CONSUMER RIGHTS AND RESPONSIBILITY POLICY

Consumers are expected to:

- Select, hire train, and supervise the Attendant.
- Use only Attendant's who are registered, screened, and employable pursuant to the Family Care Safety Registry, Employments Disqualification List, and applicable state laws and regulations.
- Prepare weekly timesheets and submit then to the Vendor.
- Explain task that are to be completed.
- Sign and complete timesheets each time the Attendants provide services.
- Select an Attendant regardless of race, color, national, sex, age, religion, political beliefs, or disability.

Consumers may not:

- Threaten or abuse the Attendant or Vendor staff (physically, verbally, or sexually);
- Engage in activities that would be considered fraud of the program.

Consumers have the right to:

- Appeal the agency's decision regarding denial, reduction, or termination of services within ninety (90) days of the date of the decision.
- You must request a hearing within ten (10) days of the date of the notice, if you wish to continue receiving services pending the hearing decision. If the agency decision is upheld, you may be help responsible for cost of any services received while the appeal is pending.
- Receive services without regard to race, color, national origin, sex, age, religion, political beliefs, or disability.
- Participate in the Vender option

May expect the aide to:

- Act in a professional manner.
- Be on time for the scheduled visits.
- Notify you if they are unable to deliver services.
- Arranges a make-up visit satisfactory to you.

May NOT expect the aide to:

- Accept food or drink, expect water.
- Accept gifts or tips.
- Give you a ride.
- Be a maid.
- Participate in Consumer-Directed option are expected to:
- Select, hire, fire, train, and supervise the Attendant.
- Prepare timesheets and submit bi-weekly to the Vendor.
- Ensure the units of service delivered not exceed those authorized.
- Use only the Attendant who is registered, screened, and employable pursuant to the Family Care Safety Registry (FCSR), Employee Disqualification List (EDL) and applicable state laws and regulations.

Consumer has read and understands their rights and responsibilities.

Consumer Name: _____Date:_____

Consumer Signature: _____Date:_____

Please print on white paper only

Reset Form | Print Form

Form **2827**

Missouri Department of Revenue
Power of Attorney

Department Use Only (MM/DD/YY)

Taxpayer Missouri Tax I.D. Number

Taxpayer Federal Employer I.D. Number

Taxpayer Social Security Number

14504010001

All appointed representatives must sign on reverse side of this form.

Taxpayer's Name or Business Name			
Spouse's Name or if a dba, state the business name			Spouse's Social Security Number
Street Address			Missouri Charter Number
City	State	Zip Code	Telephone Number (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
E-mail Address			

Representative(s)

Name of Appointed Representative	Address
Khanh Bui	3217 Lemay Ferry Rd, Saint Louis, MO 63125
Telephone Number (3 1 4) 3 2 9 - 6 0 9 9	E-mail Address unitedathome@yahoo.com
Name of Appointed Representative	Address
Chuong Dang	3217 Lemay Ferry Rd, Saint Louis, MO 63125
Telephone Number (3 1 4) 3 2 9 - 6 0 9 9	E-mail Address unitedathome@hotmail.com
Name of Appointed Representative	Address
Telephone Number (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___	E-mail Address
Name of Appointed Representative	Address
Telephone Number (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___	E-mail Address

Tax Type(s)

- ☐ Cigarette or Other Tobacco Products
- ☐ Corporation Income and Corporation Franchise
- ☐ Personal Income
- ☐ Motor Fuel
- ☐ Sales or Use
- ☒ Withholding
- ☐ Other _____

Year(s) and Period(s)

- ☒ All Tax Periods
- ☐ Tax Year or Period(s) Only _____
- ☐ Range of Tax
- ☐ Date of Death (if estate tax) ___ ___ / ___ ___ / ___ ___ ___ ___

Tax Period Beginning ___ ___ / ___ ___ / ___ ___ ___ ___ to Tax Period Ending ___ ___ / ___ ___ / ___ ___ ___ ___

Removal of Power

- ☐ All other powers of attorney on file with the Department shall remain in effect, or
- ☐ By execution of this power of attorney, all earlier powers of attorney on file with the Department are hereby revoked, except the following: (specify to whom the power of attorney was granted, date and address, or refer to attached copies of earlier powers of attorney and authorizations.) Attach additional forms if needed.

_____

_____

Signature

Under penalties of perjury, I (we) hereby certify that I (we) am (are) the taxpayer(s) named herein or that I have the authority to execute this power of attorney on behalf of the taxpayer(s).

Name	Title (if applicable)	
Signature	Date (MM/DD/YYYY) __ __ / __ __ / __ __ __ __	Taxpayer Telephone Number (__ __ __) __ __ __ - __ __ __ __
Name	Title (if applicable)	
Signature	Date (MM/DD/YYYY) __ __ / __ __ / __ __ __ __	Taxpayer Telephone Number (__ __ __) __ __ __ - __ __ __ __

Declaration of Representative(s)

Please consult Missouri Regulation **12 CSR 10-41.030** for any questions about who may serve as an attorney(s)-in-fact and what additional documentation may be required.

I declare that I am aware of Regulation **12 CSR 10-41.030** and that I am authorized to represent the taxpayers identified above for the tax matters there specified and that I am one of the following:

1. a member in good standing of the bar;
2. a certified public accountant duly qualified to practice;
3. an officer of the taxpayer organization;
4. a full-time employee of the taxpayer;
5. a fiduciary for the taxpayer;
6. an enrolled agent;
7. tax preparer, or
8. other authorized representative or agent

Note: All appointed representatives must sign below. **No digital signatures allowed**

Printed Name of Representative	Signature of Representative	Date (MM/DD/YYYY)
KHANH BUI		___ ___ / ___ ___ / ___ ___ ___ ___
Designation (Please select number from list above) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☒ 8	Title (if applicable) DIRECTOR	
Printed Name of Representative	Signature of Representative	Date (MM/DD/YYYY)
CHUONG DANG		___ ___ / ___ ___ / ___ ___ ___ ___
Designation (Please select number from list above) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☒ 8	Title (if applicable) MANAGER	
Printed Name of Representative	Signature of Representative	Date (MM/DD/YYYY)
		___ ___ / ___ ___ / ___ ___ ___ ___
Designation (Please select number from list above) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8	Title (if applicable)	
Printed Name of Representative	Signature of Representative	Date (MM/DD/YYYY)
		___ ___ / ___ ___ / ___ ___ ___ ___
Designation (Please select number from list above) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8	Title (if applicable)	

Mail to:

(Business Tax)
Taxation Division
P.O. Box 357
Jefferson City, MO 65105-0357
Phone: (573) 751-5860
Fax: (573) 522-1722
E-mail: businesstaxregister@dor.mo.gov

(Personal Tax)
Taxation Division
P.O. Box 2200
Jefferson City, MO 65105-2200
Phone: (573) 751-3505
Fax: (573) 751-2195
E-mail: income@dor.mo.gov

(Motor Fuel Tax)
Taxation Division
P.O. Box 300
Jefferson City, MO 65105-0300
Phone: (573) 751-2611
Fax: (573) 522-1720
E-mail: excise@dor.mo.gov

(Cigarette or Other Tobacco Products Tax)
Taxation Division
P.O. Box 811
Jefferson City, MO 65105-0811
Phone: (573) 751-7163
Fax: (573) 522-1720
E-mail: excise@dor.mo.gov

Visit **http://dor.mo.gov/** for additional information.

14504020001

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.

✗ **Sign your name here**

Print your name here

Print your title here Consumer

Date / /

Best daytime phone

Now give this form to the agent to complete.

Part 3: **Agent Information: If you will be an agent for an employer or payer, or want to revoke an appointment, complete this part.**

6 Agent's employer identification number (EIN) 47 – 1535785

7 Agent's name (not trade name) CHUONG DANG

8 Trade name (if any) UNITED AT HOME LLC

9 Address 3217 Lemay Ferry Rd
Number Street Suite or room number

Saint Louis | MO | 63125
City State ZIP code

Foreign country name | Foreign province/county | Foreign postal code

☑ Check here if the employer is a home care service recipient receiving home care services through a program administered by a federal, state, or local government agency.

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

X **Sign your name here**

Print your name here CHUONG DANG

Print your title here MANAGER

Date / /

Best daytime phone (314)329-6099

DIVISION OF EMPLOYMENT SECURITY

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

POWER OF ATTORNEY

I. Business/Taxpayer

Name			
Address	City	State	ZIP Code

Phone Number	FEIN	UI Tax Number

II. Does Hereby Appoint

Name of Appointed Representative		Phone Number	
CHUONG DANG		(314)329-6099	
Address	**City**	**State**	**ZIP Code**
3217 Lemay Ferry Rd	Saint Louis	MO	63125

as attorney(s)-in-fact to represent taxpayer before the Missouri Division of Employment Security with respect to the following Unemployment Insurance matter(s):

Type of Representation *(check one)*: ☒ UI Tax and Claim Matters ☐ UI Tax Only ☐ UI Claim Only

Change employer's official mailing address to that of appointed representative for (*check all that apply)*:

☐ UI Tax Matters ☐ UI Claim Matters

This authorization supersedes and revokes any prior power of attorney or authorization on file with the Missouri Division of Employment Security relating to the subject matter hereof.
The authorization does not apply to the Division of Employment Security appeals process.

III. Signature of Business Representative/Taxpayer

Name *(printed)*	Title

Signature	Date

IV. Signature of Appointed Representative

Name *(printed)*	Title
CHUONG DANG	GENERAL MANAGER

Signature	Date

V. Mail or fax completed form to:

Missouri Division of Employment Security
Attn: Liability Unit
P.O. Box 59
Jefferson City, MO 65104-0059
Fax Number: 573-751-7483

***IMPORTANT**: If needed, call 573-751-3340 for assistance in the translation and understanding of the information in this document.*

***¡IMPORTANTE!**: Si es necesario, llame al 573-751-3340 para asistencia en la traducción y entendimiento de la información en este documento.*

Missouri Division of Employment Security is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. TDD/TTY: 800-735-2966 Relay Missouri: 711

TRAINING AND ORIENTATION

Training and Orientation Objective:

- Understand Consumers responsibilities of being an employer
- Fill out Time Sheets
- Understand how to use UAH's designated electronic Time Tracking System
- Identified issues that would be considered fraud of the program
- Understand which task are Allowable and non-allowable
- Distinguish abuse, neglect and/or explorations

Consumers Responsibilities of being an employer
UAH staff will read over and demonstrate to consumers their rights and responsibilities of being an employer to their chosen care givers with the following topic:

- ✓ Selection, hiring, training and supervision of the consumer's personal care attendants
- ✓ Equal opportunity employers
- ✓ Ensuring that units submitted for reimbursement do not exceed the amounts authorized by CDS plan of care and/or the vendor within ten (10) days of any changes in circumstances affecting the CDS plan of care and/or change in the consumer's place of residence
- ✓ Maintaining an active MohealthNet (Medicaid) Status
- ✓ Training attendant(s) on how to complete the tasks authorized on the plan of care
- ✓ Providing any supplies or equipment needed for the attendants to perform tasks authorized on the consumer's plan of care (cleaning supplies, vehicles, gasoline, etc)
- ✓ Notifying attendants or UAH if consumer will not be come for scheduled work time or visit
- ✓ Notifying UAH's when consumer is hospitalized

Time Sheet
UAH staff will teach consumer on a step by step basic on how to fill out their time sheets, by making sure all of the following information are properly filled.

- ✓ Attendants name
- ✓ Consumer name
- ✓ Dates and times of services delivery
- ✓ Types of activities performed at each visit
- ✓ Attendant signature for each visit
- ✓ Consumers signature verifying
- ✓ Service delivery for each visit
- ✓ Rules and limitation of timesheets

Electronic Telephone Tracking System
UAH will demonstrate verbally and show a video clip to help consumer understand how to properly utilized the Telephone Tracking System

- ✓ How to register for telephone tracking system
- ✓ Unique Identification Number
- ✓ How to clock in and out
- ✓ How to report tasks that have been completed
- ✓ How to verify daily the clock in and clock out times

- ✓ Telephone Tracking System Rules and limitations

Identification of issues that would be considered fraud of the program

- ✓ Telephone Tracking System and Time Sheet Fraud
- ✓ Medicaid Fraud
- ✓ Falsification of documentations
- ✓ Misappropriation
- ✓ How to report fraud
- ✓ Consequences of committing fraud

Allowable and Non-allowable Tasks

- ✓ Routine tasks
- ✓ Instrumental activities
- ✓ Undue hardship
- ✓ Unmet needs

Identification of abuse, neglect, and/or exploitation
UAH shall explain to consumer different types of abuse, neglect, and exploitation. Followed by a short video clip to help consumers, especially native speakers how to better understand these types of issues and how they could get help in case it might happen to them. http://www.mimhtraining.com/dd/abuse-neglect/

- ✓ Mandated reporting of abuse/neglect
  - Physical injuries
  - Sexual injuries
  - Emotional injuries
- ✓ Neglect
  - Neglect may be passive
  - Neglect may be active
- ✓ Exploitation
- ✓ How to get help

Upon completion of the training and orientation, UAH will provide copies of documentations for consumers to sign and review. These documents are for consumers to keep with them.

- ➢ Copies of all correspondence with DHSS, the consumer's physician, other service providers, and other administrative agencies
- ➢ Documents of training in the skills needed to understand and perform the essential functions of the employer
- ➢ Documents of the consumer's emergency or backup plan
- ➢ Signed documentation that the consumer has been informed of their rights concerning hearing and consumer responsibilities.

Consumer Signature_____Date _____

United at Home Trainer_____Date_____

Save Print Reset

STATE OF MISSOURI

AUTHORIZATION FOR DISCLOSURE OF CONSUMER MEDICAL/HEALTH INFORMATION

I, _____ authorize and request
(NAME OF CONSUMER, PARENT, GUARDIAN/LEGAL REPRESENTATIVE)

Check all that apply:

- ☐ Department of Mental Health (DMH)
- ☒ Department of Health and Senior Services (DHSS)
- ☒ Department of Social Services (DSS)
- ☐ Department of Elementary and Secondary Education (DESE)
- ☐ Department of Corrections (DOC)
- ☐ Missouri Veterans Commission (MVC)
- ☐ Other _____
(NAME OF FACILITY, AGENCY, MENTAL HEALTH CENTER, PERSON)

to **disclose/release** the below specified information of:

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

WHO RECEIVED SERVICES FROM (DATES)
1

to **(check all that apply)**

- ☐ Department of Mental Health (DMH)
- ☐ Department of Health and Senior Services (DHSS)
- ☐ Department of Social Services (DSS)
- ☐ Department of Elementary and Secondary Education (DESE)
- ☐ Department of Corrections (DOC)
- ☐ Missouri Veterans Commission (MVC)
- ☒ Other United At Home
(NAME OF FACILITY, AGENCY, MENTAL HEALTH CENTER, PERSON)
3217 Lemay Ferry Rd, Saint Louis, MO 63125
(ADDRESS, CITY, STATE, ZIP)

THE PURPOSE OF THIS DISCLOSURE IS (CHECK ALL THAT APPLY)

- ☐ Eligibility Determination
- ☐ Assessment
- ☐ Aftercare
- ☐ Placement
- ☐ Transfer/Treatment
- ☐ Treatment Planning
- ☐ Continuity of Services/Care
- ☐ Conditional/Unconditional Release Hearing
- ☐ At Consumer's Request
- ☒ To share or refer my information to other Missouri state agencies (such as DMH, DHSS, DSS, DESE, DOC, MVC, etc.) to obtain services consistent with the DHSS program (please complete the name of the program in which you want to participate)
- ☐ Other (specify) _____

THE SPECIFIC INFORMATION TO BE DISCLOSED IS (CHECK ALL THAT APPLY)

- ☒ Discharge Summary
- ☒ Progress Notes
- ☒ Treatment Plan and/or Review
- ☒ Social Service Assessment
- ☒ Educational testing, IEP, transcript, and/or grading reports
- ☒ Medical/Psychiatric Assessment(s)
- ☒ Psychotherapy Notes
- ☐ Psychometric testing, including intelligence quotient (IQ) results, neurological testing, or other developmental test results.
- ☐ Other _____

1. **READ CAREFULLY:** I understand that my medical/health information records are confidential. I understand that by signing this authorization, I am allowing the release of my medical/health information. The protected health information (PHI) in my medical record includes mental/behavioral health information. In addition, it may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), other communicable diseases or environmental conditions, and/or alcohol/drug abuse.
2. Alcohol and drug abuse information records are specifically protected by federal regulations (42 CFR 2) and by signing this authorization without restrictions I am allowing the release of any alcohol and/or drug information records (if any) to the agency or person specified above. Please sign if you are authorizing the release of alcohol and drug abuse information:

   _____
3. This authorization includes both information presently compiled and information to be compiled during the course of treatment at the above-named facility or agency paying for services, during the specified time frame.
4. This authorization becomes effective on _____ . This authorization automatically expires on the following date, event or special condition _____ .
5. If I fail to specify an expiration date, this authorization will expire in one year.
6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so **IN WRITING** and present my written revocation to the health information management department (medical records) or client information center at this facility. I further understand that actions already taken based on this authorization, prior to revocation, will **NOT** be affected.
7. I understand that I have the right to receive a copy of this authorization. **A photographic copy of this authorization is as valid as the original.**
8. I understand that authorizing the disclosure of this medical/health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Section 164.524. I understand that any disclosure of information carries with the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my medical/health information, I can contact the health information management director (medical records director) or client information center, or designee, or the Privacy Officer for this covered entity.

THE FOLLOWING APPLIES TO ALCOHOL AND/OR DRUG ABUSE TREATMENT INFORMATION RECORDS: Prohibition of Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without the specific written authorization of the person to whom it pertains, or as otherwise specified by such regulations. A general authorization for disclosure of medical or other information is NOT sufficient for this purpose.

My signature below acknowledges that I have read, understand, and authorize the release of my PHI.

SIGNATURE OF CONSUMER	DATE
WITNESS	DATE
SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE	

(Please include a Description of Authority to Act on Consumer's Behalf and attach a copy of the Document Granting Authority, where applicable)

NOTICE OF REVOCATION

DATE

I, _____ , (Consumer) hereby revoke my authorization of this disclosure of information to the agency/person listed above. This revocation effectively makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected.

SIGNATURE OF CONSUMER	DATE
WITNESS	DATE
SIGNATURE OF PARENT/LEGAL GUARDIAN/REPRESENTATIVE	DATE

If you choose to revoke your authorization, please provide a copy of the completed revocation to the health information management director (medical records director), or the client information center, or to the Privacy Officer of this facility.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
P.O. BOX 570 JEFFERSON CITY, MO 65102-0570
TELÉPHONE: 573-751-6400 FAX: 573-751-6010

RELAY MISSOURI for Hearing
and Speech Impaired 1-800-735-2966
VOICE: 1-800-735-2466

PRIVACY POLICIES ACKNOWLEDGEMENT FORM

1. CLIENT NAME (PRINT CLIENT'S FIRST NAME, MIDDLE INITIAL AND LAST NAME)		
2. CLIENT DATE OF BIRTH (M/D/Y)	3. CLIENT SOCIAL SECURITY NUMBER	4. CLIENT DCN (IF APPLICABLE)

I acknowledge that I have been given a copy of the Missouri Department of Health and Senior Services Notice of Privacy Policies and have been told where I can obtain any revisions made to this Notice.

PRINT THE FIRST NAME, MIDDLE INITIAL AND LAST NAME OF THE CLIENT/PARENT/GUARDIAN/DURABLE POWER OF ATTORNEY FOR HEALTH CARE

SIGNATURE OF THE CLIENT/PARENT/GUARDIAN/DURABLE POWER OF ATTORNEY FOR HEALTH CARE (DPOA-HC)	DATE

NOTE: If this document is signed by the Guardian or Durable Power of Attorney for Health Care, attach a copy of the Letters Appointing the Guardian or a copy of the Durable Power of Attorney for Health Care.

Please check one of the following to indicate the relationship between the client and the person whose signature appears on the line above:

- ☐ CLIENT
- ☐ CLIENT'S PARENT
- ☐ CLIENT'S GUARDIAN
- ☐ CLIENT'S DPOA-HC
- ☐ CLIENT REFUSED TO SIGN FORM

(For Staff Use Only)

Name of Bureau or Program

Address **City** **State** **Zip**

Staff Signature (if present when Notice provided) **Date**

Print Name

MO 580-2833 (7-07)

Form **SS-4**
(Rev. January 2010)
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.**

OMB No. 1545-0003

EIN

Type or print clearly.

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

2 Trade name of business (if different from name on line 1) | **3** Executor, administrator, trustee, "care of" name

4a Mailing address (room, apt., suite no. and street, or P.O. box) | **5a** Street address (if different) (Do not enter a P.O. box.)

4b City, state, and ZIP code (if foreign, see instructions) | **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) ►
- ☐ Estate (SSN of decedent)
- ☐ Plan administrator (TIN)
- ☐ Trust (TIN of grantor)
- ☐ National Guard ☐ State/local government
- ☐ Farmers' cooperative ☐ Federal government/military
- ☐ 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) ►
- ☐ Banking purpose (specify purpose) ►
- ☐ Changed type of organization (specify new type) ►
- ☐ Purchased going business
- ☐ Created a trust (specify type) ►
- ☐ Created a pension plan (specify type) ►

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

12 Closing month of accounting year

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

If no employees expected, skip line 14.

Agricultural	Household	Other
	1	

14 If you expect your employment tax liability to be $1,000 or less in a full calendar year **and** want to file Form 944 annually instead of Forms 941 quarterly, check here. (Your employment tax liability generally will be $1,000 or less if you expect to pay $4,000 or less in total wages.) If you do not check this box, you must file Form 941 for every quarter. ☐

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

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

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

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

18 Has the applicant entity shown on line 1 ever applied for and received an EIN? ☐ **Yes** ☑ **No**

If "Yes," write previous EIN here ►

Third Party Designee

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

Designee's name | Designee's telephone number (include area code) ( )

Address and ZIP code | Designee's fax number (include area code) ( )

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

Name and title (type or print clearly) ► | Applicant's telephone number (include area code) ( )

Signature ► Date ► | Applicant's fax number (include area code) ( )

Please print on white paper only

Reset Form | Print Form

Form **126**

Missouri Department of Revenue
Registration or Exemption Change Request

Department Use Only (MM/DD/YY)

Missouri Tax I.D. Number

Federal Employer I.D. Number

Select one ☐ I am updating my business tax account ☐ I am updating my sales and use exemption account

Name Currently On File		Phone Number ( ) -
Address Currently On File	City	State / Zip Code

This form can be used to make changes to your sales and use, employer withholding, corporate income or franchise tax, or exemption registration records. Only complete the section(s) that apply to the changes you wish to make.

Name and Address

Change Owner Name To: (If there has been a change in ownership, a Missouri Tax Registration Application (Form 2643) must be completed in lieu of this form. Also, if your organization is incorporated, your name must be changed with the Missouri Secretary of State's Office before your account can be updated).

Change Business Name (Doing Business As) To

Change Owner or Organization Street Address To

City | State | Zip Code | County

Officers, partners, or Members

All information is required if completing the Officers, Partners, or Members Section. Attach a list if needed.

Business Tax Accounts: Adding persons indicates they have direct supervision or control over tax matters. If adding or deleting partners from a partnership account, all partners must sign this form including the partner being deleted or added. If deleting partners and only one partner remains, you must close your partnership account and complete Form 2643 to apply for a new sole owner account. Sales and Use Exemption Accounts: Only officers of the organization can be added to your account. All other persons must obtain a Missouri Power of Attorney (Form 2827).

☐ Add ☐ Remove | Title Begin or End Date (MM/DD/YYYY) __ __ / __ __ / __ __ __ __ | Name (Last, First, Middle Initial)

Title | Social Security Number | FEIN

Birthdate (MM/DD/YYYY) __ __ / __ __ / __ __ __ __ | Home Address

City | State | Zip Code | County

☐ Add ☐ Remove | Title Begin or End Date (MM/DD/YYYY) __ __ / __ __ / __ __ __ __ | Name (Last, First, Middle Initial)

Title | Social Security Number | FEIN

Birthdate (MM/DD/YYYY) __ __ / __ __ / __ __ __ __ | Home Address

City | State | Zip Code | County

Mailing Address

Change For: ☐ All Tax Types ☐ Corporate Income and Franchise Tax ☐ Employer Withholding Tax ☐ Sales and Use Tax

In Care Of (Optional) | Company Name if different from owner

Address | City | State | Zip Code | County

Close Location

Close the following business location for: ☐ Consumer's Use Tax ☐ Employer Withholding Tax ☐ Sales Tax ☐ Vendor's Use Tax

Business Name | Address

City | State

Zip Code | County | Date of Closing (MM/DD/YYYY) __ __ / __ __ / __ __ __ __

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Open Location

Open the following new business location for: ☐ Consumer's Use Tax ☐ Employer Withholding Tax ☐ Sales Tax ☐ Vendor's Use Tax

Business Name	Taxable Sales Begin Date (MM/DD/YYYY)
	__ __ / __ __ / __ __ __ __

Street or Highway Address (Do not use Rural Route or PO Box)

City	State	Zip Code	County

Sales and Use Tax

Is this business located inside the city limits of any city or municipality in Missouri? For help determining this visit **https://dors.mo.gov/tax/strgis/index.jsp**.
☐ No ☐ Yes - Specify the city:

Is this business located inside a district(s)? For example, ambulance, fire, tourism, community, or transportation development.
☐ No ☐ Yes - Specify the district name(s):

Change Sales and Use Tax Filing Frequency To: ☐ Monthly ($500 or more per month in tax) ☐ Quarterly (Less than $500 per month in tax)
☐ Annually (Less than $100 per quarter in sales tax) *Continue current filing until this change is verified by the Department.

Do you make retail sales of the following items? Select all that apply.

☐ Alcoholic Beverages ☐ Alternative Nicotine ☐ Cigarettes or Other Tobacco Products ☐ Domestic Utilities
☐ E-Cigarettes or Vapor Products ☐ Food Subject to Reduced State Food Tax Rate ☐ Items Qualifying for Show Me Green Sales Tax Holiday
☐ Items Qualifying for Back-To-School Sales Tax Holiday ☐ Lead-Acid Batteries ☐ Lease or Rent Motor Vehicles
☐ New Tires ☐ Post-Secondary Educational Textbooks ☐ Telecommunication Services
☐ Qualifying Utilities or Items Used or Consumed in Manufacturing or Mining, Research and Development, or Processing Recovered Materials.

Do you make retail sales of aviation jet fuel to Missouri customers? ..... ☐ Yes ☐ No
If yes, are your sales made at: ☐ A Missouri airport ☐ A location outside Missouri and the fuel is transported into Missouri?
If yes, is the airport located in Missouri and identified on the National Plan of Integrated Airport Systems (NPIAS)?..... ☐ Yes ☐ No
If yes, provide a list of applicable locations. _____
Do you use, store, or consume aviation jet fuel in Missouri where the seller does not collect tax? ..... ☐ Yes ☐ No
If yes, is the fuel stored, used, or consumed in an airport that is identified on the NPIAS? ..... ☐ Yes ☐ No
If yes, provide a list of applicable locations: _____

Withholding Tax

☐ I would like to change from a transient employer to a regular employer.
(Must have filed 24 consecutive months in Missouri)

Change* Withholding Tax Filing Frequency To:
☐ Monthly ($500 or more per month in tax)
☐ Quarterly (Less than $500 per month in tax)
☐ Annually (Less than $45 per quarter in tax)
☐ Quarter-Monthly (Over $9,000 per month in tax)

*Continue current filing until this change is verified by the Department.

Corporate Income Tax

Change the corporation taxable year end to:
(MM/DD) __ __ / __ __

Comments

Signature

Under penalties of perjury, I declare that the above information and any attached supplement is true, complete, and correct. This form must be signed by the owner, if the business is a sole ownership; partner, if the business is a partnership; reported officer, if the business is a corporation, or by a member, if the business is an L.L.C. as reported on the application. **No digital signatures allowed**

Signature	Printed Name
Title	**Date (MM/DD/YYYY)**
	__ __ / __ __ / __ __ __ __

Registration Change

Mail to: Taxation Division
P.O. Box 3300
Jefferson City, MO 65105-3300

Phone: (573) 751-5860
TTY: (800) 735-2966
Fax: (573) 522-1722
E-mail: businesstaxregister@dor.mo.gov

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Exemption Change

Mail to: Taxation Division
P.O. Box 358
Jefferson City, MO 65105-0358

Phone: (573) 751-2836
TTY: (800) 735-2966
Fax: (573) 522-1271
E-mail: salestaxexemptions@dor.mo.gov

Visit
http://dor.mo.gov/business/register/
for additional information.

MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

APPOINTING AN AUTHORIZED REPRESENTATIVE

Use this form if you would like an authorized representative to help you apply for MO HealthNet coverage, Temporary Assistance, Food Stamps, Child Care Subsidy, and/or act on your behalf if you get MO HealthNet coverage, Temporary Assistance, and/or Food Stamps.
If you are a resident of a Drug and Alcohol treatment and rehabilitation program and you want to apply for Food Stamp benefits, you must appoint an authorized representative who is employed by the treatment facility to apply and access benefits for you.
If you reside in a group home and are eligible for Food Stamp benefits on your own, you do not need to sign this form to apply for or receive Food Stamp benefits.
You can choose to have an authorized representative or you can act on your own behalf. If you already have a guardian, conservator, or attorney-in-fact appointed by a valid Power of Attorney under Missouri law, they must appoint an authorized representative for you. Even if you choose to have an authorized representative, the FSD may sometimes need to contact you directly.

Instructions:
1. Fill out and sign your name(s) in Sections 1 and 2. Only one (1) form is necessary if the same authorized representative is being appointed for both members of a married couple or yourself and a second parent.
2. Have the person, facility, or organization you're appointing fill out and sign their name in Section 3 to verify they accept the responsibilities listed below.
3. Return your completed form to the FSD **within 30 days** of the date(s) you and your authorized representative sign and date the form.

SECTION 1: YOUR INFORMATION AND AUTHORIZATION TO BE REPRESENTED

YOUR NAME(S)	TELEPHONE NUMBER

HOME ADDRESS	MAILING ADDRESS

DATE OF BIRTH OR DCN (CASE NUMBER)

I APPOINT AS MY/OUR AUTHORIZED REPRESENTATIVE:

NAME

MY AUTHORIZED REPRESENTATIVE IS ONE OR MORE OF THE FOLLOWING (CHECK ALL THAT APPLY):

☐ Spouse	☐ Legal Guardian	☐ Attorney	☐ Public Administrator
☐ Department of Mental Health	☐ Conservator	☐ Power of Attorney	☑ None of these

By appointing an authorized representative, you are consenting to allow FSD to send letters and notices to your authorized representative.

For Food Stamps, I/we authorize this person or organization to be responsible for (check one or more boxes):
- ☐ Helping me/us apply for Food Stamp benefits, including annual reviews, reporting changes, and receive notices.
- ☐ Access my benefits (EBT card)
- ☐ Access FSD account online communications
- ☑ Access FSD account online communications only after I am deceased

For Temporary Assistance (TA), I/we authorize this person to be responsible for (check one or more boxes):
- ☐ Helping me/us apply for TA benefits which includes acting on my/our behalf if I/we are approved for TA benefits, including annual reviews, reporting changes, and receiving notices.
- ☐ Access FSD account online communications
- ☐ Access FSD account online communications only after I am deceased

MO HealthNet, if your authorized representative helps you apply, your authorization will last until FSD makes a final decision on your application, or you can end it sooner if you notify FSD in writing. If your authorized representative acts on your behalf, your authorization will last until you end it by notifying FSD in writing.

I/we authorize this person or organization to be responsible for (check one or more boxes):
- ☐ Helping me/us apply for MO HealthNet coverage
- ☐ Acting on my/our behalf if I/we get MO HealthNet coverage, including annual reviews, and reporting changes.
- ☐ Access FSD account online communications
- ☐ Access FSD account online communications only after I am deceased.

For Child Care Subsidy, I/we authorize this person or organization to be responsible for:
- ☐ Helping me/us apply for Child Care Subsidy benefits

The person or organization I/we have appointed is age 18 or older and knows my/our situation well enough that they can complete my/our application and act on my/our behalf. They will not knowingly make a false or misleading statement, hide information, or fail to report any fact or event that is required to be reported by any law, regulation, or rule of this State or the United States.

NOTE: Organizations may not be appointed for Temporary Assistance applicants or recipients.

I/we understand that I/we am responsible for the information given by my/our authorized representative, including any information that may be incorrect.

YOUR (APPLICANT/PARTICIPANT) SIGNATURE	DATE
YOUR SPOUSE'S OR SECOND PARENT SIGNATURE	

SECTION 2: YOUR AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION AND OTHER INFORMATION (For MO HealthNet Programs; OPTIONAL FOR Food Stamp, Child Care and Temporary Assistance programs)

Please write your name and the name of a person who can receive **protected health information** (PHI) and other information about you. Write the name of a person, **not** an organization. You may skip this section if you are appointing your spouse, attorney, attorney-in-fact, guardian, conservator, or court appointed public administrator to act as your authorized representative.

I/We, (your name(s))_____ _____,
request and authorize Family Support Division to disclose information to this person:

REPRESENTATIVE NAME

Because I'm/we're giving this request and authorization, FSD may release to the person named above:

- Requests for information
- Eligibility notices and medical information about this application
- My/our annual review
- Letters about agency action

This authorization will continue during the final decision on my/our application, my/our annual review, or agency action for which I/we gave this authorization. If I/we want to end my authorization sooner, I/we must tell the FSD in writing before the final application, annual review, or agency action decision.

I/we understand that FSD is not responsible for what happens to information they release because I/we have requested and authorized them to disclose my/our Protected Health Information. I/we understand and agree that FSD has given me/us a signed copy of this form.

YOUR (APPLICANT/PARTICIPANT) SIGNATURE	DATE

YOUR SPOUSE'S OR SECOND PARENT'S SIGNATURE

SECTION 3: AUTHORIZED REPRESENTATIVE AGREEMENT AND ACCEPTANCE

Individual acting as Authorized Representative: Please fill out and sign this section.

REPRESENTATIVE'S NAME	TELEPHONE NUMBER -

REPRESENTATIVE'S MAILING ADDRESS

REPRESENTATIVE'S DATE OF BIRTH (TEMPORARY ASSISTANCE)

I am age 18 or older and know the applicant's situation well enough to complete their application or act on their behalf. I will not knowingly make a false or misleading statement, hide information, or fail to report any fact or event that is required to be reported by any law, regulation or rule of this State or the United States.

I agree to be the applicant's authorized representative for the reason(s) stated on this form. I will protect the privacy of any information I get while acting as authorized representative as required by Federal, State and local laws, regulations, ordinances, and directives about privacy.

AUTHORIZED REPRESENTATIVE'S SIGNATURE	DATE

Individual acting as authorized representative due to affiliation with an organization or facility: Please fill out and sign this section.

ORGANIZATION OR FACILITY NAME

ORGANIZATION OR FACILITY ADDRESS

ORGANIZATION OR FACILITY E-MAIL	ORGANIZATION OR FACILITY TELEPHONE

I represent the organization or facility named above. I have provided proof of my identity to the Family Support Division. I have knowledge of the applicant's or participant's situation well enough to complete their application or act on their behalf. I will not knowingly make a false or misleading statement, hide information, or fail to report any fact or event that is required to be reported by any law, regulation, or rule of this State or the United States.

I will report changes to FSD on behalf of the participant as needed. I will inform FSD if I am no longer an authorized representative.

I understand I must do the following once I stop being an authorized representative:

- Immediately stop using the EBT card.
- Notify FSD of the change in authorized representative status within 48 hours.

I agree to be the applicants authorized representative. I will protect the privacy of any information I get while acting as an authorized representative as required by Federal, State, and local laws, regulations, and directives about privacy.

AUTHORIZED REPRESENTATIVE'S SIGNATURE	DATE

Need Help?

- By Phone: **1-855-FSD-INFO (1-855-373-4636)**
- Online: **mydss.mo.gov**
- In person: **Visit any FSD Office.** To find an office in your area, call the number above or visit us online.

Please print on white paper only

It is not necessary to type hyphens or dashes.

Reset ALL PAGES of Form | Print ALL PAGES of Form

Form **2643A**

Missouri Department of Revenue
Missouri Tax Registration Application

Department Use Only (MM/DD/YY)

Missouri Tax I.D. Number (Optional)

Federal Employer I.D. Number

Answer all questions completely. Incomplete and unsigned applications will delay processing.

Reason for Application

3. Select all tax types for which you are applying:

Sales from a Missouri business location
- ☐ Retail Sales*
- ☐ Temporary Retail Sales* (Less than 191 days)
- ☐ Retail Liquor or Alcohol Sales**

Sales or Purchases from an out-of-state location
- ☐ Vendor's Use*
- ☐ Consumer's Use (Missouri purchases where tax is not collected.)

Missouri Employer Withholding Tax
- ■ Regular Withholding
- ☐ Domestic or Household Employee
- ☐ Transient Employer*

Corporate Tax
- ☐ Corporate Income
- ☐ Corporate Franchise

*Bond Required **Minimum Bond of $500 Required

Reason for Applying
- ☐ New MO Registration
- ☐ Purchase of Existing Business
- ☐ Reinstating Old Business
- ☐ Converted (must have converted through the Missouri Secretary of State's office)
- ☐ Court Appointed Receiver
- ☐ Other:

Business Name and Physical Location

4. Business Name (DBA name: attach list if necessary for additional locations)

Street, Highway (Do not use P.O. Box Number or Rural Route Number) | City

County | State | Zip Code | Business Telephone Number ( ) -

5. Will sales be made at various temporary locations in Missouri?
■ No ☐ Yes—Attach a list of all known locations. If no Missouri location is given during initial registration, a general location will be used.

6. Is this business located inside the city limits of any city or municipality in Missouri? To verify go to **https://dors.mo.gov/tax/strgis/index.jsp**
☐ No ■ Yes — Specify the city: Saint Louis

7. Is this business located inside a district(s)? For example, ambulance, fire, tourism, community or transportation development.
■ No ☐ Yes — Specify the district name(s): _____

8. Describe the business activity, stating the major products sold and services provided. _____
HomeHealth
☐ Retail _____% ☐ Wholesale _____% ☐ Service _____% ☐ Manufacturer ☐ Contractor ☐ Other _____

Business Activity

9. Do you make retail sales of the following items? Select all that apply.
☐ Alcoholic Beverages ☐ Alternative Nicotine ☐ Cigarettes or Other Tobacco Products ☐ Domestic Utilities
☐ E-Cigarettes or Vapor Products ☐ Food Subject to Reduced State Food Tax Rate ☐ Items Qualifying for Show Me Green Sales Tax Holiday
☐ Items Qualifying for Back-To-School Sales Tax Holiday **http://dor.mo.gov/business/sales/taxholiday/** ☐ Lead-Acid Batteries
☐ New Tires ☐ Post-Secondary Educational Textbooks ☐ Telecommunication Services
☐ Qualifying Utilities or Items Used or Consumed in Manufacturing or Mining, Research and Development, or Processing Recovered Materials.

10. Do you make retail sales of aviation jet fuel to Missouri customers? ☐ Yes ■ No
If yes, are your sales made at:
☐ A Missouri airport? ☐ A location outside Missouri and the fuel is transported into Missouri?
If yes, is the airport located in Missouri and identified on the National Plan of Integrated Airport Systems (NPIAS)? ☐ Yes ■ No
If yes, provide a list of applicable locations. _____

11. Do you use, store, or consume aviation jet fuel in Missouri where the seller does not collect tax? ☐ Yes ■ No
If yes, is the fuel stored, used, or consumed in an airport that is identified on the NPIAS? ☐ Yes ■ No
If yes, provide a list of applicable locations: _____

12. Do you lease or rent motor vehicles that were purchased sales tax exempt, to Missouri customers? ☐ Yes ■ No
If you are an out-of-state company, will you lease motor vehicles to a Missouri resident where the lease is entered into outside Missouri and the motor vehicle is delivered outside Missouri? ☐ Yes ■ No

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If you are an out-of-state entity doing business in Missouri, please answer the following questions. Otherwise, skip to Line 18.

Out-of-State Company

13. Do you have a location or job site in Missouri? ☐ Yes ☒ No
If yes, attach a list of your locations including address, city, state, zip code and indicate if the location is inside or outside the city limits. _____

14. Are orders taken from your Missouri customers by telephone, non-resident salesmen, etc.? If resident salesmen, attach a list where they live and indicate if they are inside or outside the city limits ☐ Yes ☒ No

15. Do your representatives who reside in Missouri:
A. Approve customer orders? ☐ Yes ☒ No
B. Make on the spot sales? ☐ Yes ☒ No
C. Maintain an inventory? ☐ Yes ☒ No
D. Deliver merchandise to the customer? ☐ Yes ☒ No

16. Do you have non-resident representatives, agents, or temporary employees coming into Missouri on a regular basis? ☐ Yes ☒ No
If yes, define the activities performed while in Missouri. _____

17. Do you have real or tangible personal property in Missouri? ☐ Yes ☒ No
If yes, please describe: _____

Ownership Type

18. Ownership Type ☒ Sole Proprietor ☐ Partnership ☐ Government ☐ Trust

All ownership types listed below, unless specifically exempted, are required to be registered with the Missouri Secretary of State's Office (register at **sos.mo.gov** or call (866) 223-6535). Your application will not be complete without providing the charter number issued to you by their office.

☐ Limited Partnership - LP Number _____

☐ Limited Liability Partnership - LLP Number _____

☒ Limited Liability Company - LLC Number _____
Taxed as a ☐ Disregarded Entity ☐ Partnership ☐ Corporation

☐ Missouri Corporation - Missouri Charter No. _____
Date Incorporated (MM/DD/YYYY) ___ ___ /___ ___ /___ ___ ___ ___

☐ Non-Missouri Corporation - Missouri Charter No. _____
State of Incorporation _____ Date Registered in Missouri (MM/DD/YYYY) ___ ___ /___ ___ /___ ___ ___ ___

☐ Not Required to register with Missouri Secretary of State

☐ Other

Owner Information

19. Owner Name (Enter Corporation, LLC or Partnership Name, if applicable)			
Address		E-mail Address	
City	State	Zip Code	County
If an individual is listed as the owner, you must also provide the following:			
Social Security Number	Date of Birth (MM/DD/YYYY)	Telephone Number	
| | | | | | | | |	___ ___ /___ ___ /___ ___ ___ ___	(___ ___ ___)___ ___ ___-___ ___ ___ ___	

Previous Owner Information

20. Is there a previous owner or operator for the business? ☐ Yes* ☐ No *If yes, the following section must be completed.

Select any of the following that you purchased from the previous owner: ☐ Inventory ☐ Fixtures ☐ Equipment ☐ Real Estate

☐ Other _____

		Purchase Price	
Name of Previous Owner or Operator		Missouri Tax Identification Number	
Physical Location of Previous Business	City	State	Zip Code
Address of Previous Business	City	State	Zip Code

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Mailing and Storage Address

Reporting forms and notices will be mailed to this address.

21. Address (street, rural route or P.O. Box)	City	State	Zip Code
Company Name if different than owner			

Which forms do you want mailed to this address?

❒ All Tax Types ❒ Sales and Use Tax ❒ Corporate Income Tax ❒ Employer Withholding Tax

Address where you will store your tax records (do not use a P.O. Box for record storage).

22. Physical Address	City	State	Zip Code

Officers, Partners, or Members

23. Provide the officers, partners, or members (L.L.C.) of your business who are responsible for the collection and remittance of tax. Listing individuals or entities here indicates they have direct supervision or control over tax matters. Attach list if needed.

Name (Last, First, Middle Initial)		Title	
Social Security Number	Federal Employer ID Number (FEIN)	Date of Birth (MM/DD/YYYY) ___ ___/___ ___/___ ___ ___ ___	
Home Address		City	
State	Zip Code	County	Title Begin Date (MM/DD/YYYY) ___ ___/___ ___/___ ___ ___ ___

Name (Last, First, Middle Initial)		Title	
Social Security Number	Federal Employer ID Number (FEIN)	Date of Birth (MM/DD/YYYY) ___ ___/___ ___/___ ___ ___ ___	
Home Address		City	
State	Zip Code	County	Title Begin Date (MM/DD/YYYY) ___ ___/___ ___/___ ___ ___ ___

Name (Last, First, Middle Initial)		Title	
Social Security Number	Federal Employer ID Number (FEIN)	Date of Birth (MM/DD/YYYY) ___ ___/___ ___/___ ___ ___ ___	
Home Address		City	
State	Zip Code	County	Title Begin Date (MM/DD/YYYY) ___ ___/___ ___/___ ___ ___ ___

Retail Sales, Consumer's or Vendor's Use Tax

24. Taxable Sales or Purchases Begin Date (MM/DD/YYYY) ___ ___/___ ___/___ ___ ___ ___

25. Temporary License (Less than 191 days) (MM/DD/YYYY)
(Example: fireworks, temporary event, etc.) Begins ___ ___/___ ___/___ ___ ___ ___ Ends ___ ___/___ ___/___ ___ ___ ___

26. Seasonal Business: If you do not make taxable sales year round, please check the months that you do.

❒ January ❒ February ❒ March ❒ April ❒ May ❒ June ❒ July ❒ August ❒ September ❒ October ❒ November ❒ December

27. Estimated sales and use tax liability (select one). Your selection will determine your return filing frequency.

❒ Monthly (over $500 a month) ❒ Quarterly ($500 or less a month) ❒ Annually (less than $100 a quarter)

28. Compute the amount of bond

Estimated Monthly Taxable Sales		Tax Rate		Monthly Tax Liability		Amount of Bond*
____________	X	____________	=	____________	X 3 =	____________

Visit **https://dors.mo.gov/tax/strgis/index.jsp** to obtain your tax rate. *If you calculate the amount of bond to be less than $500, you are only required to submit a $25 bond ($500 minimum bond for liquor sales). If you calculate your bond to be $500 or greater, you should submit the amount of bond figured. If the Department determines the bond is insufficient to cover your tax liability, the Director of Revenue may require you to adjust the bond amount to a level satisfactory to cover your tax liabilities or if returns are not filed timely and the taxes fully paid (see **12 CSR 10-104.020**). Attach the appropriate bond form to your registration based on the type of bond checked.
Visit **http://dor.mo.gov/faq/business/register.php** to access frequently asked questions.

29. Type of bond (no personal or company checks) Visit **http://dor.mo.gov/forms/index.php?category=13** to access bond forms.

❒ Cash Bond (Form 332) ❒ Certificate of Deposit (Form 4172) ❒ Irrevocable Letter of Credit (Form 2879) ❒ Surety Bond (Form 331)

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Corporate Income Tax

30. Is this corporation registered with the Internal Revenue Service as a ☐ Regular or Close Corporation ☐ Sub Chapter S Corporation

31. Corporation Tax Begin Date in Missouri (MM/DD/YYYY) ___ ___/___ ___/___ ___ ___ ___ Corporation Taxable Year End (MM/DD) ___ ___/___ ___

32. Will the corporation be required to make quarterly estimated Missouri income tax payments? If the Missouri estimated tax is expected to be at least $250, or 6.25% of the Missouri taxable income, check the "Yes" box..... ☐ Yes ☐ No

Employer Withholding Tax

33. Missouri Withholding Begin Date (MM/DD/YYYY) ___ ___/___ ___/___ ___ ___ ___ How many of your employees will work in Missouri?

34. Estimated employer withholding tax liability (select one). Your selection will determine your return filing frequency.

Estimated monthly gross wages _____ X 6% = _____

☐ Annually (less than $20 withholding tax per quarter)
☐ Monthly ($500 to $9,000 withholding tax per month)
☐ Quarterly ($20 withholding tax per quarter to $500 per month)
☐ Quarter-Monthly (weekly) (over $9,000 withholding tax per month; required to pay electronically)

35. Does a parent company file withholding tax reports and receive full compensation for timely filed returns? ..... ☐ Yes ☐ No

36. If you do not pay wages year round, please check the months that you do pay wages.

☐ January ☐ February ☐ March ☐ April ☐ May ☐ June ☐ July ☐ August ☐ September ☐ October ☐ November ☐ December

Withholding Tax Courtesy Mailing Address (a copy of all withholding tax delinquent notices will be mailed to this address)

37. Business Name (DBA name)

Street, Route or P.O. Box		City	
County	State	Zip Code	Business Telephone Number (___ ___ ___)___ ___ ___-___ ___ ___ ___

Transient Employer

38. Are you a transient employer? ..... ☐ Yes ☐ No

An employer not domiciled in Missouri and temporarily transacting business in Missouri for less than 24 consecutive months is defined as a transient employer. (Example: contractor, temporary staffing agency, etc.). For additional information, contact the Department at **businesstaxregister@dor.mo.gov** or call (573) 751-0459. If you have indicated that you are a transient employer, you must complete the entire Employer Withholding Tax Section above.

A transient employer must submit the following with this application:

- A completed insurance certification slip indicating Missouri as a covered state for worker's compensation
- Missouri Employment Security Account number, if hiring a Missouri resident: (first seven digits required)
- Your Missouri Certificate of Authority Number issued by the corporate division of the Missouri Secretary of State's Office
- A Transient Employer Bond not less than $5,000

Missouri Employment Security Account Number

Calculate your transient employer bond:

A. Missouri withholding tax Monthly gross wages _____ X 6% = _____ X 3 = _____ (a)

B. Missouri unemployment tax Average # of workers _____ X $7,000 = _____ X 3.38% _____ / 4 = _____ (b)

(a) _____ + (b) _____ = _____ (amount of bond - minimum $5,000)

Visit **http://dor.mo.gov/forms/index.php?category=13** for bond forms.

Type of bond ☐ Cash Bond (Form 332) ☐ Certificate of Deposit (Form 4172) ☐ Irrevocable Letter of Credit (Form 2879) ☐ Surety Bond (Form 331)

Signature

Comments:

Under penalties of perjury, I declare that the above information and any attached supplement is true, complete, and correct. This application must be signed by the owner, if the business is a sole proprietorship, or by an individual listed in the Officer, Partners, or Members section of this application. The signing party is acknowledging that they have direct supervision or control over tax matters.

No digital signatures allowed

Signature	Title	Date (MM/DD/YYYY) ___ ___/___ ___/___ ___ ___ ___
Typed or Printed Name	E-mail Address	

Confidentiality of Tax Records

Missouri Statute 32.057, RSMo, states that all tax records and information maintained by the Missouri Department of Revenue are confidential. The tax information can only be given to the owner, partner, member, or officer who is listed with us as such. If you wish to give an employee, attorney, or accountant access to your tax information, you must supply the Department with a power of attorney to grant the authority to release confidential information to them. Visit **http://dor.mo.gov/forms** to obtain a Power of Attorney (**Form 2827**).

Form 2643A (Revised 02-2015)

Mail to: Taxation Division
P.O. Box 357
Jefferson City, MO 65105-0357

Phone: (573) 751-5860
Fax: (573) 522-1722
E-mail: businesstaxregister@dor.mo.gov

Visit
http://dor.mo.gov/business/register/
for additional information.

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Form **8821**

(Rev. January 2018)

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.**

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 7.

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

2 Appointee. If you wish to name more than one appointee, attach a list to this form. **Check here if a list of additional appointees is attached ▶** ☐

Name and address	
CHUONG DANG 3217 LEMAY FERRY RD SAINT LOUIS MO 63125	CAF No. PTIN Telephone No. 314-623-1278 Fax No. 314-944-9008 Check if new: Address ☐ Telephone No. ☐ Fax No. ☐

3 Tax Information. Appointee 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

4 Specific use not recorded on 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 lines 5 and 6 . . . . . ▶ ☑

5 Disclosure of tax information (you **must** check a box on line 5a or 5b unless the box on line 4 is checked):

a If you want copies of tax information, notices, and other written communications sent to the appointee on an ongoing basis, check this box . . . . . ▶ ☐

Note. Appointees will no longer receive forms, publications, and other related materials with the notices.

b If you don't want any copies of notices or communications sent to your appointee, check this box . . . . . ▶ ☐

6 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 6 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 6 instructions.

7 Signature of taxpayer. If signed by a corporate officer, partner, guardian, partnership representative, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute this form with respect to the tax matters and tax periods shown on line 3 above.

▶ IF NOT COMPLETE, 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)

Check Form for Common Errors & Reminders

Form **2848**
(Rev. January 2021)
Department of the Treasury
Internal Revenue Service

Power of Attorney and Declaration of Representative

► **Go to *www.irs.gov/Form2848* for instructions and the latest information.**

OMB No. 1545-0150

For IRS Use Only
Received by:
Name
Telephone
Function
Date / /

Part I Power of Attorney

Caution: A separate Form 2848 must be completed for each taxpayer. Form 2848 will not be honored for any purpose other than representation before the IRS.

1 Taxpayer information. Taxpayer must sign and date this form on page 2, line 7.

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

hereby appoints the following representative(s) as attorney(s)-in-fact:

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

Name and address	CAF No. / PTIN / Telephone No. / Fax No.
Check if to be sent copies of notices and communications ☐	Check if new: Address ☐ Telephone No. ☐ Fax No. ☐
Name and address	CAF No. / PTIN / Telephone No. / Fax No.
Check if to be sent copies of notices and communications ☐	Check if new: Address ☐ Telephone No. ☐ Fax No. ☐
Name and address	CAF No. / PTIN / Telephone No. / Fax No.
(**Note:** IRS sends notices and communications to only two representatives.)	Check if new: Address ☐ Telephone No. ☐ Fax No. ☐
Name and address	CAF No. / PTIN / Telephone No. / Fax No.
(**Note:** IRS sends notices and communications to only two representatives.)	Check if new: Address ☐ Telephone No. ☐ Fax No. ☐

to represent the taxpayer before the Internal Revenue Service and perform the following acts:

3 Acts authorized (you are required to complete line 3). Except for the acts described in line 5b, I authorize my representative(s) to receive and inspect my confidential tax information and to perform acts I can perform with respect to the tax matters described below. For example, my representative(s) shall have the authority to sign any agreements, consents, or similar documents (see instructions for line 5a for authorizing a representative to sign a return).

Description of Matter (Income, Employment, Payroll, Excise, Estate, Gift, Whistleblower, Practitioner Discipline, PLR, FOIA, Civil Penalty, Sec. 4980H Shared Responsibility Payment, etc.) (see instructions)	Tax Form Number (1040, 941, 720, etc.) (if applicable)	Year(s) or Period(s) (if applicable) (see instructions)

4 Specific use not recorded on the Centralized Authorization File (CAF). If the power of attorney is for a specific use not recorded on CAF, check this box. See *Line 4. Specific Use Not Recorded on CAF* in the instructions . . . . . ► ☐

5a Additional acts authorized. In addition to the acts listed on line 3 above, I authorize my representative(s) to perform the following acts (see instructions for line 5a for more information): ☐ Access my IRS records via an Intermediate Service Provider;
☐ Authorize disclosure to third parties; ☐ Substitute or add representative(s); ☐ Sign a return; _____

☐ Other acts authorized: _____

b **Specific acts not authorized.** My representative(s) is (are) not authorized to endorse or otherwise negotiate any check (including directing or accepting payment by any means, electronic or otherwise, into an account owned or controlled by the representative(s) or any firm or other entity with whom the representative(s) is (are) associated) issued by the government in respect of a federal tax liability.
List any other specific deletions to the acts otherwise authorized in this power of attorney (see instructions for line 5b): _____

_____

6 **Retention/revocation of prior power(s) of attorney.** The filing of this power of attorney automatically revokes all earlier power(s) of attorney on file with the Internal Revenue Service for the same matters and years or periods covered by this form. If you **do not** want to revoke a prior power of attorney, check here . . . . . ▶ ☐

YOU MUST ATTACH A COPY OF ANY POWER OF ATTORNEY YOU WANT TO REMAIN IN EFFECT.

7 **Taxpayer declaration and signature.** If a tax matter concerns a year in which a joint return was filed, each spouse must file a separate power of attorney even if they are appointing the same representative(s). If signed by a corporate officer, partner, guardian, tax matters partner, partnership representative (or designated individual, if applicable), executor, receiver, administrator, trustee, or individual other than the taxpayer, I certify I have the legal authority to execute this form on behalf of the taxpayer.

▶ **IF NOT COMPLETED, SIGNED, AND DATED, THE IRS WILL RETURN THIS POWER OF ATTORNEY TO THE TAXPAYER.**

Signature	Date	Title (if applicable)
Print name	Print name of taxpayer from line 1 if other than individual	

Part II Declaration of Representative

Under penalties of perjury, by my signature below I declare that:

- I am not currently suspended or disbarred from practice, or ineligible for practice, before the Internal Revenue Service;
- I am subject to regulations in Circular 230 (31 CFR, Subtitle A, Part 10), as amended, governing practice before the Internal Revenue Service;
- I am authorized to represent the taxpayer identified in Part I for the matter(s) specified there; and
- I am one of the following:

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

b Certified Public Accountant—a holder of an active license to practice as a certified public accountant in the jurisdiction shown below.

c Enrolled Agent—enrolled as an agent by the IRS per the requirements of Circular 230.

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

e Full-Time Employee—a full-time employee of the taxpayer.

f Family Member—a member of the taxpayer's immediate family (spouse, parent, child, grandparent, grandchild, step-parent, step-child, brother, or sister).

g Enrolled Actuary—enrolled as an actuary by the Joint Board for the Enrollment of Actuaries under 29 U.S.C. 1242 (the authority to practice before the IRS is limited by section 10.3(d) of Circular 230).

h Unenrolled Return Preparer—Authority to practice before the IRS is limited. An unenrolled return preparer may represent, provided the preparer (1) prepared and signed the return or claim for refund (or prepared if there is no signature space on the form); (2) was eligible to sign the return or claim for refund; (3) has a valid PTIN; and (4) possesses the required Annual Filing Season Program Record of Completion(s). ***See*** **Special Rules and Requirements for Unenrolled Return Preparers** ***in the instructions for additional information.***

k Qualifying Student or Law Graduate—receives permission to represent taxpayers before the IRS by virtue of his/her status as a law, business, or accounting student, or law graduate working in a LITC or STCP. See instructions for Part II for additional information and requirements.

r Enrolled Retirement Plan Agent—enrolled as a retirement plan agent under the requirements of Circular 230 (the authority to practice before the Internal Revenue Service is limited by section 10.3(e)).

▶ **IF THIS DECLARATION OF REPRESENTATIVE IS NOT COMPLETED, SIGNED, AND DATED, THE IRS WILL RETURN THE POWER OF ATTORNEY. REPRESENTATIVES MUST SIGN IN THE ORDER LISTED IN PART I, LINE 2.**

Note: For designations d–f, enter your title, position, or relationship to the taxpayer in the "Licensing jurisdiction" column.

Designation—Insert above letter **(a–r).**	Licensing jurisdiction (State) or other licensing authority (if applicable)	Bar, license, certification, registration, or enrollment number (if applicable)	Signature	Date