

Employer Information

The employer must fill out the following:

Employer Name _____ FEIN _____

New York State Employer Identification Number _____

Employer Address _____

Employer City, State, and ZIP Code _____

Employer Telephone Number (_____) _____ Employer Contact _____

Person to contact, if different from above _____

Street Address _____

City, State, and ZIP Code _____

Date applicant was hired _____

Date applicant began employment _____

Wages _____

Under penalties of perjury, I declare that I completed this form 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 the targeted group. I hereby request a certification that the individual is a member of the targeted group.

Employer Signature: _____ Date: _____

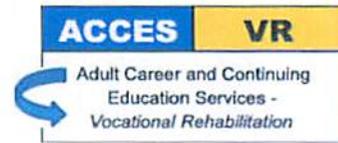
Instructions

The purpose of this form is to pre-screen applicant's eligibility for the Workers with Disabilities Tax Credit. Submitting this form is but one step in qualifying an employee for the Workers with Disabilities Tax Credit. New York State Department of Labor must certify the job applicant as a member of the targeted groups. After starting work, the employee must meet the minimum number of hours worked requirement. The employer may elect to take the tax credit by filing the applicable credit form.

Complete this form to apply for the New York State Workers with Disabilities Tax Credit after the job applicant begins work for you. Submit completed form to the **New York State Department of Labor, State Office Campus, Bldg. 12, Room 200, Albany, NY, 12240**. Keep copies of the form, along with any transmittal letters you submit, for the administration of New York State tax provisions relating to the Workers with Disabilities Tax Credit.



New York State Department of Labor
 State Office Building Campus
 Building 12, WOTC Unit, Room 200
 Albany, New York 12240



Job Applicant: Fill in the lines below and check any boxes that apply.

Your name _____ Social Security Number _____

Street address where you live _____

City or town, state, and ZIP code _____

Telephone Number (____) _____

Workers with Disabilities Tax Credit (WETC)

I have received Vocational Rehabilitation Services under a written plan from the New York State Education Department's Office of Adult Career and Continuing Education Services – Vocational Rehabilitation (ACCES-VR),

Or

I have received services by the Office of Children and Family Services' Commission for the Blind (CB)

Information Release Authorization

The Office of Adult Career and Continuing Education Services – Vocational Rehabilitation (ACCES-VR) Has my permission to release or to obtain information from agencies [including the Client Assistance Program (CAP)], individuals, or employers as are concerned with my vocational rehabilitation. This information may include reports about my physical or mental condition, official school records, facts necessary to determine my financial need or other information that ACCES-VR needs to determine my eligibility and to provide vocational rehabilitation services.

I understand that:

- All such information will be privileged and treated confidentially;
- The information will be used only for the purpose of obtaining services offered through ACCES-VR;
- I can withdraw my permission to release or obtain information by writing to ACCES-VR (this will not affect actions already taken with my permission); and
- ACCES-VR may need to use the information to administer the vocational rehabilitation program.

Signature _____

Date _____