Individual Characteristics Form
Work Opportunity Tax Credit

U.S. Department of Labor
Employment and Training Administration
U.S. Employment Service

1. CONTROL NO. (For Agency Use Only)	**Individual Information (Instructions on the Back)**	OMB Control No.: 1205-0374 Expires: 03/31/97 2. DATE RECEIVED (For Agency Use Only)

3. EMPLOYER NAME/ADDRESS	4. EMPLOYER TAX EIN NO. 6. Have you worked for the above employer before? Yes ____ No ____	5. EMPLOYMENT START DATE Starting Wage: $_____ per hour POSITION:

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

8. SOCIAL SECURITY NUMBER:

9. The above named individual is determined as having the following characteristics for WOTC Target Group Certification:

9. Is your age between 16 - 25? Yes ____ No ____ **If YES, indicate your "Date of Birth" below:** **Date of Birth**	10a. Is a veteran and a member of a family that received **AFDC (TANF)** for a period of at least 9 months in the last 21 months. Yes ____ No ____ **If YES, also complete Box 16.**	10b. Is a veteran and a member of a family that received **Food Stamps** for a period of a least 3 months in the last 15 months. Yes ____ No ____ **If YES, also complete Box 16.**
11. Is a member of a family that received **AFDC (TANF) benefits** for a period of at least 9 months in the last 18 months. Yes ____ No ____ **If YES, also complete Box 16.**	12. Is a member of a family that received **Food Stamps** for the last 6 months. Yes ____ No ____ or **If YES, also complete Box 16.** for at least a consecutive 3-month period within the last 5 months, BUT is no longer receiving them? Yes ____ No ____ **If YES, also complete Box 16.**	13. In the past year has been convicted of a felony or released from prison after a felony conviction. Yes ____ No ____ **If NO, SKIP to Box 14.** Date of Conviction _____ Date of Release _____ **Total Income** for the past **6 months** for **all** family members living in the same household? **Total Income:** _____ **(If No Income, Enter 0 above)** No. of family members living in the same household for the past 6 months, including you: _____
14. Lives and plans to continue living in a Federal **Empowerment Zone** or **Enterprise Community.** Yes ____ No ____	15. Is receiving or has received Rehabilitation Services through a State **Rehabilitation Services** program or the Veterans' Administration. Yes ____ No ____	
16. If individual is not a primary recipient of benefits, please provide the following: _____ **Name of Primary Recipient** _____ **City/State of Benefits**	17. 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.**

18. SIGNATURE:	19. DATE:

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 are mandatory as required by P.L. 104-188. Public reporting burden for this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, U.S. Employment Service, Room 4470, Washington, D.C. 20210 (Paperwork Reduction Project 1205-0374).

INSTRUCTIONS FOR COMPLETING THE INDIVIDUAL CHARACTERISTICS FORM (ICF), ETA 9061. This form is used in conjunction with IRS Form 8850 to determine eligibility for the Work Opportunity Tax Credit program. The form may be completed by the applicant, the employer or employer agent, the SESA or the participating agency and signed by the person or agency filling out this form.

Note. This form is required to be used, without modification, by all employers or third parties serving under contract as an agent or representative of the employer.

Box 1: **Control Number (for agency use only).** The SESA 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 Tax EIN.** 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 which the employee will be paid. If not known, enter an estimated wage to be paid. Also, enter the job or position title, 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 blank that corresponds to your answer.

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 16:

Read each box carefully. Enter a check mark (√) to indicate if your answer is a YES or a NO. Provide additional information where requested.

Box 17. Sources to Document Eligibility. List and/or describe the documentary* evidence or sources of collateral contacts that are attached to this form (ICF) or that will be provided. Indicate in parentheses, next to each document listed whether it is attached or forthcoming. Some examples are provided below. **The asterisk * indicates documents that may be obtained by the employer. 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**
- *I-9**

FAMILY INCOME:

(Required for Ex-Felons)
- *Pay Stubs**
- *Employer Contacts**
- *W-2 Forms*
- *UI Documents*
- *Public Assistance Records*
- *Family Members' Statements*
- *Parole Officer's Name**
- *Parole Officer's Statement*

VOCATIONAL REHABILITATION REFERRAL:
- *Voc. Rehab. Agency Contact*
- *Social Services Agency Contact*
- *Veterans' Administration*

EX-FELON STATUS:
- *Parole Officer's Name**
- *Corrections Institution Records*
- *Court Records, Extracts*
- *Contacts*

AFDC (IV-A) RECIPIENT:
- *AFDC Benefit History*
- *Signed Statement From Authorized Individual w/Specific Description of No. of Months Benefits Were Received.*
- *Case Number**

FOOD STAMP RECIPIENT:
- *Food Stamp Benefit History*
- *Signed Statement From Authorized Individual w/Specific Description of Months Benefits Were Received.*
- *Case Number**

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

NUMBER IN FAMILY:
- *Public Assistance*
- *Social Services Agencies*

EMPOWERMENT ZONES/ENTERPRISE COMMUNITIES:
- *Driver's License**
- *Work Permit**
- *Utility Bills**

NOTE: This list is not exhaustive. For more information, contact your WOTC public Employment Service office.

Box 18. Signature. If applicant completes this form he or she must enter signature here. If applicant is a minor (under age 18) the parent or guardian should sign this box. If form is completed by the employer or his/her agent enter corresponding signature here. If form was completed by the intake staff of a SESA or participating agency, enter signature of intake staff in this box.

Box 19. Date. Enter the month, day and year in which the form is completed.