DOCUMENTS NEEDED BY FACILITIES FROM APPLICANTS:

RN/LPN:

License

Certificate (Diploma)

CPR / BLS (Cognitive and Skills Assessment)

Malpractice Insurance

Physical (Done within the last 12 months)

-Current PPD (Chest X-ray if positive)

-Immunizations (LAB PRINT OUT of Mumps, Varicella, Rubella, Rubeola & Proof of a Flu Shot / Influenza Vaccination)

Resume

2 Reference Letters

2 IDs (Social Security and State Photo ID OR Social Security and Permanent Resident Card)

CNA / HHA:

License

Certificate (Diploma)

Physical (Done within the last 12 months)

-Current PPD (Chest X-ray if positive)

-Immunizations (LAB PRINT OUT of Mumps, Varicella, Rubella, Rubeola & Proof of a Flu Shot / Influenza Vaccination)

Resume

2 Reference Letters

2 IDs (Social Security and State Photo ID OR Social Security and Permanent Resident Card)

MEDICAL ASSISTANT:

Medical Assistant Certificate

CPR / BLS (Cognitive and Skills Assessment)

Phlebotomy Certificate or any other certificate you may carry

Physical (Done within the last 12 months)

-Current PPD (Chest X-ray if positive)

-Immunizations (LAB PRINT OUT of Mumps, Varicella, Rubella, Rubeola & Proof of a Flu Shot / Influenza Vaccination)

2 IDs (Social Security and State Photo ID OR Social Security and Permanent Resident Card)

Resume

Reference Letter(s)

Employment Application

→ _____

Last Name | First Name | Middle Name

→ - - / /

Social Security Number | Date of Birth | Email Address

→ ( ) - ( ) -

Home Phone Number | Cell Phone Number

→ _____

Current Street Address | Apt #

→ _____ ( ) Years ( ) Months

City | State | Zip | How long have you resided here?

→ _____ ( ) -

Name of Emergency Contact: 1 | Relation | Phone Number

→ _____ ( ) -

Name of Emergency Contact: 2 | Relation | Phone Number

Title (check one)

□ RN □ LPN □ CNA □ Other_____

Type of Work Desired (Check all that apply)

□ Hospital □ Long-Term Care □ Clinic _____ □ Rehab □ Other_____

Languages Spoken other than English

□ Spanish □ French □ Russian □ Polish □ Creole □ Other_____

Check the type of assignment(s) you are interested in (check all that apply)

□ Full-Time □ Part-Time □ Per Diem /On Call

Check the Day(s) of the week you are interested in working (check all that apply)

□ Sunday □ Monday □ Tuesday □ Wednesday □ Thursday □ Friday □ Saturday

Check the shift(s) you are interested in working (check all that apply)

□ 7am-3pm (Morning) □ 3pm-11pm (Evening) □ 11pm-7am (Overnight) □ Other_____

Are you legally authorized to work in the United States?

□ Yes □ No

Have you ever been convicted of a felony or misdemeanor crime?

□ Yes □ No

If yes, please explain *each violation*

_____

_____

Education and Training

High School Name	City	State	Zip	Country	Did you receive H.S Diploma?

College/Vocational School	City	State	Zip	Country	Highest Grade Completed

Major in College	Type of Degree (i.e. B.S./B.A./etc...)

Graduate School	City	State	Zip	Country	Did you receive Diploma?

Major in Graduate School	Type of Degree (i.e. Masters/P.H.D/etc...)

License/Certification

License Type	License/Certification Number	State	Expiration Date

License Type	License/Certification Number	State	Expiration Date

License Type	License/Certification Number	State	Expiration Date

Has your professional License/Certification ever been suspended, revoked or gone under investigation?

☐ Yes ☐ No

If yes, please explain why_____

_____

How did you hear about Match One Staffing?

☐ Mail ☐ Advertisement ☐ Other_____

☐ Website ☐ Match One Staffing Employee Name_____

Please explain any other work-related information you think would be helpful to us in considering you for employment, such as specialized training, certifications, honors, etc..._____

Based on your experience, work ethic, and devotion to Match One Staffing, tell us what you think you deserve for compensation_____$/hour

Applicant Acknowledgement

I certify that the information in this application is accurate, current and complete. I understand that mis-statements or omissions may result in disqualification from further consideration or termination of employment.

I authorize Match One Staffing to investigate my employment history, credentials and to obtain any relevant information (including a criminal background check and a credit check) needed to make an employment decision. I authorize Match One Staffing to disclose this application along with any information about me obtained through reference checks or during the course of the interview process for state, federal, contractual or accreditation audit purposes. I also authorize Match One Staffing to disclose any of my performance appraisals, disciplinary records or skills tests for the same purposes as above. I release Match One Medical Staffing and any individual or entity providing information to Match One Staffing, LLC from all liability for any damages from the disclosure of this information.

Match One Staffing, LLC, is contracted by many organizations to provide temporary, contract and per diem personnel to said organizations. It is our policy of Match One Staffing, LLC, not to allow its employees to pursue employment directly with a Match One client for a period of Three-Hundred sixty (360) days from the last date of work by the Match One employee with said client through Match One Staffing, LLC. Therefore, by signing this agreement, the Match One employee may not pursue employment directly with a Match One client they have worked for through Match One for a minimum of Three-Hundred sixty (360) days from the last date they were scheduled through Match One with said client. If the Match One employee does work directly for a Match One client that they have worked for through Match One, or any of its agents or contractors, prior to the end of the Three Hundred sixty (360) day period referenced above, the said employee will be responsible for payment of a placement fee to Match One in the amount of twenty-five percent (25%) of the individuals annualized full time salary. The facility will abide to the contract signed by facility in regards to any employee buyout situation.

I also understand and agree that:

Passing a medical examination and/or participating in a post-conditional offer medical screening may be required. If medical restrictions cannot be reasonably accommodated, I may not be hired, or if hired, employment may be terminated.

Subject to applicable state laws, the Company reserves the right to conduct drug screening and testing for reasonable suspicion at any time during employment and as a pre-employment requirement. Any violation of this policy shall result in an applicant not being hired or an adverse employment action up to and including immediate termination. Match One Staffing has the right to change this policy at any time as it requires with proper notification to employees/applicants.

I understand and agree that nothing contained in this employment application or in granting of an interview creates an employment contract between Match One Staffing and me for either employment of for the providing of any benefit. No promises regarding employment have been made to me. If an employment relationship is established, I understand that my employment will be terminable 'at will', that I will have the right to terminate my employment at any time, and that Match One Medical Staffing will retain a similar right to terminate my employment at any time.

I hereby acknowledge that I have received a copy of the Employee Handbook of Match One Staffing, LLC. I will familiarize myself with the information in this handbook. I agree to observe all of the policies in the handbook. I understand that Match One Staffing, LLC may revise its policies or practices at any time. It is part of my job to inquire about a new and updated volume to keep up with the latest industry policies and standards.

I have received and agree to wear the Match One Staffing Identification Badge whenever I am on staff at any of the facilities I work at .

I understand that should I become employed by Match One Staffing, my work assignments, schedules and/or work locations are subject to change according to the needs of the business and the clients of Match One Staffing.

X_____

Signature **Date**

DEMOGRAPHICS FORM

Last Name	
First Name	
Middle Initial	
Date Of Birth	
Complete Social Security	
Maiden Name	
Alias (AKA) Nickname	
Building Number	
Street Name	
City	
State	
Zip Code	
Apartment Number	
Home Phone	
Cell Phone	
Emergency Phone	
Place of Birth/ Country	
Sex	
Race	
Height	
Weight	
Eye Color	
Hair Color	

Form W-4 (2014)

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 2014 expires February 17, 2015. 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 $1,000 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

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 can 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. 505 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. 505 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. 505 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. 505 to see how the amount you are having withheld compares to your projected total tax for 2014. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

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 $2,000 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 $65,000 ($95,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to six eligible children or **less** "2" if you have seven or more eligible children. • If your total income will be between $65,000 and $84,000 ($95,000 and $119,000 if married), enter "1" for each eligible child	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 are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 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.

---------- **Separate 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. 1545-0074

2014

1 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 2014, 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)

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

▶START HERE. 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 documentation presented has a future expiration date may also constitute illegal discrimination.

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

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	Zip Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number
	___-___-____		

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 Registration Number/USCIS Number): _____

☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. *(See instructions)*

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date *(mm/dd/yyyy)*:

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.

Signature of Preparer or Translator:	Date *(mm/dd/yyyy)*:

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	Zip Code

STOP ***Employer Completes Next Page*** STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title:		Document Title:
Issuing Authority:		Issuing Authority:		Issuing Authority:
Document Number:		Document Number:		Document Number:
Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				

3-D Barcode
Do Not Write in This Space

Certification

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ **(*See instructions for exemptions.*)**

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Last Name *(Family Name)* First Name *(Given Name)*		Employer's Business or Organization Name
Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State / Zip Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)* Last Name *(Family Name)* First Name *(Given Name)* Middle Initial	**B.** Date of Rehire *(if applicable) (mm/dd/yyyy)*:

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

Document Title:	Document Number:	Expiration Date *(if any)(mm/dd/yyyy)*:

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 *(mm/dd/yyyy)*:	Print Name of Employer or Authorized Representative:

DOH CHRC 102 (1/07)

NYS Department of Health

ACKNOWLEDGEMENT AND CONSENT FORM FOR FINGERPRINTING AND DISCLOSURE OF CRIMINAL HISTORY RECORD INFORMATION

THIS FORM IS TO BE RETAINED BY THE AGENCY- DO NOT FORWARD TO THE DOH CHRC UNIT.

chrc@health.state.ny.us

The purpose of this form is to obtain consent from the subject individual for fingerprints and criminal history record information pursuant to Article 28-E of the Public Health Law and Section 845-b of the Executive Law.

SECTION 1 – SUBJECT INDIVIDUAL INFORMATION

LAST Name	FIRST Name	M.I.	
Date of Birth (mm/dd/yyyy)	Mother's Maiden Name	Alias: AKA	

Mailing Address (street)	City	State	Zip

SECTION 2 - ATTESTATION

1. I have applied to an agency to provide direct care or supervision to residents or patients. I understand that as part of the application process, the Public Health Law (PHL) Article 28-E requires that the New York State Department of Health perform a criminal history check on me with the New York State Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI).

2. I acknowledge and consent to having my fingerprints taken for the purpose of a criminal history record check by the DCJS and the FBI.

3. I have been advised that DOH is authorized by law to receive the results of the criminal history record check from DCJS and the FBI for the purpose of developing a criminal history record summary to be provided to the agency to which I applied for a position to provide direct care or supervision to residents or patients. I have been advised that the criminal history record summary will indicate whether I have a criminal history, as maintained by DCJS or the FBI, including convictions of a crime (felony or misdemeanor) or criminal charges which do not reflect a disposition. I have been advised that by law, DOH is authorized and may be required to provide the results of the criminal history record check through a criminal history record summary to the agency. The criminal history record summary prepared by DOH and sent to the agency will contain the results of the criminal history record check performed by DCJS. I have been advised that the information shall be confidential pursuant to applicable federal and state laws, rules and regulations and shall only be disclosed to persons authorized by law.

4. I hereby consent to DOH sharing with any DCJS agency to which I applied for a position to provide direct care or supervision, any criminal history record check information provided to DOH by the FBI, including the specific crime(s) for which I was convicted or charged, the date of the arrest for such charge, and/or date of conviction, and the jurisdiction in which the arrest or conviction took place.

5. I have been informed of the procedures and my rights to obtain, review and seek correction of my criminal history information pursuant to regulations and procedures established by the DCJS and the FBI.

6. I understand that I have the right to withdraw my application for employment, without prejudice, any time before employment is offered or declined, regardless of whether an agency, DOH or I have reviewed my criminal history information.

7. I certify to the best of my knowledge and belief that I (check as appropriate):
   - ☐ **Have** ☐ **Have not been convicted of a crime in New York State or any other jurisdiction**
   - ☐ **Do** ☐ **Do not have a final finding of patient or resident abuse**

   If you have checked either "Have" and/or "Do", please provide a brief explanation. (Optional)

   _____

8. My current mailing or home address is indicated in Section 1 of this form.

9. I have read this form and hereby consent to the request by the agency to use my fingerprints to obtain my criminal history record, if any, from the DCJS and the FBI. I hereby consent to the redisclosure of any convictions or open charges on my criminal history record, received by DOH from DCJS, to the requesting agency. I declare and affirm that the information I have provided on this consent form is true, complete and accurate and that the fingerprints to be submitted are my own (not applicable for Expedited Review submitted pursuant to CHRC Form 104).

Applicant Signature: _____ Date: _____

Signature of Parent or Legal Guardian_____ Date: _____
(if subject individual is under 18 years of age)

SECTION 3 – AGENCY AUTHORIZED PERSON INFORMATION

Agency Name:	PFI/Operating License Number:
Print Name of Authorized Person:	Title:
Signature of Authorized Person:	Date:

Form **8850**
(Rev. January 2012)
Department of the Treasury
Internal Revenue Service

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

▶ 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 _____

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.

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 County Agency, Inc. Telephone no. 718-387-7702 EIN ▶ 92-0183285

Street address 129 South 8th Street

City or town, state, and ZIP code Brooklyn, NY 11211

Person to contact, if different from above TC Services Inc Telephone no. (212) 994-2714

Street address 11 Hershel Terrace

City or town, state, and ZIP code Monsey, NY 10952

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 . . . . . 30 min.

Preparing and sending this form to the SWA . . . . . 37 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:M:S, 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

OMB No. 1205-0371
Expiration Date: June 30, 2015

Individual Characteristics Form (ICF)

Work Opportunity Tax Credit

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)
County Agency, Inc.	129 South 8th Street Brooklyn, NY 11211 718-387-7702	92-0183285

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 a Rural Renewal County or Empowerment Zone? 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. **Sources used to document eligibility:** (**Employers/Consultants:** List all documentation provided or forthcoming. **SWAs:** 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.

24(a). Signature: (See instructions in Box 24.(b) for who signs this signature block)	**24. (b) Signatory Options:** Indicate with a ✓ mark who signed this form: ☐ Employer, ☐ Consultant, ☐ SWA, ☐ Participating Agency, ☐ Applicant, or ☐ Parent/Guardian (if applicant is a minor)	**25. Date:**