



APPLICATION FOR EMPLOYMENT

PLEASE PRINT:

Name: _____ Date of application: _____
 Last First Middle

Preferred Name: _____

Address: _____
 Street City State Zip Code

Position(s) applying for: _____

Name of Referral: _____

Cell Phone (____) _____ Home Phone (____) _____

Email: _____

Best phone number and time to call (____) _____ : _____ am/pm

Social Security No ----- _____

If under 18, can you provide a work permit? Yes No

Have you filed an application here before? Yes No

If yes, please provide date ____/____/____

Have you previously been employed here? Yes No

If yes, please provide dates of employment: ____/____/____ to ____/____/____

Are you legally eligible for employment in this country? Yes No

(Proof of US Citizenship or immigration status will be required upon employment)

Date available for work ____/____/____

Type of employment desired Full Time Part Time Temporary Seasonal Educational Co-op

Are you on layoff and subject to recall..... Yes No

Are you able to meet the attendance and shift requirements of the job? Yes No

Will you agree to work overtime? Yes No

Have you ever been bonded? Yes No

Driver's license number (if required by job) _____ State: _____

EMPLOYMENT HISTORY

List your last four (4) employers, assignments, or volunteer activities, starting with the most recent, including military experience. Explain any gaps in employment in comments section below. **If including military experience, please do not disclose or provide the reason why you were discharged.**

Employer	Telephone	<u>Dates Employed</u>	Summarize the nature of the work performed and job responsibilities
Address		From	
Job Title			
Immediate Supervisor and Title		To	
Reason for Leaving			

Employer	Telephone	<u>Dates Employed</u>	Summarize the nature of the work performed and job responsibilities
Address		From	
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Address		From	
Job Title			
Immediate Supervisor and Title		To	
Reason for Leaving			

Comments (including explanation of any gaps in employment):

Skills and qualifications (summarize special skills and qualifications acquired from employment or other experiences that may qualify you to work with our company):

REFERENCES

List name and telephone number of three (3) business/work references that are **not** related to you. If not applicable, list three (3) school or personal references who are **not** related to you.

Name	Telephone number	Years known

List professional, trade, business, or civic associations and any offices held (exclude memberships, which would reveal sex, race, religion, national origin, age, color, disability, or other protected status).

Organization	Offices Held

List special accomplishments, publications, awards (exclude information which would reveal sex, race, religion, national origin, age, color, disability, or other protected status).

List additional information you would like us to consider:

It is understood and agreed upon that if I am employed by Rolling Hills Operations LLC d/b/a Rolling Hills Care Center, any misrepresentation by me in this application will be sufficient cause for termination of this applicant's employment with Rolling Hills Care Center. Furthermore, I understand that just as I am free to resign at any time, Rolling Hills Care Center reserves the right to terminate my employment at any time, with or without prior notice.

I give the Employer the right to investigate all references and to secure additional information about me, if job related. I hereby release Rolling Hills Care Center and its representatives from any and all liability of any type whatsoever for seeking such information and I hereby release all persons, corporations, limited liability companies and all other entities furnishing such information from any and all liability of any type whatsoever in connection therewith.

Signature of Applicant: _____

Date: _____ / _____ / _____

Rolling Hills Care Center is an Equal Opportunity Employer. Applicants for employment are considered without regard to race, creed, color, national origin, nationality, ancestry, sex/gender, affectional or sexual orientation, gender identity or expression, age, marital status, civil union status, domestic partnership status, familial status, religion, atypical heredity cellular or blood trait, genetic information, liability for service in the Armed Forces of the United States or disability.



By signing below, I am authorizing Rolling Hills Care Center to conduct a reference check with my previous and/or current employers identified in my application. I understand that the information obtained from my present and past employers may include, but is not limited to, information regarding my work performance, professional demeanor, rehire potential, and dates of employment. The references that may be obtained from current and previous employers may include inquiries directed to supervisors, relatives and colleagues at my current and past employers. I release my present and past employer(s) and all other persons furnishing information from any liability or damage to me which relates to the furnishing of said information.

Applicant Signature

Date

APPLICANTS: PLEASE DO NOT WRITE BELOW THIS LINE

=====

Dear Personnel Director:

We are considering the applicant named below for employment at Rolling Hills Care Center. To help us determine whether this person is loyal, trustworthy and of good character, we ask that you answer all questions as completely and as specifically as you can. Please note applicant's signature above, authorizing the release of information for this reference.

Thank you in advance for your cooperation. If I can ever provide you with a reference, please feel free to contact me.

Sincerely yours,

Director of Human Resources

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Name of Applicant: _____

Company Name: _____

Position Held: _____

Dates Employed: _____ to _____

EVALUATION	EXCELLENT	GOOD	FAIR	POOR
Job Knowledge				
Quality of Care				
Attitude & Interpersonal Skills				
Attendance				
Punctuality				
Personal Appearance				

Reason for leaving: _____

Eligible for re-employment: Yes No If not, please explain: _____

Signature: _____

Title: _____

Date: _____



EMPLOYEE COVER SHEET

For Internal Use Only

DATE: _____

NAME: _____ TELEPHONE: _____

DEPARTMENT: _____ Position: _____

Interviewed with: _____

Interviewer comments: _____

Interview results: Make offer? Y / N

Why? _____

Job reference check:

1) _____

2) _____

3) _____

Nurse License No: _____ Verified w/ Board of Nursing: Y / N

Hired: _____ Full-/Part-Time/Per Diem: _____

Hire information:

Starting date: _____ Shift/hours: _____

Additional hire information: _____



SIMPLIFIED SCREENING FORM FOR EMPLOYER HIRING INCENTIVES

EMPLOYER: Rolling Hills Operations LLC

Candidate's Personal Information

Full Name: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

City State ZIP Code

Home Phone: _____ Alternate Phone: _____

Email: Please provide email: _____

SSN: _____

Date of Birth: _____

Hiring Incentive Qualification Questions

Are you currently employed? YES NO If no, enter the last date you were employed: _____ / _____ / _____

Have you or any member of your family received Food Stamps (SNAP) in last 18 months (circle)? YES NO If yes, provide Name, City/State of Recipient: _____

Have you or any member of your family received Welfare (TANF) at any time during the past 18 months? YES NO If yes, provide Name, City/State of Recipient: _____

Are you a Veteran? YES NO Can you supply a DD-214 if needed?: YES NO

Pre-Screening Notice and Certification Request for the Work Opportunity Credit

Information about Form 8850 and its separate instructions is at www.irs.gov/form8850.

Job applicant: Fill in the lines below and check any boxes that apply. Complete only this side.

Your name _____ Social security number: _____

Street address where you live _____

City or town, state, and ZIP code _____

County _____ Telephone number _____

If you are under age 40, enter your date of birth (month, day, year) _____

- 1 Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.
- 2 Check here if **any** of the following statements apply to you.
- I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the past 18 months.
 - I am a veteran and a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) for at least a 3-month period during the past 15 months.
 - I was referred here by a rehabilitation agency approved by the state, an employment network under the Ticket to Work program, or the Department of Veterans Affairs.
 - I am at least age 18 but **not** age 40 or older and I am a member of a family that:
 - a. Received SNAP benefits (food stamps) for the past 6 months; **or**
 - b. Received SNAP benefits (food stamps) for at least 3 of the past 5 months, **but** is no longer eligible to receive them.
 - During the past year, I was convicted of a felony or released from prison for a felony.
 - I received supplemental security income (SSI) benefits for any month ending during the past 60 days.
 - I am a veteran and I was unemployed for a period or periods totaling at least 4 weeks but less than 6 months during the past year.
- 3 Check here if you are a veteran and you were unemployed for a period or periods totaling at least 6 months during the past year.
- 4 Check here if you are a veteran entitled to compensation for a service-connected disability and you were discharged or released from active duty in the U.S. Armed Forces during the past year.
- 5 Check here if you are a veteran entitled to compensation for a service-connected disability and you were unemployed for a period or periods totaling at least 6 months during the past year.
- 6 Check here if you are a member of a family that:
- Received TANF payments for at least the past 18 months; **or**
 - Received TANF payments for any 18 months beginning after August 5, 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended during the past 2 years; **or**
 - Stopped being eligible for TANF payments during the past 2 years because federal or state law limited the maximum time those payments could be made.
- 7 Check here if you are in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation.

Signature—All Applicants Must Sign

Under penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

Job applicant's signature

Date

For Employer's Use Only

Employer's name: Rolling Hills Operations LLC Telephone no. 908-236-2011 EIN: 01-0784546

Street address 16 Cratetown Rd.

City or town, state, and ZIP code Lebanon, NJ 08833

Person to contact, if different from above DAVID SCHWAB Telephone no. 516-855-7263

Street address SMARTCHART INC DBA EMPLOYER TAX ADVISORS 1056 NEW MCNEIL AVENUE

City or town, state, and ZIP code LAWRENCE, NY 11559

If, based on the individual's age and home address, he or she is a member of group 4 or 6 (as described under *Members of Targeted Groups* in the separate instructions), enter that group number (4 or 6) _____

Date applicant:

Gave information	Was offered job	Was hired	Started job
_____	_____	_____	_____

Under penalties of perjury, I declare that the applicant provided the information on this form on or before the day a job was offered to the applicant and that the information I have furnished is, to the best of my knowledge, true, correct, and complete. Based on the information the job applicant furnished on page 1, I believe the individual is a member of a targeted group. I hereby request a certification that the individual is a member of a targeted group.

Employer's signature ^a	Title	Date
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Privacy Act and Paperwork Reduction Act Notice

Section references are to the Internal Revenue Code.

Section 51(d)(13) permits a prospective employer to request the applicant to complete this form and give it to the prospective employer. The information will be used by the employer to complete the employer's federal tax return. Completion of this form is voluntary and may assist members of targeted groups in securing employment. Routine uses of this form include giving it to the state workforce agency (SWA), which will contact appropriate sources to confirm that the applicant is a member of a targeted group. This form may also be given to the Internal Revenue Service for administration of the Internal Revenue laws, to the Department of Justice for civil and

criminal litigation, to the Department of Labor for oversight of the certifications performed by the SWA, and to cities, states, and the District of Columbia for use in administering their tax laws. 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 section 6103.

The time needed to complete and file this form will vary depending on individual circumstances. The estimated average time is:

- Recordkeeping** 6 hr., 27 min.
- Learning about the law or the form** 24 min.
- Preparing and sending this form to the SWA** 31 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making this form simpler, we would be happy to hear from you. You can send us comments from www.irs.gov/formspubs. Click on "More Information" and then on "Give us feedback." Or you can send your comments to:

Internal Revenue Service
Tax Forms and Publications
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224

Do not send this form to this address. Instead, see *When and Where To File* in the separate instructions.



1. Control No. (For Agency use only)	APPLICANT INFORMATION (See instructions on reverse)	2. Date Received (For Agency Use only)
EMPLOYER INFORMATION		
3. Employer Name ROLLING HILLS OPERATIONS LLC	4. Employer Address and Telephone 16 Cratetown Rd. Lebanon, NJ 08833 908-236-2011	5. Employer Federal ID Number (EIN) 01-0784546
APPLICANT INFORMATION		
6. Applicant Name (Last, First, MI)	7. Social Security Number	8. Have you worked for this employer before? Yes <input type="checkbox"/> No <input type="checkbox"/> If YES , enter last date of employment: _____
APPLICANT CHARACTERISTICS FOR WOTC TARGET GROUP CERTIFICATION		
9. Employment Start Date	10. Starting Wage	11. Position
12. Are you at least age 16, but under age 40? If YES , enter your <i>date of birth</i> _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	
13. Are you a Veteran of the U.S. Armed Forces? If NO , go to Box 14. If YES , are you a member of a family that received Supplemental Nutrition Assistance Program (SNAP) benefits (Food Stamps) for at least 3 months during the 15 months before you were hired? If YES , enter name of <i>primary recipient</i> _____ and <i>city and state</i> where benefits were received _____. OR, are you a veteran entitled to compensation for a service-connected disability? If YES , were you discharged or released from active duty within a year before you were hired? Yes <input type="checkbox"/> No <input type="checkbox"/> OR, were you unemployed for a combined period of at least 6 months (whether or not consecutive) during the year before you were hired? Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	
14. Are you a member of a family that received Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps) benefits for the 6 months before you were hired? OR, received SNAP benefits for at least a 3-month period within the last 5 months But you are no longer receiving them? If YES to either question , enter name of <i>primary recipient</i> _____ and city And <i>state</i> where benefits were received _____	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	
15. Were you referred to an employer by a Vocational Rehabilitation Agency approved by a State? OR, by an Employment Network under the Ticket to Work Program? OR, by the Department of Veterans Affairs?	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	
16. Are you a member of a family that received TANF assistance for at least the last 18 months		

before you were hired? OR , are you a member of a family that received TANF benefits for any 18 months beginning after August 5, 1997, and the earliest 18-month period beginning after August 5, 1997, ended within 2 years before you were hired? OR , did your family stop being eligible for TANF assistance within 2 years before you were hired because a Federal or state law limited the maximum time those payments could be made? If NO , are you a member of a family that received TANF assistance for any 9 months during the 18-month period before you were hired? If YES, to any question , enter name of <i>primary recipient</i> _____ and the <i>city and state</i> where benefits were received _____	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	
17. Were you convicted of a felony or released from prison after a felony conviction during the year before you were hired? If YES , enter <i>date of conviction</i> _____ and <i>date of release</i> _____. Was this a Federal _____ or a State conviction _____? (Check one)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
18. Do you live in an Empowerment Zone or Rural Renewal County (RRC)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
19. Do you live in an Empowerment Zone and are at least age 16, but not yet 18, on your hiring date?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
20. Did you receive Supplemental Security Income (SSI) benefits for any month ending within 60 days before you were hired?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. Are you a veteran unemployed for a combined period of at least 6 months (whether or not consecutive) during the year before you were hired?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
22. Are you a veteran unemployed for a combined period of at least 4 weeks but less than 6 months (whether or not consecutive) during the year before you were hired?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
23. Are you an individual who is or was in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period you received unemployment compensation? If YES , what state did you receive unemployment compensation in? _____ (Enter state where UI compensation was received)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
24. Sources used to document eligibility: (Employers/Consultants: List all documentation provided or forthcoming. For SWA Staff: List all documentation used in determining target group eligibility and enter your initials and date when the determination was made.)		
I certify that this information is true and correct to the best of my knowledge. I understand that the information above may be subject to verification.		
25(a). Signature: (See instructions in Box 25.(b) for who signs this signature block)	25.(b) Indicate with a ✓ mark who signed this form: <input type="checkbox"/> Employer, <input type="checkbox"/> Consultant, <input type="checkbox"/> SWA, <input type="checkbox"/> Participating Agency, <input type="checkbox"/> Applicant, or <input type="checkbox"/> Parent/Guardian (if applicant is a minor)	26. Date:

INSTRUCTIONS FOR COMPLETING THE INDIVIDUAL CHARACTERISTICS FORM (ICF), ETA 9061. This form is used together with IRS Form 8850 to help state workforce agencies (SWAs) determine eligibility for the Work Opportunity Tax Credit (WOTC) Program. The form may be completed, on behalf of the applicant, by: 1) the employer or employer representative, the SWA, a participating agency, or 2) the applicant directly (if a minor, the parent or guardian must sign the form) and signed (Box 25a.) by the individual completing the form. This form is required to be used, without modification, by all employers (or their representatives) seeking WOTC certification.
Boxes 1 and 2. **SWA.** For agency use only.

Boxes 3-5. **Employer Information.** Enter the name, address including ZIP code, telephone number, and employer Federal ID number (EIN) of the employer requesting the certification for the WOTC. Do not enter information pertaining to the employer's representative, if any.

Boxes 6-11. **Applicant Information.** Enter the applicant's name and social security number as they appear on the applicant's social security card. In Box 8, indicate whether the applicant previously worked for the employer, and if Yes, enter the last date or approximate last date of employment. This information will help the "48-hour" reviewer to, early in the verification process, eliminate requests for former employees and to issue denials to these type of requests, or certifications in the case of "qualifying rehires" during valid "breaks in employment" (see pages III-12 and III-13, Nov. 2002, Third Ed., ETA Handbook 408) during the first year of employment.

Boxes 12-23. **Applicant Characteristics.** Read questions carefully, answer each question, and provide additional information where requested.

The Protecting Americans from Tax Hikes Act of 2015 retroactively reauthorized current target groups for a 5-year period, January 1, 2015 through December 31, 2019, and extended the Empowerment Zones designations for a two-year period, January 1, 2015 through December 31, 2016. The Act introduced a new target group, Qualified Long-term Unemployment Recipient (LTUR), for new hires that begin to work for an employer on or after January 1, 2016 – December 31, 2019, see Box 23. For guidance see IRS Relief Period in TEGL No. TEGL 25-15 and IRS Notice 2016-22 and 2016-40.

Box 24 **Sources to Document Eligibility.** The applicant or employer is requested to provide documentary evidence to substantiate the **YES answers** in Boxes 12 - 23. List or describe the documentary evidence that is attached to the ICF or that will be provided to the SWA. Indicate in parentheses next to each document listed whether it is attached (A) or forthcoming (F). Some examples of acceptable documentation are provided below. A letter from the agency that administers a program may be furnished specifically addressing the question to which the applicant answered YES. For example, if an applicant answers YES to either question in Box 14 and enters the name of the primary recipient and the city and state in which the benefits were received, the applicant could provide a letter from the appropriate SNAP (formerly Food Stamp) agency stating to whom SNAP benefits were paid, the months for which they were paid, and the names of the individuals included on the grant for each month. SWAs use this box to list the sources used to verify target group eligibility, followed with their initials and the date the determination was completed.

Description of Examples of Documentary Evidence and Collateral Contacts. Employers/Consultants: You may check with your SWA to find out what other sources you can use to prove target group eligibility. (You are encouraged to provide copies of documentation or names of collateral contacts for each question for which you answered **YES**.)

QUESTION 12

- Birth Certificate or Copy of Hospital Record
- Driver's License
- School I.D. Card¹
- Work Permit¹
- Federal/State/Local Gov't I.D.¹

QUESTION 13

- DD-214 or Discharge Papers
- Reserve Unit Contacts
- Letter of Separation or other agency documents issued only by the Department of Veterans Affairs (DVA) on DVA Letterhead certifying the Veteran has a service-connected disability and signed by the individual who verified this information.

QUESTIONS 14 & 16

- TANF/SNAP (Food Stamp) Benefit History or Case Number Identifier
- Signed statement from Authorized Individual with a specific description of the months benefits that were received

QUESTION 15

- Vocational Rehabilitation Agency Contact
- Veterans Administration for Disabled Veterans
- Signed letter of separation or related document from authorized Individual on DVA letter head or agency stamp with specific description of months benefits were received.
- **For SWAs:** To determine *Ticket Holder* (TH) eligibility, Fax page 1 of Form 8850 to MAXIMUS at: 703-683-1051 to verify if applicant: 1) is a TH, and 2) has an Individual Work Plan from an Employment Network.

QUESTION 17

- Parole Officer's Name or Statement
- Correction Institution Records
- Court Records Extracts

QUESTION 18 & 19

- To determine if a Designated Community Resident lives in a RRC, visit the site: www.usps.com. **Click on Find Zip Code; Enter & Submit Address/Zip Code; Click on Mailing Industry Information; Download and Print the Information**, then compare the county of the address to the list in the January 2012 Instructions to IRS 8850.
- To determine if the DCR or a Summer Youth lives in an Empowerment Zone, use the Empowerment Zones (EZ) Locator Address Lookup tool available on the WOTC site: <https://www.doleta.gov/business/incentives/opptax/resources>.

QUESTION 20

- SSI Record or Authorization
- SSI Contact
- Evidence of SSI Benefits

QUESTIONS 21, 22

- Unemployment Insurance (UI) Claims Records
- UI Wage Records

QUESTION 23

- UI Wage Records
- UI Claims Records
- Self-Attestation Form, ETA Form 9175

QUESTION 24

- **Employers/Representatives:** List All sources used and provided to the SWA to document target group eligibility. **SWA Staff:** List all documentation used to determine/verify eligibility in the target group requested by the employer/rep., to reach the final determination.

Notes:

1. Where a Federal/State/Local Gov't., School I.D. Card, or Work Permit does not contain age or birth date, another valid document must be obtained to verify an individual's age.
2. ESPL No. 05-98, dated 3/18/98, officially rescinded the authority to use Form I-9 as proof of age and residence. **Therefore, the I-9 is no longer a valid piece of documentary evidence.**

Box 25.(a) **Signature.** The person who completes the form signs the signature block.

Box 25(b) **Signature Options.** (a) Employer or Authorized Representative, (b) SWA staff, (c) Participating Agency staff, or (d) Applicant (If applicant is a minor, the parent or guardian must sign).

Box 26. **Date.** Enter the month, day and year when the form was completed.

Persons are not required to respond to this collection of information unless it displays a currently valid OMB Control Number. Respondent's obligation to reply to these questions is required to obtain and retain benefits per law 104-188. Public reporting burden for this collection of information is estimated to average 20 minutes per response including the time for reading instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing burden to the U.S. Department of Labor, Employment and Training Administration, Division of National Programs, Tools, and Technical Assistance, 200 Constitution Ave., NW, Room C-4510, Washington, D.C. 20210 (Paperwork Reduction Project Control No. 1205-0371).

..... ✂
(Cut along dotted line and keep in your files)

TO: THE JOB APPLICANT OR EMPLOYEE,

Privacy Act Statement: *The Internal Revenue Code of 1986, Section 51, as amended and its enacting legislation, P.L. 104-188, specify that the State Workforce Agencies are the "designated" agencies responsible for administering the WOTC certification procedures of this program. The information you have provided completing this form will be disclosed by your employer to the State Workforce Agency. Provision of this information is voluntary. However, the information is required for your employer to receive the federal tax credit. IF THE INFORMATION YOU PROVIDE IS ABOUT A MEMBER OF YOUR FAMILY, YOU SHOULD PROVIDE HIM/HER A COPY OF THIS NOTICE.*



LONG-TERM UNEMPLOYMENT RECIPIENT SELF-ATTESTATION FORM Work Opportunity Tax Credit (WOTC) Program

Instructions: This Self-Attestation Form (SAF) is to be completed, signed, and dated by the new hire only. Employers or consultants submit this SAF to the State Workforce Agency with IRS Form 8850 or if filed separately, with ETA Form 9061 (or ETA Form 9062) for each certification request filed for the new target group.

Under penalties of perjury, I declare that this information is true and correct to the best of my knowledge.

New Hire's Signature: _____ Date _____

New Hire Name: _____

Social Security Number: _____ - □□□□
(Enter last four digits)

Employer Name: _____

Please check the statements below if they apply to you.

I declare that I was in a period of unemployment that is at least 27 consecutive weeks and for all or part of that period I received unemployment compensation.

I declare that I have been in a period of unemployment since _____.
(Enter start date)

Privacy Act Notice:

The Internal Revenue Code of 1986, Section 51, as amended and its enacting legislation, P.L. 104-188, specify that the State Workforce Agencies are the "designated" agencies responsible for administering the WOTC certification procedures of this program. The information you have provided completing this form will be disclosed by your employer to the State Workforce Agency. Provision of this information is voluntary; however the information is required to determine your employer's eligibility for the federal tax credit.

Public Burden Statement:

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. Respondents' obligation to complete this form is required to obtain or retain benefits (P.L. 111-5). Public reporting burden is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate to the U.S. Department of Labor, Division of National Programs Tools Technical Assistance, Room C-4510, Washington, D.C. 20210 (Paperwork Reduction Project 1205-0371). Please do not submit completed forms to this address.
