

1. CONTROL NO.
(For Agency Use Only)

U.S. DEPARTMENT OF LABOR
Employment and Training Administration
INDIVIDUAL CHARACTERISTICS FORM
Work Opportunity Tax Credit

2. DATE RECEIVED
(For Agency Use Only)

Individual Information
(Instructions on the Back)

3. EMPLOYER NAME/ADDRESS

4. EMPLOYER TAX EIN NO.

5. EMPLOYMENT START DATE:

Starting Wage:

\$ _____ per hour

POSITION:

6. Have you worked for the above employer before?

Yes _____ No _____

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

8. SOCIAL SECURITY NUMBER:

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 at 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 _____

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 _____

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: _____

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:

Notes. 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:

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

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

EMPOWERMENT ZONES/ENTERPRISE COMMUNITIES:

- Driver's License*
- Work Permit*
- Utility Bills*

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.

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 EMPLOYMENT SECURITY AGENCY (ENTER CORRESPONDING PARTICIPATING AGENCY HERE) _____

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 ON A MEMBER OF YOUR FAMILY, YOU SHOULD PROVIDE HIM/HER A COPY OF THIS NOTICE.



		OMB Approval No. 1205-0374 Expiration Date: 03/31/97
1. INITIATING AGENCY CODE (For Agency Use Only) CODE: _____ _____ Participating Agency _____ SESA		2. CONTROL NO. (For Agency Use Only) CONTROL NO. _____ _____ Participating Agency _____ SESA
3. TYPE OF CONDITIONAL CERT. (" / " One) a. <input type="checkbox"/> Original b. <input type="checkbox"/> Revalidation		4. DATE COMPLETED (Mo., Day, Yr.)
5. State Employment Security Agency's Name and Address	6. SIGNATURE (Authorized Official)	7. TELEPHONE NO.

PART 1. INTRODUCTION

8. NAME OF INDIVIDUAL (Last, First Middle)		9. SOCIAL SECURITY NO.
10. ADDRESS (Number, Street, City, State, Zip Code)	11. TARGET GROUP CODE (" / " One) <input type="checkbox"/> Summer Youth (SY) Enter Code if not SY: _____	12. SIGNATURE

NOTE TO EMPLOYER:

13. The above named individual may be eligible for certification under the Work Opportunity Tax Credit (WOTC) program, as authorized under the IRS Code, Sec. 51. If the person is not employed before (Mo., Day, Yr.), this eligibility determination is subject to review.

in the event you hire this person, you should request the certification necessary for you to claim a Work Opportunity Tax Credit. Simply, complete the Employer Declaration below, mail to the Designated Local Agency together with the PSN, not later than the 21st. day after the applicant starts work, and the Employee WOTC Certification Form will be returned to you, if all statutory requirements have been met.

PART II. EMPLOYER DECLARATION

I, HEREBY, DECLARE that the above named person was or will be employed by:

14. NAME OF FIRM:	15. POSITION/JOB TITLE	16. EMPLOYMENT START DATE (Mo., Day, Yr.)	17. STARTING WAGE: \$ _____ per hour
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Please send a WOTC certification for this employee. The certification is for the purpose of obtaining benefits of the WOTC, under Sec. 51 of the Internal Revenue Service. Employers are advised, that such credit will cease immediately upon notification of any subsequent invalidation. Employers are further advised that if the certification herein requested is for a member of the SUMMER YOUTH target group, the tax credit for which he/she may be eligible is subject to the limits described at Sec. 51 (d)(7) of the Internal Revenue Code.

NOTE: Falsification of data on this form is a FEDERAL CRIME in violation of 18 USC 1001. Falsification of work or concealment of information is PUNISHABLE by a fine of no more than \$10,000 or imprisonment of not more than 5 years.

Persons are not required to respond to this collection of information unless it displays a currently valid OMB Control Number. Respondents 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 collection of 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 N-4470, Washington, D.C. 20210 (Paperwork Reduction Project 1205-0374).

INTRODUCTION: CONDITIONAL CERTIFICATION FORM (CCF) ETA 9062. When a SESA or participating agency has determined that a job-ready applicant is, tentatively **ELIGIBLE**, as member of a target group, for the WOTC program, it shall use the following required form, without modification, to show that an eligibility determination was made for the person named on this form.

NOTE: The Conditional Certification (CC) serves as an official record of the determination, alerts prospective employers to the availability of the tax credit if this person is hired, and provides a means for the employer to request a WOTC Certification for this person.

INSTRUCTIONS FOR COMPLETING THE "Conditional Certification" FORM. (Boxes 1 - 13 are for participating agency and SESA use only)

- Box 1: Initiating Agency Code.** If the CC was established by the participating agency, enter its code. SESAs assign codes to designate each participating agency to indicate the initiating source for the eligibility determination process. If the eligibility determination was performed by the SESA, enter the SESA code, if available. Indicate with a check mark "✓" if initiating agency is a Participating Agency or SESA.
- Box 2: Control Number.** In the majority of the cases, the participating agency determines the control number, however, SESAs may --for internal control purposes-- develop their own control number system. It may be a Social Security number, case number, or some other appropriate designation, which permits easy filing, identification and retrieval of forms. Enter corresponding Control Number and indicate with a check mark "✓" whether the source is a Participating Agency or SESA.
- Box 3: Type of Conditional Certification.** This system distinguishes between "Original," if the individual is being processed for the first time, or "Revalidation," if the eligibility process was performed within the previous 12-month period, 45 days for the Ex-Felon and Summer youth target groups only. Otherwise, the Conditional Certification is counted as "Original." Indicate with a check mark "✓" whether eligibility determination is "Original" or "Revalidation."
- Box 4: Date Completed.** Enter the month, day, year in which the eligibility determination was completed.
- Box 5: SESA Name and Address (if known), of the SESA responsible for processing Certifications' requests for the employer indicated in Box 14). LEAVE BLANK IF SESA NAME AND ADDRESS IS NOT KNOWN.** Otherwise, enter or stamp complete address, including zip code and telephone.
- Box 6: Signature.** Enter signature of the authorized conditionally-certifying official.
- Box 7: Telephone No.** Enter corresponding SESA or participating agency area code, telephone number and extension, if available.

Part I. INTRODUCTION.

- Box 8: Name of Individual.** Enter the individual's/applicant's full name (i.e., last name, first name and middle initial).
- Box 9: Social Security Number.** Enter the individual's/applicant's social security number.
- Box 10: Address.** Enter the individual's/applicant's home address, including apartment number, zip code and telephone number.
- Box 11: Target Group Code.** Enter a check mark (✓) to indicate if "Summer Youth" or "Other," and enter code for specific target group if different from Summer Youth, based on client's information and documentation provided.
- Box 12: Signature.** Get individual's/applicant's signature. If a minor (under 18), parent or guardian must sign here.
- Box 13: CC Validity Period (This box is to be completed by the SESA or Participating Agency only).** Enter the month, day, year when the CC expires (e.g., 45 days for Ex-Felons and Summer Youth, and longer periods as appropriate for the five other target groups).

Part II. EMPLOYER DECLARATION:

- Box 14: Name of Firm.** Enter full name of the employing firm (the firm where the employee will actually work).
- Box 15: Position/Job Title.** Enter the position or job title in which the employee will be performing.
- Box 16: Employment Start Date.** Enter the date on which the employee has begun or will begin work for the employing firm.
- Box 17: Starting Wage.** Enter the wage or salary which the employee will be paid. If not known, enter an estimated wage to be paid.



OMB Approval No. 1205-0374
 Expires: 03/31/97

1. NAME AND ADDRESS OF CERTIFYING AGENCY	2. CONTROL NO. (For Agency Use Only)	3. DATE COMPLETED
	4. TELEPHONE NO.	5. INITIATING AGENCY CODE (For Agency Use Only)

PART A. EMPLOYER

6. NAME AND ADDRESS OF FIRM	7. TELEPHONE NO.	8. EMPLOYER TAX EIN NO.
	9. REPRESENTATIVE'S NAME AND TITLE	

PART B. EMPLOYEE

10. NAME AND ADDRESS OF EMPLOYEE	11. SOCIAL SECURITY NO.	12. EMPLOYMENT START DATE (Mo. Day, Yr.)
	13. TARGETED GROUP <input type="checkbox"/> Summer Youth (SY) Code if not SY: _____	

PART C. CERTIFICATION

I HEREBY CERTIFY, that the individual named in Part B, meets the eligibility criteria of Sec. 51 of the Internal Revenue Code

14. NAME OF CERTIFYING OFFICER (Print or Type)	15. SIGNATURE (Certifying Officer)	16. DATE
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COMMENTS: Minimum Employment Period. Under the provisions of the Small Business Job Protection Act of 1996, employers can only claim the WOTC, for those target group members, who either were employed by the employer for, at least, 180 days (20 days in the case of summer youth employees), or have completed, at least, 400 hours of work performed for the employer (120 hours in the case of summer youth employees).

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. Respondents' 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 collection of 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 N-4470, Washington, D.C. 20210 (Paperwork Reduction Project 1205-0374).

INSTRUCTIONS FOR COMPLETING AND ISSUING THE CERTIFICATION FORM (CF) ETA 9063 TO QUALIFIED EMPLOYERS. Documentary evidence of eligibility, income (for Ex-Felons only) and/or sources of collateral contacts are required to issue a WOTC Certification. Information on the Certification substantiates the employer's claim to a tax credit.

Note. SESAs must inform each employer who receives a WOTC Certification of the required **Minimum Employment Period** as stated in the "Comments Box" of the Certification. Enforcement of the requirement is an IRS responsibility.

Boxes to be completed on the Certification:

- Box 1: Name and Address.** Identify the SESA as the sole, authorized, certifying agency and include the appropriate address and zip code.
- Box 2. Control Number.** Enter the control number developed by the SESA for its own use.
- Box 3. Date Completed.** Enter the month, day and year when the form was completed.
- Box 4. Telephone Number.** Enter area code and telephone number of certifying SESA.
- Box 5. Initiating Agency Code.** Enter agency code developed by SESA for its own use.
- Box 6. Name and Address of Firm.** Enter employer's name and address including zip code.
- Box 7. Telephone Number.** Enter area code and telephone number of employer.
- Box 8. Employer Tax EIN Number.** Enter employer's taxpayer identification number as it appears in his/her income tax return.
- Box 9. Representative's Name and Title.** Enter the name and title of the individual or consulting firm authorized by the employer to act on his/her behalf.
- Box 10. Name and Address of Employee.** Enter the employee's full name (i.e., last name, first and initial) and address including zip code and telephone number, if available.
- Box 11. Social Security No.** Enter the employee's social security number.
- Box 12. Employment Start Date.** Enter the month, day and year when the employee began to work for the employing firm.
- Box 13. Targeted Group.** Indicate, with a check mark "✓," if Summer Youth, or enter code for other target groups.
- Box 14. Certifying Official.** Type or print full name and title of authorized certifying official.
- Box 15. Signature.** Enter authorized, certifying official's signature.
- Box 16. Date.** Enter month, day and year when the Certification is issued by the certifying official.



OMB Approval No. 1205-0374
Expiration Date: 03/31/97

1. NAME OF INDIVIDUAL:	Agency Declaration of Verification Results (OPTIONAL)	2. SOCIAL SECURITY NO.
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3. EMPLOYER NAME AND ADDRESS

THE SECTION BELOW IS TO BE COMPLETED BY THE DESIGNATED LOCAL CERTIFYING AGENCY ONLY.

4. CERTIFYING AGENCY CC Issued By: ___ Participating Agency ___ SESA	5. DATE CERTIFIED
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6. SOURCES USED TO DOCUMENT ELIGIBILITY:
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7. AUDIT SAMPLE RESULTS (Complete ONLY if selected as part of RANDOM SAMPLE in quarterly audit)

- a. I have reviewed/contacted the source(s) indicated in box 6 above and have confirmed that the certified individual is **ELIGIBLE.**
- b. I have reviewed/contacted the source(s) indicated in box 6 above and have confirmed that the certified individual is **INELIGIBLE because.**

- c. I have not been able to establish that the certified individual is **INELIGIBLE because.**

8. NAME AND TITLE OF REVIEWER (Type or print)	9. SIGNATURE	10. DATE
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NOTE: Falsification of data on this form is a FEDERAL CRIME in violation of 18 USC 1001. Falsification or work or concealment of information is PUNISHABLE by a FINE of no more than \$10,000 or IMPRISONMENT of not more than 5 years.

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INTRODUCTION/BACKGROUND TO THE AGENCY DECLARATION OF VERIFICATION RESULTS (ADVR), ETA FORM 9065. The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 (P.L. 97-248), reemphasized the "testing" of "TJTC Certifications," which was mandated by the Economic Recovery Tax Act (ERTA) of 1981 (P.L. 97-34). Besides specifying that funds "be used to test whether individuals certified as members of targeted groups...are eligible for such certification (including the use of statistical sampling techniques)...," the Act requires the Secretary of Labor to, annually, report the results of these tests to the Congress. These provisions apply in full force to the certification process under the WOTC program.

Note. Verification activities require testing the validity of all Certifications issued by the SESAs, including the Conditional Certifications and other documentation which results in Certifications. Quality reviews and audits are both parts of verification. A General Accounting Office (GAO) report recommended that verification activities be done by "other than the person who originally processed..." the Individual Characteristics Form or the Conditional Certifications.

DEFINITIONS:

1. **Quality Reviews** - the review, at specific points in the eligibility determination/certification process, of forms, and other documentation, including the Certification itself, to ensure that the required information is complete, consistent and accurately recorded.
2. **Audit** - the post-issuance examination of a random sample of Certifications and supporting documentation to verify the validity of the Certifications issued.

INSTRUCTIONS FOR COMPLETING THE AGENCY DECLARATION OF VERIFICATION RESULTS (ADVR).

- Box 1:** **Name of Individual.** Enter the full name (last, first and middle initial) of the certified target group member/employee.
- Box 2:** **Social Security No.** Enter the employee's social security number.
- Box 3:** **Employer Name and Address.** Enter employer's name and address including zip code and telephone number.
- Box 4:** **Certifying Agency.** Enter name of SESA issuing Certification. Indicate with a check mark "✓" whether CC was issued by a Participating Agency or a SESA.
- Box 5:** **Date Certified.** Enter month, day and year when the Certification was issued.
- Box 6:** **Documentary Sources.** List and/or describe the documentary evidence or sources of collateral contacts that are attached to the Certification and/or Individual Characteristics Form.
- Box 7:** **Audit Sample Results.** Indicate with a "✓" if individual is "eligible" or "ineligible." If "ineligible," for b. or c., explain why and follow instructions below.
- a. If review of documentation reveals that the Certified individual is Eligible, enter a check mark "✓."
 - b. If review of documentation reveals that the Certified individual is Ineligible, explain why, and for Conditional Certifications (CCs) prepare and send:
 - Notification of Invalidation (NOI) to the applicant and the SESA/WOTC staff; and
 - Notify employer to whom applicant was referred that the CC is invalid because of missing or incorrect information/items and that without such information no Certification can be issued.
 - c. If review of documentation reveals that the SESA has not been able to establish eligibility indicate and explain the reasons.
- For invalid Certifications, prepare and send to employer a Notice of Revocation (NOR) explaining the reasons of such action and send a copy to the Regional Office and the IRS in Washington, D.C., since employer eligibility for the tax credit does not cease until the date that the employer is notified, in writing, that the Certification has been invalidated, thereby, revoked.
- a. If review of documentation reveals that the SESA has not been able to establish eligibility indicate and explain the reasons.
- Box 8:** **Name and Title of Reviewer.** Type or print full name and title of authorized staff conducting audit review.
- Box 9:** **Signature.** Enter signature of authorized reviewer conducting audit.
- Box 10:** **Date.** Enter month, day and year when audit was conducted.

by Target Group and Participating Agency
Work Opportunity Tax Credit - Report No. 1



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No. 1205-0371
Expires: 03/31/97

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Line No.	Participating Agency	Period Ending	TARGETED GROUPS										Conditional Certifications		
			WELFARE			EZ/EC		Economically Disadvantaged		Total			Original	Revalidation	
			IV-A Recipient	Veteran	Food Stamp Recipient	High-Risk Youth	Summer Youth	Ex-Felon	Vocational Rehab. Referrals						
	A	B	C	D	E	F	G	H	I	J	K				
1	JTPA SDA														
2	ETA Grantees														
3	Vocational Rehab.														
4	Welfare Offices														
5	SSA District Offices														
6	Veterans Affairs Offs.														
7	State Employment Office														
8	Job Corps														
9	Other														
10	TOTAL														
11	Invalidations														

Name and Title of Responsible Official
Date Signed
Signature

State	Period Ending	<p>Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. Respondents obligation to reply to these requirements are mandatory as required by 20 CFR 652.3. Public reporting for this collection of information is estimated to average 8 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of 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, 'J.S. Employment Service, Room N-4470, Washington, D.C. 20210 (Paperwork Reduction Project 1205-0240).</p>	<p>OMB Approval No. 1205-0371 Expires: 03/31/97</p>
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IRS PRE-SCREENING NOTICE

TARGET GROUPS	CONDITIONAL CERTIFICATION	SELF-IDENTIFICATION	EMPLOYER IDENTIFICATION	CERTIFICATIONS
1. IV-A Recipient				
2. Veteran				
3. Food Stamp Recipient				
4. (EZ/EC) High-Risk Youth				
5. (EZ/EC) Summer Youth				
6. Ex-Felon				
7. Vocational Rehab. Referrals				
TOTALS				

Characteristics of Individuals Eligible and for Whom Certifications Are Authorized

No.	CHARACTERISTICS	CONDITIONAL CERTIFICATIONS	CERTIFICATIONS
1	Wages	Under Federal Minimum Wage	
2	Note: Federal Minimum - \$4.75 Oct. 1996 \$4.25 Apr. 1991	Federal Minimum Wage to \$4.99	
3		\$5.00 - \$5.99	
4		\$6.00 - \$6.99	
5		\$7.00 and Over	
6		Occupational Categories	Professional, Technical, Managerial
7	Clerical and Sales		
8	Service		
9	Farm, Forestry, Fishery		
10	Processing		
11	Machine Trades		
12	Bench Work		
13	Structural		
14	Miscellaneous		

Name and Title of Responsible Official

Signature

Date Signed (Mo., Day, Yr.)



State _____ Period Ending _____

OMB Approval No. 1205-0371
Expires: 03/31/97

A. CERTIFICATIONS ISSUED

- 1. Universe Size
- 2. Sample Size
- 3. Number Ineligible
- 4. Percent Ineligible (Complete Line Nos. 5 & 6 ONLY
If the entry for Line No. 4 is 5 percent or greater.)
- 5. Number Ineligible - 2nd Sample
- 6. Percent Ineligible - 2nd Sample

B. ECONOMIC DETERMINATIONS (Ex-Convict ONLY)

- 7. Universe Size
- 8. Sample Size
- 9. Number Ineligible
- 10. Percent Ineligible (Complete Line Nos. 11 & 12 ONLY
If the entry for Line No. 10 is 5 percent or greater.)
- 11. Percent Ineligible - 2nd Sample
- 12. Number Ineligible - 2nd Sample

Comments _____

Name and Title of Responsible Official _____ Signature _____ Date Signed (Mo., Day, Yr.) _____

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