VAN HEALTHCARE
NURSING & REHABILITATION

Application for Employment

Applicant Instructions

Thank you for your interest in working at our facility. We appreciate your application and look forward to the possibility of your joining our team. This sheet is for your information. Please feel free to take it with you for your reference.

Please complete the application. Please neatly print all information so it may be easily read. Be sure all blanks are completely filled out and signed. Addresses must be complete with zip codes and apartment numbers. Use the abbreviation N/A if a particular provision or section in the application is not applicable to you.

You may indicate your interest in as many job openings as you like on one application. Applications and attached documents become the property of this facility once they have been submitted. You are responsible for ensuring that copies of any documents that you wish to attach to your application are, in fact, attached. All required resumes, transcripts, tests and certifications must be attached to the application when submitted. If you already have these documents on file with our office, please notify the Receptionist when you submit your application.

The Personnel Office will not make copies of resumes, transcripts, applications, or other materials. When you are finished with your application, please give it to the Receptionist. We will submit it to the hiring supervisor and you will be contacted by them if you are selected for an interview.

INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED

Applications will be held open for ninety days. After ninety days if you are still interested in a position with our company you will need to resubmit an application.

Employment decisions are made solely on the basis of qualifications to perform the work for which you are applying. Qualifications include education, training, work experience and other factors which are relevant in determining job performance. Credentials and experience will be verified through schools, former employers and licensing/certification agencies, if applicable. As an Equal Opportunity Employer, decisions to hire and promote are made without regard to race, color, creed, national origin, sex physical or mental disability (unrelated to ability to do the job) or age (defined by law).

The Company utilizes the E-Verify system for all employment verifications.

In accordance with the Department of Justice, Immigration & Naturalization Service you will be required to complete an Employment Eligibility Verification form I-9 and furnish documents in accordance with the list of acceptable documents. This requirement mustbe met at the time ofemployment.

PLEASE NOTE THE FOLLOWING

Federal/State regulations require that all employees be tested annually for TB. If you have had a TB test within the last year you must contact your previous employer and provide this facility with a copy of your test showing the dates of test and results. If you test positive we require, prior to employment, documentation from the health department that verifies that you, 1). Will always test positive, 2). Reason for positive results and 3). Are eligible to work in this industry.

This facility does not subscribe to the workers compensation program. We handle employee injuries that occur on the job through our own work injury program. You will have certain responsibilities in that regard if you are employed and wish to have such benefits available to you.

APPLICATION FOR EMPLOYMENT

Date: _____ Email Address: _____

Name: _____
Last First Middle

Address _____ City/State _____ Zip _____

Telephone Number _____ Alternate Number _____

Position(s) Applying For

1) _____ **2)** _____

Preferred Shift ⎦ Days ⎦ Evenings ⎦ Nights ⎦ Other **Type of Employment** □ Full Time □ Part Time □ Other	**Salary Desired** **$ /year**
Are you available to work weekends? □ Yes □ No **Are you available to work evenings?** □ Yes □ No	**Date Available** ____/____/____

Are you legally eligible for employment in the United States? □ Yes □ No
(Proof of identity and employment eligibility will be required upon employment.)

Have you been discharged or asked to resign in the last five years? □ No □ Yes *If yes, why?*
Have you ever been convicted of a crime/felony under any name? □ No □ Yes *If yes, why?* ***Criminal convictions are not an absolute bar to employment, but will be considered in relation to specific job requirements.***

EDUCATION	Name of School	City	State	
High School			Diploma? ⎦ Yes □ No	Received GED? ⎦ Yes □ No
College			Degree? ⎦ Yes □ No Type?	Graduation Date ____/____/
College			Degree? ⎦ Yes □ No Type?	Graduation Date ____/____/
College			Degree? ⎦ Yes □ No Type?	Graduation Date ____/____/
Other: Business College, Technical School and other special courses.				
Other Skills: Typing, Computer, Office Equipment, etc.				

PROFESSIONAL LICENSURE AND CERTIFICATION

Are you currently:	**☐ Registered**	**☐ Licensed**	**☐ Certified**	
Are you eligible for:	**☐ Registered**	**☐ Licensed**	**☐ Certified**	
	Type	**State Issued**	**Date**	**Number**
If Licensed, Registered or Certified				

PREVIOUS EXPERIENCE

Current or Most Recent Employer			
From ___/___/ To	Company:	Phone Number: ( )	Immediate Supervisor:
Salary: $	Address:	May we contact them? ☐ Yes ☐ No	Reason for leaving:
Job Title			
Nature of Duties:			
1st Previous Employer			
From ___/___/ To	Company:	Phone Number: ( )	Immediate Supervisor:
Salary: $	Address:	May we contact them? ☐ Yes ☐ No	Reason for leaving:
Job Title			
Nature of Duties:			
2nd Previous Employer			
From ___/___/ To	Company:	Phone Number: ( )	Immediate Supervisor:
Salary: $	Address:	May we contact them? ☐ Yes ☐ No	Reason for leaving:
Job Title			
Nature of Duties:			
3rd Previous Employer			
From ___/___/ To	Company:	Phone Number: ( )	Immediate Supervisor:
Salary: $	Address:	May we contact them? ☐ Yes ☐ No	Reason for leaving:
Job Title			
Nature of Duties:			

Do you have any commitments or agreements with another employer that might affect your employment with this facility?
⌋ Yes □ No If yes, please explain: _____

Please explain any gaps in employment dates:

_____

_____

_____

Please provide any additional information regarding any change of name, use of assumed name or nickname necessary to enable a check on your record (if applicable):

I authorize you, at the time of my application for employment or the course of my employment, to obtain information from any source as to my education, experience, competence, character or medical history, as it relates to the position for which I applied or in which I may be employed unless otherwise stated. I certify that the information contained in this application is true, complete, and correct to the best of my knowledge and belief and understand that if I am hired, this application will be transferred to my individual personnel file. I understand that any falsification or omission of information may cause my immediate dismissal or rejection of this application. I agree that all statements made in this application may be investigated. I also understand that I may be required to successfully complete a medical exam to include urine drug screen for initial and/or continued employment. I further understand that any employment is not for a stated period of time and may be terminated with or without cause, at any time, at the option of either myself or my employer. If I am employed, I agree to comply with and be bound by the rules and procedures of this facility.

_____ _____

Applicant's Signature Date

Per our drug policies and procedures this facility may perform pre-employment and for caused alcohol or awareness altering substances.

_____ _____

Applicant's Signature Date

Employment Verification Record

Applicant Permission:

I, the undersigned, hereby authorize the release of information related to my employment. I will save this facility any previous employer or their employees harmless from the exchange of such information. I further relinquish any and all right or claims to proceedings of any nature related to the exchange and consideration of such information.

_____ _____

Applicant Signature Date

Name of Person applying for job: _____

Position Applied For: _____

Name of Company/reference Contact: _____

Reference Telephone Number: _____

Referral Source: ☐ Professional ☐ Personal

OFFICE USE:

Dates of Employment: (start)_____(end) _____

Job(s) Held:_____Verify Ending Pay: _____

Would you Re-hire? ☐ Yes ☐ No ☐ Prefer not to answer

Reason for leaving (if known): _____

Name and Job Title of person providing information: _____

Facility employee obtaining information: _____

Professional License / Certification Verification Form

Employee Must Complete (please print):

Date: _____

Employee Name: _____

Address: _____

I attest under penalty of perjury, that I am a:

☐ Registered Nursing in the State of Texas:
License Number:_____ Date of Expiration: _____

☐ Licensed Vocational Nurse in the State of Texas:
License Number:_____ Date of Expiration: _____

☐ Certified Medication Aide in the State of Texas:
License Number:_____ Date of Expiration: _____

☐ Certified Nurse Aide in the State of Texas:
License Number:_____ Date of Expiration: _____

I further attest, under penalty of perjury, that the document I have presented as evidence of my licensure is genuine and related to me. I am aware that misrepresentation of this face is punishable by Texas State Law.

Date:_____ Employee Signature: _____

FOR OFFICE USE ONLY

Date of Hire:_____ State Agency Verifying License: _____

Authorized Employee Obtaining Verification: _____

Director of Nursing Signature: _____

Facility Administrator Signature: _____

If information obtained online, complete this form and attach printed website information to the completed document.

Applicant Tracking Record

Name: _____

Position Applied For: _____

How did you hear about the position you applied for today?

☐ Newspaper: Name of Paper _____

☐ Online Ad (Craig's List, Career Builder, Indeed, Monster, etc.) _____

☐ Radio Advertisement: Name _____

☐ Personal Referral: Name _____

☐ Walk in

☐ Previously employed by this facility or any related facilities: Facility _____

********** Office Use Only **********

Facility Name: _____

Date of Application: _____

Date of Hire (if applicable): _____

Other pertinent information: _____

_____

_____

INVESTIGATION FOR CRIMINAL CONVICTIONS

1. I understand that my employment is temporary until an investigation is made to see if I have a conviction for a felony or misdemeanor for certain types of offenses. A complete listing of the offenses is located in the facility policy for Criminal Background Checks.
2. I understand the Texas DPS Criminal records; Nurse Aide Registry and Misconduct Registry will all be accessed for any record of violation that could bar employment from this facility.
3. I understand that I will be immediately terminated if I have a conviction for an offense like those listed in Chapter 250 of the Health and Safety Code, or listed under the current facility policy.
4. I understand that I must provide the following listed information for purposes of the facility to assist in completing a background investigation.
5. The Misconduct Registry is a tracking system conducted by the DADS that maintains a listing of any individual that has committed the act of abuse, neglect, exploitation, or misappropriation. This facility will check this registry prior to hire and are prohibited from hiring anyone that is listed on the registry.
7. I have been informed that I may request a copy of the facility policy for criminal history checks.

Below are some of the offenses that may bar employment. This listing is not all-inclusive of the offenses that may bar employment. For a full listing please review the facility policy on Criminal Background Checks.

Criminal Homicide Kidnapping Unlawful Restraint Indecent Exposure Indecency with a Child Assault Aggravated Assault Sexual Assault Improper relationship between and educator and student Injury to a Child, Elderly Individual or Disabled Individual Deadly Conduct Sale/Purchase of Child Abandoning or Endangering Child Agreement to Abduct from Custody Terroristic Threat Aiding Suicide Arson Robbery/Aggravated Robbery Online Solicitation of a Minor Money Laundering Medicaid Fraud Cruelty to Animals Burglary Theft False Identification as a Peace Officer Misapplication of Fiduciary Property or Property of a Financial Institution Securing execution of a Document by Deception Disorderly Conduct

Please Type or Print Legibly:

Name (Last, First, Middle)		**Other Names / Alias (Married, Maiden)**
Social Security No.	**Date of Birth (mo/day/yr)**	**Sex:** **Male_____Female_____**
Race / Ethnicity **Black____White_____Other_____**		**Signature:**
		Date:

Facility Instructions: Use the above information to complete The Criminal History Check Form. Place this copy in the Employee's personnel file.

FOR FACILITY USE ONLY

Nurse Aide Registry Checked Date_____By _____
Findings: ☐ Employable ☐ Not Employable

Misconduct Registry Checked Date_____By _____
Findings: ☐ Employable ☐ Not Employable

Criminal History Checked Date_____By_____
Findings: ☐ Employable ☐ Not Employable
Comments: _____

DPS Computerized Criminal History (CCH) Verification

(AGENCY COPY)

I, _____ , acknowledge that a Computerized Criminal

APPLICANT or EMPLOYEE NAME (Please print)

History (CCH) check will be performed by accessing the Texas Department of Public Safety Secure Website and will be based on name and DOB identifiers I supply. (This is not a consent form.) Authority for this agency to access an individual's criminal history data may be found in Texas Government Code 411; Subchapter F.

Name-based information is not an exact search and only fingerprint record searches represent true identification to criminal history, therefore the organization conducting the criminal history check is not allowed to discuss with me any criminal history record information obtained using this method. The agency may request that I have a fingerprint search performed to clear any misidentification based on the result of the name and DOB search. Once this process is completed the information on my fingerprint criminal history record may be discussed with me.

In order to complete the process I must make an appointment with the Fingerprint Applicant Services of Texas (FAST) as instructed online at www.txdps.state.tx.us */Crime Records/Review of Personal Criminal History* or by calling the DPS Program Vendor at 1-888-467-2080, submit a full and complete set of fingerprints, request a copy be sent to the agency listed below, and pay a fee of $24.95 to the fingerprinting services company.

(This copy must remain on file by your agency. Required for future DPS Audits)

_____
Signature of Applicant or Employee

_____
Date

_____
Agency Name (Please print)

Agency Representative Name (Please print)

_____
Signature of Agency Representative

_____
Date

Please:
Check and Initial each Applicable Space

CCH Report Printed:

YES _____ NO _____ _____ initial

Purpose of CCH: _____

Empl ___ Vol/Contractor ___ _____ initial

Date Printed:_____ _____ initial

Destroyed Date: _____ _____ initial

Retain in your files

Rev. 09/2013

Form **8850**
(Rev. March 2016)
Department of the Treasury
Internal Revenue Service

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.***

OMB No. 1545-1500

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 Van Healthcare Telephone no. 903-863-8641 EIN ▸ 81-4064446

Street address 169 S. Oaks Street

City or town, state, and ZIP code Van, TX 75790

Person to contact, if different from above Joe Neal Telephone no. 254-399-6788

Street address 6500 Horizon Circle

City or town, state, and ZIP code Waco, TX 76712

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 ▸ **Title** **Date**

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.

U.S. Department Labor
Employment and Training Administration

Individual Characteristics Form (ICF)
Work Opportunity Tax Credit

OMB Control No. 1205-0371
Expiration Date: January 31, 2020

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	4. Employer Address and Telephone	5. Employer Federal ID Number (EIN)
Van Senior Care, LLC	6500 Horizon Circle Waco, TX 76712 254-399-6788	81-4064446

APPLICANT INFORMATION

6. Applicant Name (Last, First, MI)	7. Social Security Number	8. Have you worked for this employer before? Yes ____ No ____ **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? Yes ___ No ___
If YES, enter your *date of birth* _____

13. Are you a Veteran of the U.S. Armed Forces? Yes ___ No ___
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? Yes ___ No ___
If YES, enter name of *primary recipient* _____ and *city and state* where benefits were received _____.
OR, are you a veteran entitled to compensation for a service-connected disability? Yes ___ No ___
If YES, were you discharged or released from active duty within a year before you were hired? Yes ___ No ___
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 ___ No ___

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? Yes ___ No___
OR, received SNAP benefits for at least a 3-month period within the last 5 months
But you are no longer receiving them? Yes ___ No___
If YES to either question, enter name of *primary recipient* _____ and city And *state* where benefits were received _____.

15. Were you referred to an employer by a Vocational Rehabilitation Agency approved by a State? Yes ___ No___
OR, by an Employment Network under the Ticket to Work Program? Yes ___ No___
OR, by the Department of Veterans Affairs? Yes ___ No___

16. Are you a member of a family that received TANF assistance for at least the last 18 months

before you were hired? Yes___ No___

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? Yes___ No___

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? Yes___No___

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? Yes___No___

If YES, to any question, enter name of *primary recipient* _____ and the *city and state* where benefits were received _____.

17. Were you convicted of a felony or released from prison after a felony conviction during the year before you were hired? Yes___No___

If YES, enter *date of conviction* _____ and *date of release* _____.

Was this a Federal ____ or a State conviction_____? (Check one)

18. Do you live in an Empowerment Zone or Rural Renewal County (RRC)? Yes__ No __

19. Do you live in an Empowerment Zone and are at least age 16, but not yet 18, on your hiring date? Yes __ No __

20. Did you receive Supplemental Security Income (SSI) benefits for any month ending within 60 days before you were hired? Yes__ No__

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__ No__

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__ No__

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? Yes__ No__

If YES, what state did you receive unemployment compensation in? _____

(Enter state where UI compensation was received)

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: ☐ Employer, ☐ Consultant, ☐ SWA, ☐ Participating Agency, ☐ Applicant, or ☐ 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. <u>Employers/Consultants</u>: 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.**)

<u>QUESTION 12</u>

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

<u>QUESTION 13</u>

- DD-214 or Discharge Papers
- Reserve Unit Contacts
- Letter of Separation or other agency documents issued <u>only</u> 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.

<u>QUESTIONS 14 & 16</u>

- 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

<u>QUESTION 15</u>

- 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 C*ode; **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/wotcResources.cfm.

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.

(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.*