NEW EMPLOYEE ORIENTATION PACKET

Welcome to Quality Business Solutions, Inc.!!

Quality Business Solutions, Inc. (QBS) is a Professional Employer Organization that provides Human Resource services including but not limited to payroll processing, benefits administration, and employment compliance. We have contracted with your present employer to provide these services. Therefore, we are the employer -of-record and should be listed as your employer for employment verification purposes. The client for whom you perform your job will provide you direction in your day-to-day duties.

Enclosed you will find the necessary documents that must be completed in ink and received by Quality Business Solutions, Inc. before your paychecks are processed. These documents are *mandatory* according to federal and state laws.

We encourage you to call us with any questions at any time during our employment relationship (877)834-3985.

QBS
Simplifying HR Benefiting Business

Employee Orientation Packet Directions

1. New Hire and Emergency Contact Information.
- Fill out completely

2. Federal Form W-4
- Fill out the bottom half of the form completely
- Make sure to include your filing status as single or married, total number of allowances, any additional amount to withhold, and your signature

3. Correction of Paychecks and Work-Related Injury/Illness Reporting
- Read and sign

4. Medical & Dental Insurance Disclaimer
- If eligible for coverage, read and fill out completely

5. Voluntary EEO Form
- Should be filled out only of the employee chooses to complete

6. Terms of Employment & New Hire Information Sheet
- Should be completed with supervisor
- Benefits eligibility and enrollment to be explained

7. Employment Eligibility Verification I-9 Forms
- Fill out Section 1 completely and sign
- You must provide acceptable forms of identification, as listed, for QBS to complete and sign Section 2

8. Form 8850 Work Opportunity and Welfare-to-Work-Credits
- Read, complete if appropriate, sign and date

Simplifying HR Benefiting Business

New Hire Information

The following information is the minimum required in order to input a new employee into the QBS payroll system. A Quality Business Solutions Orientation Packet must be completed by each new employee immediately upon hire then forwarded to QBS within two business days.

All paperwork must be received by QBS before the employee's first paycheck is processed or they are covered by workers comp; otherwise, QBS reserves the right to suspend payroll for any employee due to missing or incomplete paperwork.

SSN:_____ Date of Birth:_____

First Name: _____ MI: ___ Last Name: _____

Address: _____

City: _____ State: _____ Zip:_____

Home Phone:_____Mobile Phone: _____

Emergency Contact Information

Person to Notify: _____

Relationship to Employee: _____

Phone Number(s): _____

FOR EMPLOYER USE

Job Title/Position: _____ ☐ FT ☐ PT

Hire Date:_____ Work Location/Dept:_____

Pay Rate: $_____Per_____ Pay Method: _____
(Wkly/Bi-Wkly/Semi-Monthly/Monthly/Yearly)

CORRECTION OF PAYCHECKS

Quality Business Solutions, Inc. prepares and issues your paycheck with information provided by client companies. We have established the following procedures for addressing issues involving paycheck mistakes/disputes.

If you feel that the paycheck issued to you is incorrect due to mistakes/disputes involving rate of pay, hours worked, overtime, or for any other reason, contact your supervisor at your worksite immediately. If the issue cannot be resolved with your supervisor, contact the payroll department at Quality Business Solutions, Inc. at (877) 834 -3985 within 48 hours of the receipt of your paycheck, report the nature of the mistake/dispute, and forward a written statement by mail of the reasons why you think the paycheck issued to you is incorrect to: Quality Business Solutions, Inc. 280 Hindman Rd., Travelers Rest, SC 29690.

In order to ensure your rights regarding the accuracy of your paycheck, the written statement should be postmarked within 48 hours of receipt of your paycheck. Quality Business Solutions, Inc. will investigate the facts concerning paycheck mistake/dispute and will either reissue a correct paycheck or explain in writing why it has determining that no correction is indicated.

By signing this Notice you acknowledge receiving a copy of it, reading and understanding your rights and duties under the procedure referred to.

_____ _____

Employee Signature **Date**

WORK-RELATED INJURY/ILLNESS REPORTING

When a work related injury or accident occurs, you are to report it to your supervisor as soon as possible following the incident or to Quality Business Solutions, Inc. at (877) 834-3985. Failure to report the accident/injury in a timely fashion could delay insurance company payment of medical bills, and/or wages, or result in the denial of the claim.

I acknowledge that I have read this notice and I am aware of the potential consequences for failure to report a work related injury or accident in a timely fashion.

In the event a workplace injury occurs I understand that my social security number is a valid and correct number, otherwise benefits will not be paid on my behalf.

_____ _____

Employee Signature **Date**

Medical & Dental Insurance Disclaimer

Complete only if you are (1) eligible for coverage that is available and (2) do not wish to participate in the plans at this time.

Group medical and dental insurance is available to full-time employees, in certain geographic areas, that consistently work at least thirty (30) hours per week. It is the responsibility of each eligible employee to apply or waive coverage within 31 days from the date of hire or from the date of a change to full-time status.

PLEASE NOTE: Eligible employees may apply for or change their coverage for themselves and their dependents at a later date in the following circumstances: annual open enrollment or a change in family status (defined as marriage, divorce, legal separation, death, birth or adoption of a child, loss of other coverage, major change in other coverage, or eligibility for Medicare). In the event of a change in family status, it is the employee's responsibility to notify the employer within 30 days from the date of the change and to provide documented proof. Other insurance plan stipulations may apply.

"At this time I hereby waive group health coverage for..." (check all that apply):

☐ **Employee** ☐ **Spouse** ☐ **Dependent**

Reason for waiving coverage (check one):

☐ **Do not wish to have coverage at this time**

☐ **Covered by other insurance (complete the following)**

Name of Insured _____

Insurance Company _____

_____ _____

EMPLOYEE SIGNATURE **DATE**

QBS-EMP-6 (July 2006)

QBS
Simplifying HR Benefiting Business

Quality Business Solutions, Inc. Second Injury Fund Questionnaire

Failure to answer this questionnaire truthfully may bar you from receiving future Workers' Compensation Benefits.

PART ONE This form is to be completed only after an offer of employment has been made. NOT during the pre-employment interview

(Please print clearly)

Last Name	First Name	M.I.	Social Security Number

Street Address	City	State	Zip Code	Home Phone (Incl. Area Code)

PART TWO

		YES	NO			YES	NO
1	Epilepsy	○	○	18	Hyperinsulism	○	○
2	Diabetes	○	○	19	Muscular Dystrophy	○	○
3	Cardiac Disease	○	○	20	Arteriosclerosis	○	○
4	Arthristis	○	○	21	Thrombophlebitis	○	○
5	Amputated Foot. Leg or Arm	○	○	22	Varicose Veins	○	○
6	Loss of Sight of one or both eyes or	○	○	23	Heavy metal poisoning	○	○
	Partial loss of more than 75% bilateral (both)	○	○	24	Ionizing Radiation Injury	○	○
7	Residual disability from Poliomyelitis	○	○	25	Compressed Air Sequelae	○	○
8	Cerebral Palsy	○	○	26	Ruptured Disc	○	○
9	Multiple Sclerosis	○	○	27	Hodgkins Disease	○	○
10	Parkinson's Disease	○	○	28	Brain Damage	○	○
11	Cerebral Vascular Accident (Stroke)	○	○	29	Deafness or Hearing Loss (total/part)	○	○
12	Tuberculosis	○	○	30	Cancer	○	○
13	Silicosis	○	○	31	Sickle-Cell Anemia	○	○
14	Psychoneurotic Disability following treatment	○	○	32	Pulmonary Disease	○	○
	In a recognized medical or mental institution			33	Mental Retardation	○	○
	(includes alcohol/ drug rehabilitation)			34	Any other disease, condition, or impair-	○	○
15	Hemophilia	○	○		ment which is permanent in nature.**		
16	Chronic Osteomyelitis	○	○		**If you have ever been rated by a phy-		
17	Ankylosis of Joints	○	○		sician, list rating body part and physician		
					who assigned rating.		

PART THREE

	YES	NO
Have you ever been injured on the job? (List part of body injured)	○	○
Did you receive Workers' Compensation Benefits? (List employer)	○	○
Did you receive any permanent disability? (List rating)	○	○

PART FOUR

	YES	NO
Have you ever been treated for back problems? (list physician and date of treatment)	○	○
Have you ever had surgery? (Specify illness and date of operation)	○	○
Have you ever been involved in a serious accident? (explain)	○	○

List names of all physcians/hospitals, whom you have sough treatment from in the past (include out of state):

I hereby certify that I have answered this questionnaire truthfully and to the best of my knowledge.

_____ _____

Signature Date

280 Hindman Road
Travelers Rest, South Carolina 29690
(864) 834-3985
Fax (864) 834-5642

INJURY MANAGEMENT

Quality Business Solutions, Inc. **Workers Compensation**
Employee Acknowledgement Form

Policy Statement:

Controlling workers' compensation costs, while providing quality medical care and appropriate benefits is in your best interest and in ours. Let's use our resources wisely.

Goal:

To provide quality medical care to employee's injured in the course and scope of their employment at Quality Business Solutions to assure prompt payment of wage replacement benefits when appropriate; and, to facilitate return-to-work as quickly as possible within the injured employee's restrictions.

Employee Duties:

- Report injuries immediately to your immediate supervisor. Failure to do so may jeopardize your benefits.
- If you need medical treatment, advise your supervisor so that an appointment can be scheduled.
- If treatment is needed between office hours, call the Urgent Care Provider on the provider list to schedule an appointment. Unless emergency care is needed, treatment elsewhere will not be paid for by Quality Business Solutions **or its service center.**
- If the physician releases you to modified, alternate, or regular duties, contact your supervisor before leaving the physician's office. If after hours, contact your supervisor the next business day.
- If the doctor disables you from work, contact your supervisor immediately.
- If there is a change of physicians, or you are referred to a specialist, advise your supervisor.
- Always keep your supervisor aware of your next scheduled appointment. Failure to attend appointments could jeopardize continuation of benefits. If time is needed during normal working hours to attend these appointments, notify your supervisor once you are aware of the date of the appointment.
- Bring any questions, concerns, or problems regarding your treatment, work status or benefits to the attention of your supervisor and she will put you in contact with the **insurance department.**
- Accept modified or alternate work, within your restrictions as approved by the treating physician. Modified or alternate duty work is temporary. As your restrictions allow, the duties will be altered and/or expanded. The goal is to allow you to return to your regular duties as soon as possible; allowing appropriate healing time for your well being and the safety of others. Failure to do so may result in loss of benefits.
- Accept a regular, permanent position within your restrictions, once an offer has been made to you in writing. Failure to do so may result in a loss of benefits and/or disciplinary action.

I acknowledge that I have read and understand Quality Business Solutions Injury Management and Return-to-Work Program.

Employee Signature _____ Date _____

ACKNOWLEDGEMENT AND RECORDS RELEASE

I understand this questionnaire is for the purposes of enabling my employer to fulfill the requirements of the State Second Injury Fund, and it is in no way connected to the Company's decision to hire me. The information provided is not to be used by the Company as a basis of denying me placement within the Company or promotion, or to discriminate against me in any way. The information provided is true to the best of my information and belief. In the event of a future work related accident, my employer is authorized to request and review medical records pertaining to any of the conditions described herein as well as any records maintained by any government agency, past employer, or treatment facility with respect to any personal injuries I have received.

_____ _____

Employee's Signature Date

_____

Witness Signature

Voluntary EEO Form

Each year Quality Business Solutions, Inc. must file an EEO-1 Employer Information Report as required by federal law, Title VII of the Civil Rights Act. When EEO-1 reporting is filed, it includes only the number of employees of each gender and race in each job classification. No employee names are ever reported. Employees may voluntarily complete the following information to be used only for EEO-1 reporting purposes. This information is kept separate from the employee's personnel file.

EMPLOYEE NAME: _____

JOB TITLE: _____

CHECK ONE FOR EACH:

Gender

☐ **Male (M)**

☐ **Female (F)**

Race

☐ **Caucasian/White (C)**
☐ **Black (B)**
☐ **Asian of Pacific Islander (O)**
☐ **Spanish or Hispanic (S)**
☐ **American Indian or Eskimo (I)**

_____ _____

EMPLOYEE SIGNATURE **DATE**

280 Hindman Road
Travelers Rest, South Carolina 29690
(864) 834-3985
Fax (864) 834-5642

DIRECT DEPOSIT

Authorization Agreement for Direct Deposit

Employee Name: _____ SSN#: _____
(Please Print)

Address: _____

City/State/Zip: _____

Telephone: _____

Client Name: _____

Financial Institution: _____

Transit/ABA No.: _____
(Must have copy of check or bank's phone number.)

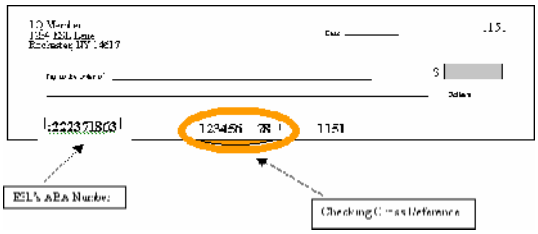
Account Number: _____
(Please attach a voided check. A copy will be fine.)

_____Percentage/Amount ☐ Checking Account ☐ Savings Account

I hereby authorize Quality Business Solutions, Inc., to initiate credit entries to my bank account indicated above, and I authorize the financial institution named above to process said credit entries.

This authority is to remain in full force and effect until Quality Business Solutions, Inc., has received written notification from me of its termination in such manner as to afford Quality Business Solutions, Inc. and the financial institution a reasonable opportunity to act on it.

_____ _____
(Signature MUST be that of a signer on the account) (Date)



280 Hindman Road
Travelers Rest, South Carolina 29690
(864) 834-3985
Fax (864) 834-5642

Drug Free Workplace Policy

Quality Business Solutions, Inc. is committed to conduct its business with high regard for the health and safety of its employees, clients, their customers and suppliers, the protection of its assets and the maintenance of the productive work environment. In keeping with this commitment, employees and job applicants may be asked to provide body substance samples (i.e. urine and/or blood) to determine the use of: amphetamines, barbiturates, marijuana, cocaine, opiates, phencyclidine (PCP) and alcohol. Quality Business Solutions, Inc. will take all reasonable precautions to protect the confidentiality of all substance abuse test results. Tests may be conducted in any of the following situations:

PRE-EMPLOYMENT – As a pre-qualification to assuming any position, prospective employees may be required to provide a body fluid for testing.

REASONABLE CAUSE – Testing of this kind occurs when workplace behavior, which by objective observation, indicates that an employee may be impaired or under the influence of drugs or alcohol.

POST ACCIDENT – Any employee/sub-contractor who is involved in a serious incident or accident while on duty, whether on or off the employer's premises, may be asked to provide a body substance sample.

RANDOM TESTING – All employees will be subject to random testing at any time without notice.

Any employee who tests positive will be suspended and have an opportunity to be re-tested in two weeks , at the expense of the employee, or earlier at the request of the employee. Any employee who tests positive on two consecutive tests will be subject to termination. Any employee who refuses to submit testing will be treated in accordance with the company's disciplinary procedures concerning insubordination.

QUALITY BUSINESS SOLUTIONS, INC IS A DRUG FREE WORKPLACE

I have read and understand Quality Business Solutions, Inc. concerning drugs in the workplace.

_____ _____

Employee Signature Date

Form **8850**
(Rev. January 2006)
Department of the Treasury
Internal Revenue Service

Pre-Screening Notice and Certification Request for the Work Opportunity and Welfare-to-Work Credits

► See separate instructions.

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 _____

Telephone number ( ) -

If you are under age 25, enter your date of birth (month, day, year) __/__/__

Work Opportunity Credit

1 ☐ Check here if you are a Hurricane Katrina employee. Enter the address of your main home on August 28, 2005, and the state and county or parish in which it was located.

_____

2 ☐ Check here if you received a conditional certification from the state employment security agency (SESA) or a participating local agency for the work opportunity credit.

3 ☐ 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 last 18 months.
- I am a veteran and a member of a family that received food stamps for at least a 3-month period within the last 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 25 or older and I am a member of a family that:

  a Received food stamps for the last 6 months **or**

  b Received food stamps for at least 3 of the last 5 months, **but** is no longer eligible to receive them.
- Within the past year, I was convicted of a felony or released from prison for a felony **and** during the last 6 months I was a member of a low-income family.
- I received supplemental security income (SSI) benefits for any month ending within the last 60 days.

Welfare-to-Work Credit

4 ☐ Check here if you received a conditional certification from the SESA or a participating local agency for the welfare-to-work credit.

5 ☐ Check here if you are a member of a family that:

- Received TANF payments for at least the last 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 within the last 2 years, **or**
- Stopped being eligible for TANF payments within the last 2 years because federal or state law limited the maximum time those payments could be made.

All Applicants

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 _____ Telephone no. ( ) - _____ EIN ▶ _____

Street address _____

City or town, state, and ZIP code _____

Person to contact, if different from above _____ Telephone no. ( ) - _____

Street address _____

City or town, state, and ZIP code _____

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 / /

Complete Only If Box 1 on Page 1 is Checked

State and county or parish of job _____

☐ Check if the individual was not my employee on August 28, 2005 and this is the first time the employee has been hired by me since August 28, 2005.

Under penalties of perjury, I declare that the applicant completed 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 or a long-term family assistance recipient. I hereby request a certification that the individual is a member of a targeted group or a long-term family assistance recipient.

Employer's signature ▶ **Title** **Date** / /

Privacy Act and Paperwork Reduction Act Notice

Section references are to the Internal Revenue Code.

Section 51(d)(12) 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 and long-term family assistance recipients in securing employment. Routine uses of this form include giving it to the state employment security agency (SESA), which will contact appropriate sources to confirm that the applicant is a member of a targeted group or a long-term family assistance recipient. 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 SESA, 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 . . . .5 hrs., 30 min.
Learning about the law or the form . . . . . 24 min.
Preparing and sending this form to the SESA . . . . . 30 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 write to the Internal Revenue Service, Tax Products Coordinating Committee, SE:W:CAR:MP:T:T:SP, 1111 Constitution Ave. NW, IR-6406, Washington, DC 20224.

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

Form W-4 (2011)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2011 expires February 16, 2012. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $950 and includes more than $300 of unearned income (for example, interest and dividends).

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2011. See Pub. 919, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A	
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B	
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C	
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D	
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E	
F	Enter "1" if you have at least $1,900 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F	
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $61,000 ($90,000 if married), enter "2" for each eligible child; then **less** "1" if you have three or more eligible children. • If your total income will be between $61,000 and $84,000 ($90,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have six or more eligible children	G	
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▶	H	

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($10,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

Cut here and give Form W-4 to your employer. Keep the top part for your records.

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-2159

2011

1 Type or print your first name and middle initial.	Last name	2 **Your social security number**
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐	

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	5
6	Additional amount, if any, you want withheld from each paycheck	6 $
7	I claim exemption from withholding for 2011, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▶	7

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

Employee's signature
(This form is not valid unless you sign it.) ▶ **Date** ▶

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2011 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions	1	$
2	Enter: { $11,600 if married filing jointly or qualifying widow(er); $8,500 if head of household; $5,800 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2011 adjustments to income and any additional standard deduction (see Pub. 919)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2011 Form W-4 Worksheet* in Pub. 919.)	5	$
6	Enter an estimate of your 2011 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $3,700 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	1	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3"	2	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	3	

Note. If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4	Enter the number from line 2 of this worksheet	4	
5	Enter the number from line 1 of this worksheet	5	
6	**Subtract** line 5 from line 4	6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	$
9	Divide line 8 by the number of pay periods remaining in 2011. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2010. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $5,000	0	$0 - $8,000	0
5,001 - 12,000	1	8,001 - 15,000	1
12,001 - 22,000	2	15,001 - 25,000	2
22,001 - 25,000	3	25,001 - 30,000	3
25,001 - 30,000	4	30,001 - 40,000	4
30,001 - 40,000	5	40,001 - 50,000	5
40,001 - 48,000	6	50,001 - 65,000	6
48,001 - 55,000	7	65,001 - 80,000	7
55,001 - 65,000	8	80,001 - 95,000	8
65,001 - 72,000	9	95,001 -120,000	9
72,001 - 85,000	10	120,001 and over	10
85,001 - 97,000	11		
97,001 -110,000	12		
110,001 -120,000	13		
120,001 -135,000	14		
135,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $65,000	$560	$0 - $35,000	$560
65,001 - 125,000	930	35,001 - 90,000	930
125,001 - 185,000	1,040	90,001 - 165,000	1,040
185,001 - 335,000	1,220	165,001 - 370,000	1,220
335,001 and over	1,300	370,001 and over	1,300

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

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

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

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

OMB No. 1615-0047; Expires 08/31/12

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

Form I-9, Employment Eligibility Verification

Instructions

Read all instructions carefully before completing this form.

Anti-Discrimination Notice. It is illegal to discriminate against any individual (other than an alien not authorized to work in the United States) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents presented have a future expiration date may also constitute illegal discrimination. For more information, call the Office of Special Counsel for Immigration Related Unfair Employment Practices at 1-800-255-8155.

What Is the Purpose of This Form?

The purpose of this form is to document that each new employee (both citizen and noncitizen) hired after November 6, 1986, is authorized to work in the United States.

When Should Form I-9 Be Used?

All employees (citizens and noncitizens) hired after November 6, 1986, and working in the United States must complete Form I-9.

Filling Out Form I-9

Section 1, Employee

This part of the form must be completed no later than the time of hire, which is the actual beginning of employment. Providing the Social Security Number is voluntary, except for employees hired by employers participating in the USCIS Electronic Employment Eligibility Verification Program (E-Verify). **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

Noncitizen nationals of the United States are persons born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.

Employers should note the work authorization expiration date (if any) shown in **Section 1**. For employees who indicate an employment authorization expiration date in **Section 1**, employers are required to reverify employment authorization for employment on or before the date shown. Note that some employees may leave the expiration date blank if they are aliens whose work authorization does not expire (e.g., asylees, refugees, certain citizens of the Federated States of Micronesia or the Republic of the Marshall Islands). For such employees, reverification does not apply unless they choose to present in Section 2 evidence of employment authorization that contains an expiration date (e.g., Employment Authorization Document (Form I-766)).

Preparer/Translator Certification

The Preparer/Translator Certification must be completed if **Section 1** is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete **Section 1** on his or her own. However, the employee must still sign **Section 1** personally.

Section 2, Employer

For the purpose of completing this form, the term "employer" means all employers including those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors. Employers must complete **Section 2** by examining evidence of identity and employment authorization within three business days of the date employment begins. However, if an employer hires an individual for less than three business days, **Section 2** must be completed at the time employment begins. Employers cannot specify which document(s) listed on the last page of Form I-9 employees present to establish identity and employment authorization. Employees may present any List A document **OR** a combination of a List B and a List C document.

If an employee is unable to present a required document (or documents), the employee must present an acceptable receipt in lieu of a document listed on the last page of this form. Receipts showing that a person has applied for an initial grant of employment authorization, or for renewal of employment authorization, are not acceptable. Employees must present receipts within three business days of the date employment begins and must present valid replacement documents within 90 days or other specified time.

Employers must record in Section 2:

1. Document title;
2. Issuing authority;
3. Document number;
4. Expiration date, if any; and
5. The date employment begins.

Employers must sign and date the certification in **Section 2**. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. If photocopies are made, they must be made for all new hires. Photocopies may only be used for the verification process and must be retained with Form I-9. **Employers are still responsible for completing and retaining Form I-9.**

For more detailed information, you may refer to the *USCIS Handbook for Employers* (Form M-274). You may obtain the handbook using the contact information found under the header "USCIS Forms and Information."

Section 3, Updating and Reverification

Employers must complete **Section 3** when updating and/or reverifying Form I-9. Employers must reverify employment authorization of their employees on or before the work authorization expiration date recorded in **Section 1** (if any). Employers **CANNOT** specify which document(s) they will accept from an employee.

A. If an employee's name has changed at the time this form is being updated/reverified, complete Block A.

B. If an employee is rehired within three years of the date this form was originally completed and the employee is still authorized to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.

C. If an employee is rehired within three years of the date this form was originally completed and the employee's work authorization has expired **or** if a current employee's work authorization is about to expire (reverification), complete Block B; and:

1. Examine any document that reflects the employee is authorized to work in the United States (see List A **or** C);
2. Record the document title, document number, and expiration date (if any) in Block C; and
3. Complete the signature block.

Note that for reverification purposes, employers have the option of completing a new Form I-9 instead of completing **Section 3.**

What Is the Filing Fee?

There is no associated filing fee for completing Form I-9. This form is not filed with USCIS or any government agency. Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the Privacy Act Notice below.

USCIS Forms and Information

To order USCIS forms, you can download them from our website at www.uscis.gov/forms or call our toll-free number at 1-800-870-3676. You can obtain information about Form I-9 from our website at www.uscis.gov or by calling 1-888-464-4218.

Information about E-Verify, a free and voluntary program that allows participating employers to electronically verify the employment eligibility of their newly hired employees, can be obtained from our website at www.uscis.gov/e-verify or by calling 1-888-464-4218.

General information on immigration laws, regulations, and procedures can be obtained by telephoning our National Customer Service Center at 1-800-375-5283 or visiting our Internet website at www.uscis.gov.

Photocopying and Retaining Form I-9

A blank Form I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed Form I-9s for three years after the date of hire or one year after the date employment ends, whichever is later.

Form I-9 may be signed and retained electronically, as authorized in Department of Homeland Security regulations at 8 CFR 274a.2.

Privacy Act Notice

The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by authorized officials of the Department of Homeland Security, Department of Labor, and Office of Special Counsel for Immigration-Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

Paperwork Reduction Act

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 12 minutes per response, including the time for reviewing instructions and completing and submitting the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachusetts Avenue, N.W., 3rd Floor, Suite 3008, Washington, DC 20529-2210. OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**

OMB No. 1615-0047; Expires 08/31/12

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

Form I-9, Employment Eligibility Verification

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification *(To be completed and signed by employee at the time employment begins.)*

Print Name: Last	First	Middle Initial	Maiden Name

Address *(Street Name and Number)*	Apt. #	Date of Birth *(month/day/year)*

City	State	Zip Code	Social Security #

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- ☐ A citizen of the United States
- ☐ A noncitizen national of the United States (see instructions)
- ☐ A lawful permanent resident (Alien #) _____
- ☐ An alien authorized to work (Alien # or Admission #) _____ until (expiration date, if applicable - *month/day/year*)

Employee's Signature | Date *(month/day/year)*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature	Print Name

Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 2. Employer Review and Verification *(To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)*

	List A	OR	List B	AND	List C
Document title:					
Issuing authority:					
Document #:					
Expiration Date *(if any)*:					
Document #:					
Expiration Date *(if any)*:					

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* _____ **and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative	Print Name	Title

Business or Organization Name and Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 3. Updating and Reverification *(To be completed and signed by employer.)*

A. New Name *(if applicable)*	B. Date of Rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: _____ Document #: _____ Expiration Date *(if any)*: _____

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Date *(month/day/year)*

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be unexpired

LIST A **Documents that Establish Both Identity and Employment Authorization**	OR	LIST B **Documents that Establish Identity**	AND	LIST C **Documents that Establish Employment Authorization**
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** Social Security Account Number card other than one that specifies on the face that the issuance of the card does not authorize employment in the United States
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)				**2.** Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**3.** Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		**3.** School ID card with a photograph		
		4. Voter's registration card		**4.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. In the case of a nonimmigrant alien authorized to work for a specific employer incident to status, a foreign passport with Form I-94 or Form I-94A bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, as long as the period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form		**5.** U.S. Military card or draft record		
		6. Military dependent's ID card		
		7. U.S. Coast Guard Merchant Mariner Card		**5.** Native American tribal document
		8. Native American tribal document		**6.** U.S. Citizen ID Card (Form I-197)
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		**7.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**10.** School record or report card		**8.** Employment authorization document issued by the Department of Homeland Security
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)

Individual Characteristics Form
Work Opportunity Tax Credit

U.S. Department of Labor
Employment & Training Administration

1. CONTROL NO. (For Agency Use Only)	Individual Information (Instructions on the Back)	OMB No. 1205-0371 Expires: 8/31/09 2. DATE RECEIVED (For Agency Use Only)

3. EMPLOYER NAME/ADDRESS:	4. EMPLOYER FEDERAL ID NO. 6. Have you worked for the above employer before? Yes_____ No_____ If Yes, enter date and year: _____	5. EMPLOYMENT START DATE:: Starting Wage: $_____ per hour POSITION:

7. NAME OF INDIVIDUAL (Last, First, Middle):

8. SOCIAL SECURITY NUMBER:

The above named individual is determined to have the following characteristics for WOTC target group certification:

9. Is your age between 18 but **not** yet age 40? Yes_____ No_____ If YES, indicate your "Date of Birth" below: Date of Birth: _____	10. Is a veteran and a member of a family that received Food Stamps for a period of at least 3 months in the last 15 months. Yes_____ No_____ If YES, also complete Box 17.	11. Is a member of a family that received TANF benefits for any 9 months in the last 18 months. Yes_____ No_____ If YES, also complete Box 17.
12. Is a member of a family that received Food Stamps for the last 6 months. Yes_____ No_____ , or for at least a 3-month period within the last 5 months, BUT is no longer receiving them. Yes_____ No_____ If YES to either, also complete Box 17.	13. In the past year, individual has been convicted of a felony or released from prison after a felony conviction. Yes_____ No_____ If YES, complete below: Date of Conviction _____ Date of Release _____	14. Lives and plans to continue living in a federal Empowerment Zone, Enterprise Round II or Renewal Community. Yes _____ No ____ 16. Received Supplemental Security Income (SSI) benefits for any month ending within the last 60 days. Yes_____ No_____
15. Is receiving or has received Rehabilitation Services through a State Rehabilitation Services' program or the Veterans' Administration. Yes_____ No_____		17. If individual is not a primary recipient of benefits, please provide the following: _____ Name of Primary Recipient _____ City/State of Benefits

18. Is a "ticket holder" under the Ticket to Work Program Yes _____ No _____	19. The "ticket holder" has an Individual Work Plan (IWP) from an Employment Network (EN). Yes _____ No _____

20. Is a member of a family that::

- Has received/is receiving TANF payments for at least the last 18 consecutive months; Yes ____ No ____ or
- Has received/is receiving TANF payments for any 18 months starting after August 5, 1997; and the earliest 18-month period beginning after August 5, 1997, and ended within the last 2 years; or Yes _____No ____ or
- Stopped being eligible for TANF payments within the last 2 years because Federal or state law limited the maximum time those payments could be made, and having a hiring date not more than 2 years after the date of cessation of TANF benefits. Yes _____ No ____

21. SOURCES USED TO DOCUMENT ELIGIBILITY:

Note: I certify that the Information is true and correct to the best of my knowledge. I understand that the information above may be subject to verification. The signature of the party completing this form is required below. If applicant is a minor, the parent or guardian should sign this box.

22. SIGNATURE:	23. DATE:

INSTRUCTIONS FOR COMPLETING THE INDIVIDUAL CHARACTERISTICS FORM (ICF), ETA 9061. This form is used together with IRS Form 8850 to help SWAs determine eligibility for the consolidated Work Opportunity Tax Credit Program. The form may be completed by the applicant, the employer or employer representative/consultant, the SWA/DLA or the Participating Agency and signed by the person or agency filling out this form. This form is required to be used, without modification, by all employers and/or their representatives seeking the WOTC.

Box 1: **Control Number (for agency use only).** The SWA/DLA or participating agency determines the Control Number. It may be a Social Security Number, case number, or other appropriate designation which permits easy filing, identification and retrieval of forms. Enter this number here.

Box 2: **Date (for agency use only).** Enter the month, day, and year when the form is received.

Box 3: **Employer Name/Address.** Enter the name and address including zip code and telephone number of the employer applying for a WOTC Employer Certification.

Box 4: **Employer Federal ID No.** Enter employer's federal taxpayer identification number.

Box 5: **Employment-Start Date//Wage/Position or Title**. Enter the employment start date, the starting hourly wage, that the employee will be paid. If not known, enter an estimated wage. Also, enter the job or position title, under which the individual or prospective employee will be performing for this employer.

Box 6: **Previous Employment for This Employer.** This requires a YES or NO answer. Enter a check mark (✓) in the corresponding blank. If Yes, enter date and year.

Box 7: **Name of Individual.** Enter full name of Individual or prospective employee.

Box 8: **Social Security Number.** Enter individual's social security number here.

Boxes 9 through 20 (Read each box carefully). Enter a check mark (✓) to indicate If your answer is a YES or a NO. Provide additional information where requested for the WOTC target group eligibility.

Box 21. Sources to Document Eligibility. List or describe the documentary* evidence or sources of collateral contacts that are attached to the ICF form or that will be provided. Indicate in parentheses, next to each document listed, whether it is attached or forthcoming. Some examples are provided below. Employers may also obtain a letter from the agency that administers a relevant program, stating that the employee or a member of his/her household meets one of the eligibility requirements.

Examples of Documentary Evidence or Collateral Contacts:

AGE/BIRTHDATE:
(Required for High-Risk Summer Youth & Food Stamp)
- Birth Certificate
- Driver's License
- School I.D. Card*
- Work Permit
- Federal/State/Local Gov't I.D.*
- Hospital Record of Birth

FAMILY INCOME:
(Required for Ex-felon)
- Pay Stubs
- Employer Contacts
- W-2 Forms
- UI Documents
- Public Assistance Records of No. of Months Benefits Were Received.
- Family Members' Statements
- Parole Officer's Name
- Parole Officer's Statements

SSI RECIPIENT:
- SSI Record or Authorization
- SSI Contact
- Evidence of SSI Issuance

EX-FELON STATUS:
- Parole Officer's Name
- Correction Institution Records
- Court Record, Extracts

TANF (IV-A) RECIPIENT:
- TANF Benefit History
- Signed Statement from Authorized Individual w/ Specific Description of Months Benefits Were Received.
- Case Number Identifier

NUMBER IN FAMILY
- Public Assistance
- Social Services Agencies

VETERANS' STATUS:
- DD-214
- Reserve Unit Contacts
- Discharge Papers*

VOCATIONAL REHABILITATION REFERRAL:
- Voc. Rehab. Agency Contact

VOC REHAB (Continued)
- Signed statement from authorized individual w/specific description of months benefits received
- Veterans Administration Records

LONG-TERM FAMILY ASSISTANCE RECIPIENT
- TANF Benefits History
- Signed Statement from authorized individual with specific description of months benefits received
- Case Number Identifier

EMPOWERMENT ZONES/ENTERPRISE/ RENEWAL COMMUNITIES:
- Driver's License
- Work Permit
- Utility Bills
- Signed Statement From Authorized Individual w/ Specific Description
- Lease Document
- Voter Registration Card
- Food Stamp Award

EZ/EC/RCs (Continued)
Letter
- Social Security Agency Letter
- Library Card**
- Landlord's Statement
- Letter From Social Service Agencies
- School Records
- Medicaid/Medicare Card
- Property Tax Record
- Public Assistance Record
- Rent Receipts
- School I.D. Card**
- W-4
- Selective Service Registration Card

TICKET HOLDER (Ticket to Work Program)
- SWAs must establish applicant's eligibility by calling MAXIMUS to verify if applicant: 1) is a ticket holder and 2) has and IWP from an Employment Network (EN).

NOTE: This list is not an exhaustive list. For more information, contact your WOTC public State Workforce Agency.

*Where any item of documentation such as a Federal I.D. Card does not contain age or birth date, the SWA/DLA must obtain another documentary source to verify the individual's age.

**Where any item of documentary evidence, such as library card does not contain the holder's address, the SWA/DLA must obtains documentary evidence issued in the jurisdiction where the EZ/EC or RC is located showing the holder's address.

22. Signature. Affix your signature.

23. 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 requirements is required to obtain and retain benefits per P.L. 104˙184. Public reporting burden for this collection of information is estimated to average .33 minutes per response, including the time for reading instructions, searching existing data sources, gathering and maintaining the data needed; and completing and reviewing the intonation. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Division of Adult Services, Room C-4514, Washington, D.C. 20210 (Paperwork Reduction Project 1205-0371).

(Cut along doted line and keep in your files)

TO THE JOB APPLICANT OR EMPLOYEE:

THE INFORMATION AND THE SUPPORTING DOCUMENTATION YOU HAVE PROVIDED IN COMPLETING THIS FORM —OR IN SOME CASES OTHER INFORMATION THAT COULD VERIFY THE RESPONSES YOU HAVE GIVEN TO THE ITEMS/QUESTIONS IN THIS FORM— WILL BE DISCLOSED BY YOUR EMPLOYER TO THE STATE WORKFORCE AGENCY (SWA) [ENTER CORRESPONDING SWA NAME BELOW:

_____

IN ORDER TO QUALIFY FOR A FEDERAL EMPLOYER TAX CREDIT, 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.

FORM

MW 507

Employee's Maryland Withholding Exemption Certificate

Print your full name	Your Social Security number
Address (including ZIP code)	County of residence (or Baltimore City)

Check the box that applies:

☐ Withhold at Single Rate

☐ Married (surviving spouse or unmarried Head of Household) Rate

☐ Married, but withhold at Single Rate

1. Total number of exemptions you are claiming not to exceed **line f** in worksheet below 1. _____

2. Additional withholding per pay period under agreement with employer 2. _____

3. I claim exemption from withholding because I do not expect to owe Maryland tax. See instructions below and check boxes that apply.

   ☐ a. Last year I did not owe any Maryland income tax and had a right to a full refund of all income tax withheld.

   AND

   ☐ b. This year I do not expect to owe any Maryland income tax and expect to have the right to a full refund of all income tax withheld. (This includes seasonal and student employees whose annual income will be below the minimum filing requirement).

   If both **a** and **b** apply, enter year applicable _____(year effective) Enter "EXEMPT" here 3. _____

4. I claim exemption from withholding because I am domiciled in one of the following states. Check state that applies.

   ☐ District of Columbia ☐ Pennsylvania ☐ Virginia ☐ West Virginia

   I further certify that I do not maintain a place of abode in Maryland as described in the instructions on page 2.

   Enter "EXEMPT" here 4. _____

Under the penalty of perjury, I further certify that I am entitled to the number of withholding allowances claimed on line 1 above, or if claiming exemption from withholding, that I am entitled to claim the exempt status on line 3 or line 4, whichever applies.

Employee's signature _____ Date _____

Employer's name and address (including zip code) (For employer use only)	Federal employer identification number

Worksheet and instructions

Enter on line 1 above, the number of personal exemptions that you will be claiming on your tax return; however, if you wish to claim more exemptions, or if your adjusted gross income will be more than $100,000, you must complete the worksheet below, if you are filing single or married filing separately ($150,000, if you are filing jointly or as head of household).

Line 1	
a. Multiply the number of your personal exemptions by the value of each exemption from the table on page 2. (Generally the value of your exemption will be $3,200; however, if your federal adjusted gross income is expected to be over $100,000, the value of your exemption may be reduced. **Do not claim any personal exemptions that you are currently claiming at another job, or any exemptions being claimed by your spouse.** To qualify as your dependent, you must be entitled to an exemption for the dependent on your federal income tax return for the corresponding tax year. **NOTE:** Dependent taxpayers may not claim themselves as an exemption.	a. _____
b. Multiply the number of additional exemptions you are claiming for dependents who are 65 years of age or older by the value of each exemption from the table on page 2.	b. _____
c. Enter the estimated amount of your itemized deductions (excluding state and local income taxes) that exceed the amount of your standard deduction, alimony payments, allowable childcare expenses, qualified retirement contributions, business losses and employee business expenses for the year. Do not claim any additional amounts you are currently claiming at another job; or any amounts being claimed by your spouse. NOTE: Standard deduction allowance is 15% of Maryland adjusted gross income with a minumum of $1,500 and a maximum of $2,000.	c. _____
d. Enter $1,000 for additional exemptions for taxpayer and/or spouse at least 65 years of age and/or blind.	d. _____
e. Add total of lines a through d.	e. _____
f. Divide the amount on line e by $3,200. **Drop any fraction. Do not round up.** This is the **maximum** number of exemptions you may claim for withholding tax purposes.	f. _____

If Your federal AGI is between		If you will file your tax return	
		Single or Married Filing Separately Your Exemption is	Joint, Head of Household, or Qualifying Widow(er) Your Exemption is
$0	$100,000	$3,200	$3,200
$100,001	$125,000	$2,400	$3,200
$125,001	$150,000	$1,800	$3,200
$150,001	$175,000	$1,200	$2,400
$175,001	$200,000	$1,200	$1,800
$200,001	$250,000	$600	$1,200
In excess of $250,000		$600	$600

-Line 2

ADDITIONAL WITHHOLDING PER PAY PERIOD UNDER AGREEMENT WITH EMPLOYER If you are not having enough tax withheld, you may ask your employer to withhold more by entering an additional amount on line 2.

Line 3

WHO MAY CLAIM EXEMPTION FROM WITHHOLDING OF INCOME TAX You may be entitled to claim an exemption from the withholding of Maryland income tax if:

a. last year you did not owe any Maryland income tax and had a right to a full refund of any tax withheld; and

b. this year you do not expect to owe any Maryland income tax and expect to have a right to a full refund of all income tax withheld. If you are eligible to claim this exemption, your employer will not withhold Maryland income tax from your wages.

STUDENTS AND SEASONAL EMPLOYEES whose annual income will be below the minimum filing requirements should claim exemption from withholding. This provides more income throughout the year and avoids the necessity of filing a Maryland income tax return.

Line 4

CERTIFICATION OF NONRESIDENCE IN THE STATE OF MARYLAND This line is to be completed by residents of the District of Columbia, Pennsylvania, Virginia or West Virginia who are employed in Maryland and who do not maintain a place of abode in Maryland for 183 days or more.

Line 4 is *not* to be used by residents of other states who are working in Maryland, because such persons are liable for Maryland income tax and withholding from their wages is required.

If you are domiciled in the District of Columbia, Pennsylvania or Virginia and maintain a place of abode in Maryland for 183 days or more, you become a statutory resident of Maryland and you are required to file a resident return with Maryland reporting your total income. You must apply to your domicile state for any tax credit to which you may be entitled under the reciprocal provisions of the law.

If you are domiciled in West Virginia, you are not required to pay Maryland income tax on wage or salary income, regardless of the length of time you may have spent in Maryland.

GENERAL INSTRUCTIONS

FEDERAL PRIVACY ACT INFORMATION Social Security numbers must be included. The mandatory disclosure of your Social Security number is authorized by the provisions set forth in the Tax-General Article of the Annotated Code of Maryland. Such numbers are used primarily to administer and enforce the individual income tax laws and to exchange income tax information with the Internal Revenue Service, other states and other tax officials of this state. Information furnished to other agencies or persons shall be used solely for the purpose of administering tax laws or the specific laws administered by the person having statutory right to obtain it.

DUTIES AND RESPONSIBILITIES OF EMPLOYER Retain this certificate with your records. You are required to submit a copy of this certificate to the Compliance Division, Compliance Programs Section, 301 West Preston Street, Baltimore, MD 21201, when received if:

1. you have any reason to believe this certificate is incorrect;
2. the employee claims more than 10 exemptions;
3. the employee claims exemptions from withholding because he/she had no tax liability for the preceding tax year, expects to incur no tax liability this year and the wages are expected to exceed $200 a week; or
4. the employee claims exemptions from withholding on the basis of nonresidence.

Upon receipt of any exemption certificate (Form MW 507), the Compliance Division will make a determination and notify you if a change is required.

Once a certificate is revoked by the Comptroller, the employer must send any new certificate from the employee to the Comptroller for approval before implementing the new certificate.

If an employee claims exemption under 3 above, a new exemption certificate must be filed by February 15th of the following year.

DUTIES AND RESPONSIBILITIES OF EMPLOYEE If, on any day during the calendar year, the number of withholding exemptions that the employee is entitled to claim is less than the number of exemptions claimed on the withholding exemption certificate in effect, the employee shall file a new withholding exemption certificate with the employer within 10 days after the change occurs.

For additional information please call 410-767-1300 or toll-free at 1-800-492-1751 or visit **www.marylandtaxes.com**