your information changes after you submit this form, you **must** report those changes to PPL by calling 888-752-8250.

### Part 1 - Apply for the Difficulty of Care Federal Income Exclusion

Check all boxes that are true for you, the attendant:

- I provide services to the member in our shared home.
- I live and perform the routines of private life, including shared meals and holidays in this home.
- I do not have a separate home where I live.

If you check all three boxes above, you qualify for the exclusion. If you checked no (0) boxes or only one or two boxes, you **do not** qualify for the exclusion.

### Part 2 - Remove the Difficulty of Care Federal Income Exclusion

If you no longer provide services to the member in the home you share with that member, check the following box:

- I no longer qualify for the Difficulty of Care Federal Income Exclusion because I no longer provide services to the member in our shared home.

By checking the box, PPL will begin withholding federal and state taxes and reporting your earnings to federal and state tax agencies.

### Part 3 - Agree and Sign

By signing below, I confirm that I have read this form, and that all the information I have given on this form is correct and complete.

**Attendant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Attendant Printed Name (first and last):** \_\_\_\_\_ **PPL ID:** \_\_\_\_\_



# Employment Eligibility Verification

## Department of Homeland Security

### U.S. Citizenship and Immigration Services

**USCIS**  
**Form I-9**  
OMB No.1615-0047  
Expires 05/31/2027

**START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the [Instructions](#).**

**ANTI-DISCRIMINATION NOTICE:** All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

**Section 1. Employee Information and Attestation:** Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.

Last Name (Family Name)		First Name (Given Name)		Middle Initial (if any)	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number (if any)	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		Employee's Email Address		Employee's Telephone Number	
<p><b>I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.</b></p>		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):				
		<input type="checkbox"/> 1. A citizen of the United States				
		<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)				
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)				
<input type="checkbox"/> 4. An alien authorized to work until _____ (exp. date, if any)						
If you check <b>Item Number 4.</b> , enter one of these:						
USCIS A-Number		OR	Form I-94 Admission Number		OR	Foreign Passport Number and Country of Issuance
Signature of Employee				Today's Date (mm/dd/yyyy)		

**If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the [Preparer and/or Translator Certification](#) on Page 3.**

**Section 2. Employer Review and Verification:** Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)	<p><b>Additional Information</b></p>    <p>Check here if you used an alternative procedure authorized by DHS to examine documents.</p>				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

<p><b>Certification:</b> I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.</p>		First Day of Employment (mm/dd/yyyy):
Last Name, First Name and Title of Employer or Authorized Representative		Signature of Employer or Authorized Representative
		Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name		Employer's Business or Organization Address, City or Town, State, ZIP Code

**For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 4.**

## LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

\* Documents extended by the issuing authority are considered unexpired.

Employees may present one selection from List A or a combination of one selection from List B and one selection from List C.

**Examples of many of these documents appear in the Handbook for Employers (M-274).**

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
<ol style="list-style-type: none"> <li>1. U.S. Passport or U.S. Passport Card</li> <li>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</li> <li>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</li> <li>4. Employment Authorization Document that contains a photograph (Form I-766)</li> <li>5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole:               <ol style="list-style-type: none"> <li>a. Foreign passport; and</li> <li>b. Form I-94 or Form I-94A that has the following:                   <ol style="list-style-type: none"> <li>(1) The same name as the passport; and</li> <li>(2) An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.</li> </ol> </li> </ol> </li> <li>6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI</li> </ol>	OR	<ol style="list-style-type: none"> <li>1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address</li> <li>2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address</li> <li>3. School ID card with a photograph</li> <li>4. Voter's registration card</li> <li>5. U.S. Military card or draft record</li> <li>6. Military dependent's ID card</li> <li>7. U.S. Coast Guard Merchant Mariner Card</li> <li>8. Native American tribal document</li> <li>9. Driver's license issued by a Canadian government authority</li> <li style="text-align: center;"><b>For persons under age 18 who are unable to present a document listed above:</b></li> <li>10. School record or report card</li> <li>11. Clinic, doctor, or hospital record</li> <li>12. Day-care or nursery school record</li> </ol>	AND	<ol style="list-style-type: none"> <li>1. A Social Security Account Number card, unless the card includes one of the following restrictions:               <ol style="list-style-type: none"> <li>(1) NOT VALID FOR EMPLOYMENT</li> <li>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</li> <li>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</li> </ol> </li> <li>2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)</li> <li>3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal</li> <li>4. Native American tribal document</li> <li>5. U.S. Citizen ID Card (Form I-197)</li> <li>6. Identification Card for Use of Resident Citizen in the United States (Form I-179)</li> <li>7. Employment authorization document issued by the Department of Homeland Security               <p style="margin-left: 20px;">For examples, see <a href="#">Section 7</a> and <a href="#">Section 13</a> of the M-274 on <a href="https://uscis.gov/i-9-central">uscis.gov/i-9-central</a>.</p> <p style="margin-left: 20px;">The Form I-766, Employment Authorization Document, is a List A, <b>Item Number 4</b>, document, not a List C document.</p> </li> </ol>
<p><b>Acceptable Receipts</b></p> <p>May be presented in lieu of a document listed above for a temporary period.</p> <p>For receipt validity dates, see the M-274.</p>				
<ul style="list-style-type: none"> <li>• Receipt for a replacement of a lost, stolen, or damaged List A document.</li> <li>• Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual.</li> <li>• Form I-94 with "RE" notation or refugee stamp issued to a refugee.</li> </ul>	OR	<p>Receipt for a replacement of a lost, stolen, or damaged List B document.</p>	AND	<p>Receipt for a replacement of a lost, stolen, or damaged List C document.</p>

\*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.



# Supplement A, Preparer and/or Translator Certification for Section 1

Department of Homeland Security  
U.S. Citizenship and Immigration Services

USCIS  
Form I-9  
Supplement A  
OMB No. 1615-0047  
Expires 05/31/2027

Last Name ( <i>Family Name</i> ) from <b>Section 1</b> .	First Name ( <i>Given Name</i> ) from <b>Section 1</b> .	Middle initial (if any) from <b>Section 1</b> .
----------------------------------------------------------	----------------------------------------------------------	-------------------------------------------------

**Instructions:** This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

**I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.**

Signature of Preparer or Translator			Date ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )		First Name ( <i>Given Name</i> )		Middle Initial ( <i>if any</i> )
Address ( <i>Street Number and Name</i> )		City or Town	State	ZIP Code

**I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.**

Signature of Preparer or Translator			Date ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )		First Name ( <i>Given Name</i> )		Middle Initial ( <i>if any</i> )
Address ( <i>Street Number and Name</i> )		City or Town	State	ZIP Code

**I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.**

Signature of Preparer or Translator			Date ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )		First Name ( <i>Given Name</i> )		Middle Initial ( <i>if any</i> )
Address ( <i>Street Number and Name</i> )		City or Town	State	ZIP Code

**I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.**

Signature of Preparer or Translator			Date ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )		First Name ( <i>Given Name</i> )		Middle Initial ( <i>if any</i> )
Address ( <i>Street Number and Name</i> )		City or Town	State	ZIP Code



# Supplement B, Reverification and Rehire (formerly Section 3)

Department of Homeland Security  
U.S. Citizenship and Immigration Services

**USCIS**  
**Form I-9**  
**Supplement B**  
OMB No. 1615-0047  
Expires 05/31/2027

Last Name ( <i>Family Name</i> ) from Section 1.	First Name ( <i>Given Name</i> ) from Section 1.	Middle initial (if any) from Section 1.
--------------------------------------------------	--------------------------------------------------	-----------------------------------------

**Instructions:** This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the [Handbook for Employers: Guidance for Completing Form I-9 \(M-274\)](#)

Date of Rehire ( <i>if applicable</i> )	New Name ( <i>if applicable</i> )		
Date ( <i>mm/dd/yyyy</i> )	Last Name (Family Name)	First Name (Given Name)	Middle Initial

**Reverification:** If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) ( <i>mm/dd/yyyy</i> )
----------------	--------------------------	------------------------------------------------

**I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.**

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date ( <i>mm/dd/yyyy</i> )
-----------------------------------------------	----------------------------------------------------	------------------------------------

Additional Information (Initial and date each notation.)	Check here if you used an alternative procedure authorized by DHS to examine documents.
----------------------------------------------------------	-----------------------------------------------------------------------------------------

Date of Rehire ( <i>if applicable</i> )	New Name ( <i>if applicable</i> )		
Date ( <i>mm/dd/yyyy</i> )	Last Name (Family Name)	First Name (Given Name)	Middle Initial

**Reverification:** If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) ( <i>mm/dd/yyyy</i> )
----------------	--------------------------	------------------------------------------------

**I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.**

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date ( <i>mm/dd/yyyy</i> )
-----------------------------------------------	----------------------------------------------------	------------------------------------

Additional Information (Initial and date each notation.)	Check here if you used an alternative procedure authorized by DHS to examine documents.
----------------------------------------------------------	-----------------------------------------------------------------------------------------

Date of Rehire ( <i>if applicable</i> )	New Name ( <i>if applicable</i> )		
Date ( <i>mm/dd/yyyy</i> )	Last Name (Family Name)	First Name (Given Name)	Middle Initial

**Reverification:** If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) ( <i>mm/dd/yyyy</i> )
----------------	--------------------------	------------------------------------------------

**I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.**

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date ( <i>mm/dd/yyyy</i> )
-----------------------------------------------	----------------------------------------------------	------------------------------------

Additional Information (Initial and date each notation.)	Check here if you used an alternative procedure authorized by DHS to examine documents.
----------------------------------------------------------	-----------------------------------------------------------------------------------------

# Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.

Give Form W-4 to your employer.

Your withholding is subject to review by the IRS.

# 2026

<b>Step 1:</b> <b>Enter Personal Information</b>	(a) First name and middle initial	Last name	(b) Social security number
	Address		Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to <a href="http://www.ssa.gov">www.ssa.gov</a> .
	City or town, state, and ZIP code		
	(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

**Caution:** To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.

**TIP:** Consider using the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to determine the most accurate withholding for the rest of the year if you: are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

**Complete Steps 2-4 ONLY if they apply to you; otherwise, skip to Step 5.** See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App).

**Step 2: Multiple Jobs or Spouse Works**

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App) for the most accurate withholding for this step (and Steps 3-4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(b) is more accurate

**Complete Steps 3-4(b) on Form W-4 for only ONE of these jobs.** Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3-4(b) on the Form W-4 for the highest paying job.)

<b>Step 3:</b> <b>Claim Dependent and Other Credits</b>	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly):			
	(a) Multiply the number of qualifying children under age 17 by \$2,200 . . . . .		<b>3(a)</b> \$	
	(b) Multiply the number of other dependents by \$500 . . . . .		<b>3(b)</b> \$	
	Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here . . . . .		<b>3</b>	\$

<b>Step 4:</b> <b>Other Adjustments</b>	(a) <b>Other income (not from jobs).</b> If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . .	<b>4(a)</b> \$
	(b) <b>Deductions.</b> Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here . . . . .	<b>4(b)</b> \$
	(c) <b>Extra withholding.</b> Enter any additional tax you want withheld each pay period . . . . .	<b>4(c)</b> \$

Exempt from withholding	I claim exemption from withholding for 2026, and I certify that I meet <b>both</b> of the conditions for exemption for 2026. See <i>Exemption from withholding</i> on page 2. I understand I will need to submit a new Form W-4 for 2027 <input type="checkbox"/>
-------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

<b>Step 5:</b> <b>Sign Here</b>	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.	
	Employee's signature (This form is not valid unless you sign it.)	Date

<b>Employers Only</b>	Employer's name and address	First date of employment	Employer identification number (EIN)

## General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

### Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to [www.irs.gov/FormW4](http://www.irs.gov/FormW4).

### Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

**Exemption from withholding.** You may claim exemption from withholding for 2026 if you meet both of the following conditions: you had no federal income tax liability in 2025 **and** you expect to have no federal income tax liability in 2026. You had no federal income tax liability in 2025 if (1) your total tax on line 24 on your 2025 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2026 tax return. To claim exemption from withholding, certify that you meet both of the conditions by checking the box in the *Exempt from withholding* section. Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2027.

**Your privacy.** Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

**When to use the estimator.** Consider using the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App) if you:

1. Are submitting this form after the beginning of the year;
2. Expect to work only part of the year;
3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;
4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or
5. Prefer the most accurate withholding for multiple job situations.

**TIP:** Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

**Self-employment.** Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to figure the amount to have withheld.

**Nonresident alien.** If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

## Specific Instructions

**Step 1(c).** Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

**Step 2.** Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work. Submit a separate Form W-4 for each job.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

Instead, if you (and your spouse) have a total of only two jobs, you may check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount of tax withheld will be larger the greater the difference in pay is between the two jobs.



**Multiple jobs.** Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.

**Step 3.** This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain credits. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

### Step 4.

**Step 4(a).** Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

**Step 4(b).** Enter in this step the amount from the Deductions Worksheet, line 15, if you expect to claim deductions other than the basic standard deduction on your 2026 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for qualified tips, overtime compensation, and passenger vehicle loan interest; student loan interest; IRAs; and seniors. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain deductions. For additional eligibility requirements, see Pub. 501.

**Step 4(c).** Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe when you file your tax return.

**Step 2(b) – Multiple Jobs Worksheet** (Keep for your records.)



If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

**Note:** If more than one job has annual wages of more than \$120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App).

**1 Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 5. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** \$ \_\_\_\_\_

**2 Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

**a** Find the amount from the appropriate table on page 5 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** \$ \_\_\_\_\_

**b** Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 5 and enter this amount on line 2b . . . . . **2b** \$ \_\_\_\_\_

**c** Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** \$ \_\_\_\_\_

**3** Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. . . . . **3** \_\_\_\_\_

**4 Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (plus any other additional amount you want withheld) . . . . . **4** \$ \_\_\_\_\_

Step 4(b)—Deductions Worksheet (Keep for your records.)



See the Instructions for Schedule 1-A (Form 1040) for more information about whether you qualify for the deductions on lines 1a, 1b, 1c, 3a, and 3b.

1 Deductions for qualified tips, overtime compensation, and passenger vehicle loan interest.
a Qualified tips. If your total income is less than \$150,000 (\$300,000 if married filing jointly), enter an estimate of your qualified tips up to \$25,000
b Qualified overtime compensation. If your total income is less than \$150,000 (\$300,000 if married filing jointly), enter an estimate of your qualified overtime compensation up to \$12,500 (\$25,000 if married filing jointly) of the "and-a-half" portion of time-and-a-half compensation
c Qualified passenger vehicle loan interest. If your total income is less than \$100,000 (\$200,000 if married filing jointly), enter an estimate of your qualified passenger vehicle loan interest up to \$10,000
2 Add lines 1a, 1b, and 1c. Enter the result here
3 Seniors age 65 or older. If your total income is less than \$75,000 (\$150,000 if married filing jointly):
a Enter \$6,000 if you are age 65 or older before the end of the year
b Enter \$6,000 if your spouse is age 65 or older before the end of the year and has a social security number valid for employment
4 Add lines 3a and 3b. Enter the result here
5 Enter an estimate of your student loan interest, deductible IRA contributions, educator expenses, alimony paid, and certain other adjustments from Schedule 1 (Form 1040), Part II. See Pub. 505 for more information
6 Itemized deductions. Enter an estimate of your 2026 itemized deductions from Schedule A (Form 1040). Such deductions may include qualifying:
a Medical and dental expenses. Enter expenses in excess of 7.5% (0.075) of your total income
b State and local taxes. If your total income is less than \$505,000 (\$252,500 if married filing separately), enter state and local taxes paid up to \$40,400 (\$20,200 if married filing separately)
c Home mortgage interest. If your home acquisition debt is less than \$750,000 (\$375,000 if married filing separately), enter your home mortgage interest expense (including mortgage insurance premiums)
d Gifts to charities. Enter contributions in excess of 0.5% (0.005) of your total income
e Other itemized deductions. Enter the amount for other itemized deductions
7 Add lines 6a, 6b, 6c, 6d, and 6e. Enter the result here
8 Limitation on itemized deductions.
a Enter your total income
b Subtract line 4 from line 8a. If line 4 is greater than line 8a, enter -0- here and on line 10. Skip line 9
9 Enter: \$768,700 if you're married filing jointly or a qualifying surviving spouse; \$640,600 if you're single or head of household; \$384,350 if you're married filing separately
10 If line 9 is greater than line 8b, enter the amount from line 7. Otherwise, multiply line 7 by 94% (0.94) and enter the result here
11 Standard deduction.
Enter: \$32,200 if you're married filing jointly or a qualifying surviving spouse; \$24,150 if you're head of household; \$16,100 if you're single or married filing separately
12 Cash gifts to charities. If you take the standard deduction, enter cash contributions up to \$1,000 (\$2,000 if married filing jointly)
13 Add lines 11 and 12. Enter the result here
14 If line 10 is greater than line 13, subtract line 11 from line 10 and enter the result here. If line 13 is greater than line 10, enter the amount from line 12
15 Add lines 2, 4, 5, and 14. Enter the result here and in Step 4(b) of Form W-4

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

### Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$0	\$480	\$850	\$850	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020
\$10,000 - 19,999	0	480	1,480	1,850	2,050	2,220	2,220	2,220	2,220	2,220	2,220	2,620
\$20,000 - 29,999	480	1,480	2,480	3,050	3,250	3,420	3,420	3,420	3,420	3,420	3,820	4,820
\$30,000 - 39,999	850	1,850	3,050	3,620	3,820	3,990	3,990	3,990	3,990	4,390	5,390	6,390
\$40,000 - 49,999	850	2,050	3,250	3,820	4,020	4,190	4,190	4,190	4,590	5,590	6,590	7,590
\$50,000 - 59,999	1,020	2,220	3,420	3,990	4,190	4,360	4,360	4,760	5,760	6,760	7,760	8,760
\$60,000 - 69,999	1,020	2,220	3,420	3,990	4,190	4,360	4,760	5,760	6,760	7,760	8,760	9,760
\$70,000 - 79,999	1,020	2,220	3,420	3,990	4,190	4,760	5,760	6,760	7,760	8,760	9,760	10,760
\$80,000 - 99,999	1,020	2,220	3,420	4,240	5,440	6,610	7,610	8,610	9,610	10,610	11,610	12,610
\$100,000 - 149,999	1,870	4,070	6,270	7,840	9,040	10,210	11,210	12,210	13,210	14,210	15,360	16,560
\$150,000 - 239,999	1,870	4,100	6,500	8,270	9,670	11,040	12,240	13,440	14,640	15,840	17,040	18,240
\$240,000 - 319,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,780	14,980	16,180	17,380	18,580
\$320,000 - 364,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,860	15,860	17,860	19,860	21,860
\$365,000 - 524,999	2,720	5,920	9,390	12,260	14,760	17,230	19,530	21,830	24,130	26,430	28,730	31,030
\$525,000 and over	3,140	6,840	10,540	13,610	16,310	18,980	21,480	23,980	26,480	28,980	31,480	33,990

### Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$90	\$850	\$1,020	\$1,020	\$1,020	\$1,070	\$1,870	\$1,870	\$1,870	\$1,870	\$1,870	\$1,970
\$10,000 - 19,999	850	1,780	1,980	1,980	2,030	3,030	3,830	3,830	3,830	3,830	3,930	4,130
\$20,000 - 29,999	1,020	1,980	2,180	2,230	3,230	4,230	5,030	5,030	5,030	5,130	5,330	5,530
\$30,000 - 39,999	1,020	1,980	2,230	3,230	4,230	5,230	6,030	6,030	6,130	6,330	6,530	6,730
\$40,000 - 59,999	1,020	2,880	4,080	5,080	6,080	7,080	7,950	8,150	8,350	8,550	8,750	8,950
\$60,000 - 79,999	1,870	3,830	5,030	6,030	7,100	8,300	9,300	9,500	9,700	9,900	10,100	10,300
\$80,000 - 99,999	1,870	3,830	5,100	6,300	7,500	8,700	9,700	9,900	10,100	10,300	10,500	10,700
\$100,000 - 124,999	2,030	4,190	5,590	6,790	7,990	9,190	10,190	10,390	10,590	10,940	11,940	12,940
\$125,000 - 149,999	2,040	4,200	5,600	6,800	8,000	9,200	10,200	10,950	11,950	12,950	13,950	14,950
\$150,000 - 174,999	2,040	4,200	5,600	6,800	8,150	10,150	11,950	12,950	13,950	14,950	16,170	17,470
\$175,000 - 199,999	2,040	4,200	6,150	8,150	10,150	12,150	13,950	15,020	16,320	17,620	18,920	20,220
\$200,000 - 249,999	2,720	5,680	7,880	10,140	12,440	14,740	16,840	18,140	19,440	20,740	22,040	23,340
\$250,000 - 449,999	2,970	6,230	8,730	11,030	13,330	15,630	17,730	19,030	20,330	21,630	22,930	24,240
\$450,000 and over	3,140	6,600	9,300	11,800	14,300	16,800	19,100	20,600	22,100	23,600	25,100	26,610

### Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$280	\$850	\$950	\$1,020	\$1,020	\$1,020	\$1,020	\$1,560	\$1,870	\$1,870	\$1,870
\$10,000 - 19,999	280	1,280	1,950	2,150	2,220	2,220	2,220	2,760	3,760	4,070	4,070	4,210
\$20,000 - 29,999	850	1,950	2,720	2,920	2,980	2,980	3,520	4,520	5,520	5,830	5,980	6,180
\$30,000 - 39,999	950	2,150	2,920	3,120	3,180	3,720	4,720	5,720	6,720	7,180	7,380	7,580
\$40,000 - 59,999	1,020	2,220	2,980	3,570	4,640	5,640	6,640	7,750	8,950	9,460	9,660	9,860
\$60,000 - 79,999	1,020	2,610	4,370	5,570	6,640	7,750	8,950	10,150	11,350	11,860	12,060	12,260
\$80,000 - 99,999	1,870	4,070	5,830	7,150	8,410	9,610	10,810	12,010	13,210	13,720	13,920	14,120
\$100,000 - 124,999	1,870	4,270	6,230	7,630	8,900	10,100	11,300	12,500	13,700	14,210	14,720	15,720
\$125,000 - 149,999	2,040	4,440	6,400	7,800	9,070	10,270	11,470	12,670	14,580	15,890	16,890	17,890
\$150,000 - 174,999	2,040	4,440	6,400	7,800	9,070	10,580	12,580	14,580	16,580	17,890	18,890	20,170
\$175,000 - 199,999	2,040	4,440	6,400	8,510	10,580	12,580	14,580	16,580	18,710	20,320	21,620	22,920
\$200,000 - 249,999	2,720	5,920	8,680	10,900	13,270	15,570	17,870	20,170	22,470	24,080	25,380	26,680
\$250,000 - 449,999	2,970	6,470	9,540	12,040	14,410	16,710	19,010	21,310	23,610	25,220	26,520	27,820
\$450,000 and over	3,140	6,840	10,110	12,810	15,380	17,880	20,380	22,880	25,380	27,190	28,690	30,190



# FAMLI Program Notice

Colorado's Family and Medical Leave Insurance (FAMLI)  
Paid time for the moments that matter

You may qualify for FAMLI paid leave if you earned \$2,500 over the previous year, and need to:



Care for a new child through birth, adoption, or foster placement



Care for your own serious health condition



Care for a family member with a serious health condition



Support a family member preparing for military deployment



Seek safety or support related to domestic violence, stalking, or sexual assault



Care for a newborn in a Neonatal Intensive Care Unit or higher level of care

## What You Pay

For 2026, your employer sends 0.44% of your wages to the FAMLI benefit fund. This shows up on your paystub as "FAMLI premium."

## Your Rights

- If you've worked for your employer for 180 days, your job is protected when you return.
- Your employer may not retaliate, interfere, or discriminate against you for using FAMLI benefits.
- If something feels wrong, you can file a complaint by contacting the FAMLI Division.
- If your claim is denied, you can file a reconsideration at [myfamliplus.state.co.us](https://myfamliplus.state.co.us).

## How Much Leave You Can Take

12 Weeks

Up to 12 weeks each year

4 Weeks

Up to 4 extra weeks for pregnancy or childbirth complications

12 Weeks

Up to 12 more weeks for Neonatal Care Leave

You can take leave all at once, intermittently, or on a reduced schedule. FAMLI leave may reduce your available FMLA leave.

## What You'll Receive



Weekly payment of up to 90% of your wages (sliding scale, based on income)



Benefits that are not taxed by Colorado. Federal taxes may apply.



You can estimate your weekly benefit at [famli.colorado.gov](https://famli.colorado.gov).

## How To Apply



Apply at: [myfamliplus.state.co.us](https://myfamliplus.state.co.us)



Give 30 days' notice when possible, or notify your employer as soon as you can.



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

Learn more: [famli.colorado.gov](https://famli.colorado.gov)  
For assistance, call: 1-866-263-2654  
Visit: 707 17th Street, Suite 150, Denver, CO.