



SUFFOLK COUNTY ONE-STOP EMPLOYMENT CENTER



Suffolk County Department of Labor, Licensing & Consumer Affairs

725 Veterans Memorial Highway
Hauppauge, NY 11788
email: sc.dol@suffolkcountyny.gov
www.suffolkcountyny.gov/labor

ADDRESS CORRESPONDENCE TO:
P.O. Box 6100
Hauppauge, NY 11788-0099
Phone # (631) 853-6600

SUMMER YOUTH WORK EXPERIENCE PROGRAM 2016 APPLICATION PACKAGE INSTRUCTIONS

1. Application pages must be **complete and legible**. All signatures must be in script and be similar throughout. **Note:** Complete page 1 on the Summer Youth Work Experience Program Application. If you answered yes to question 17 ***please continue***.
2. All applicants must complete the attached Youth Services Application (pages 2 & 3) and the Suffolk County Department of Labor, Licensing and Consumer Affairs Summer Work Experience Program form (page 4).
3. If you are a foster child, you must provide documentation of your status from your Suffolk County Department of Social Services (DSS) foster care caseworker on their Agency letterhead, and the foster care caseworker must also sign page 3 of the Summer Youth Work Experience Application.
4. W-4 Form must be completed and **signed**; it must be printed neatly, without white out and with the **name as it appears** on Social Security card.
5. Two "Applicant/Participant Memoranda of Understanding" are included. Please read, sign both, and keep the second (page 10) for your records.
6. All applicants must have a Social Security card and a **copy** must be submitted with the application.
7. All applicants who will be under the age of 18 as of July 5, 2016 must submit their **original** Student Employment Certificate (working card).
8. Applicants who will be age 18 on July 5, 2016 must submit a **copy** of a photo I.D.
9. All applicants claiming U.S. Citizenship must submit a **copy** of their Birth Certificate with the application. All applicants who are not citizens must submit a copy of their Alien ID card (both sides).
10. All male applicants age 18, or who will turn 18 prior to August 19, 2016, must document their Selective Service Registration. You can register or receive verification online at www.sss.gov/.
11. Send application to Suffolk County Department of Labor, Licensing and Consumer Affairs Youth Programs, P.O. Box 6100, Hauppauge, New York 11788-0099.

Please Note: All applications must be reviewed and certified as eligible by the Suffolk County Department of Labor Licensing and Consumer Affairs.

REMEMBER - SUBMISSION OF AN APPLICATION DOES NOT GUARANTEE A JOB. THE SUFFOLK COUNTY DEPARTMENT OF LABOR, LICENSING AND CONSUMER AFFAIRS WILL AUTHORIZE THOSE INDIVIDUALS WHO HAVE BEEN SELECTED FOR PARTICIPATION. Selected youth will be notified by their worksite as to when and where to report.

DOL-S161 (3/03)

Auxiliary aids and services available upon request to individuals with disabilities.
An Equal Opportunity Employer Program

Frank Nardelli
Commissioner

Steven Bellone
Suffolk County Executive

James DiLiberto
Workforce Development Board Chair

**SUFFOLK COUNTY DEPARTMENT OF LABOR, LICENSING AND CONSUMER AFFAIRS
SUMMER YOUTH WORK EXPERIENCE PROGRAM 2016**

www.co.suffolk.ny.us/labor

The Suffolk County Department of Labor, Licensing and Consumer Affairs has funding from the Temporary Assistance to Needy Families (TANF) program to run a summer work experience program. This program gives young people the chance to work and earn money. Wages for in-school youth do not affect public assistance grants.

To apply for the TANF Work Experience Program you must complete the following application package and meet the eligibility requirements of the program.

1. ____/____/____ 2. ____/____/____ 3. ____ 4. ____/____/____
 TODAY'S DATE BIRTHDATE AGE SOCIAL SECURITY NUMBER

5. _____ 6. _____ 7. ____ 8. ____
 LAST NAME FIRST NAME MI SEX

9. _____
 STREET ADDRESS

10. _____ 11. ____ 12. _____ - _____
 TOWN STATE ZIP CODE

13. _____
 MAILING ADDRESS, *if different*

15. (____) _____ - _____ 16. (____) _____ - _____
 AREA CODE TELEPHONE # ALTERNATE TELEPHONE
 (FAMILY MEMBER)

14. RACE/ETHNIC (CIRCLE ONE)

WHITE	1
BLACK	2
HISPANIC	3
AMERICAN INDIAN/ ALASKAN NATIONAL	4
ASIAN/PACIFIC IS.	5
OTHER	6

 E-MAIL ADDRESS

17. **Are you:**
 A youth at least 14 years old and under the age of 21? YES NO

If **YES**, then proceed to complete the application, you **may** be eligible for the TANF Summer Youth Work Experience Program.

If **NO** – you are not eligible for this program.

1) Do you have a High School Diploma or GED?
 YES NO

2) Please identify any disabilities you may
 Have below:

Deaf	<input type="checkbox"/>
Blind	<input type="checkbox"/>
Extremities	<input type="checkbox"/>
Learning	<input type="checkbox"/>
Internal	<input type="checkbox"/>
Multiple	<input type="checkbox"/>

3) Highest Grade Completed as of June
 2016 _____

4) Limited English YES NO

5) Do you receive Family Assistance
 (TANF)? YES NO

**In order to be eligible you MUST be within
 the following income guidelines.**
TANF Income Standards

Family Size	Monthly Income	Annual Income
1	\$1,980	\$23,760
2	\$2,670	\$32,040
3	\$3,360	\$40,320
4	\$4,050	\$48,600
5	\$4,740	\$56,880
6	\$5,430	\$65,160

For family units with more than six members,
 add \$693 monthly or \$8,320 annually for each
 additional family member.

Citizen/Non-Citizen Status

A. Are you a United States citizen? YES NO If not, please complete the following information:

INS Form Number: _____
Alien Number: _____
Date of Entry into United States: _____

Income of Family Members

A. Do you (the youth applicant) currently receive benefits under one or more of these programs?

FAMILY ASSISTANCE SAFETY NET	MEDICAID	SNAP/FOOD STAMPS	HEAP	SSI

B. Tell us about any Income of your family members

Include the gross income (income before taxes and deductions) of each family member who lives with you. Family members include your mother, father, stepmother, stepfather, legal guardian, any brothers or sisters (including half-siblings) who are under 18 years of age (or 18 and in secondary school) and these siblings' parents. If you have a child of your own, you should include that child, any brothers or sisters of the child, and the child's parent. You should not include any of these people if they do not live with you. If you are married, you should include your spouse, but do not need to include your parents or siblings.

List all sources of gross income, including wages, social security benefits, public assistance benefits, child support, alimony, etc., received and any other recurring income of a family member. You do not need to include any earned income (wages) received by you or any other family member who is under 18 years of age (or 18 and in secondary school) but must include any unearned income.

FAMILY SIZE AND INCOME

FAMILY HOUSEHOLD MEMBER'S NAME	RELATIONSHIP	INCOME SOURCE WAGES, SOCIAL SECURITY, ETC.	RECEIVED CHECK ONE		
			Yearly	Monthly	Weekly

APPLICANT NOTIFICATION AND SIGNATURE

The individual signing this application may be asked to prove any or all your statements. If we ask you to do this, we will tell you how to prove your statements.

We are asking for Social Security number(s) because any person applying for or receiving federal services must give us his or her Social Security number; Social Security numbers are required under federal law (Section 409(a)(4) of the Social Security Act) and federal regulations (45 CFR 264.10). We may use Social Security number(s) to do computer matches with other programs to prove you are receiving these programs (for example, food stamps), to do a computer match to verify other information on the application, or to verify your alien status.

By signing this, I am swearing, under penalty of perjury, that all of the above statements are true to the best of my knowledge and that I am willing to cooperate with any efforts to verify the information provided.

Signed: _____ Date: _____

Relationship to Applicant: _____

If the applicant lives with his or her parents, a parent or other adult relative caretaker must sign this form for the application to be complete. The Commissioner of the Department of Social Services or his or her designee must sign for children in foster care.

SCDOLLCA SUMMER WORK EXPERIENCE PROGRAM

NAME _____ SOCIAL SECURITY # _____

CURRENTLY ATTENDING SCHOOL FULL TIME YES NO SEQUENCE/MAJOR COURSE OF STUDY _____

VOCATIONAL TRAINING COURSES _____

The Barriers to Employment listed below are factors that can make an applicant eligible according to the criteria set by New York State. Please check any that apply to you that you would like us to consider in reviewing your application.

BARRIERS TO EMPLOYMENT:
CHECK THOSE WHICH APPLY

SPECIFIC NEEDS TO OVERCOME BARRIERS:
CHECK THOSE WHICH APPLY

GUIDE FOR OCCUPATIONAL EXPLORATION
CHECK AREAS OF INTEREST

- | | | | | |
|--|---|---|--|-------------------------------------|
| <input type="checkbox"/> PREGNANT/PARENTING | <input type="checkbox"/> CHILDCARE | <input type="checkbox"/> GED TRAINING | <input type="checkbox"/> ARTISTIC | <input type="checkbox"/> MECHANICAL |
| <input type="checkbox"/> RUN-AWAY/HOMELESS | <input type="checkbox"/> FAMILY COUNSELING | <input type="checkbox"/> HEALTH CARE | <input type="checkbox"/> SCIENTIFIC | <input type="checkbox"/> INDUSTRIAL |
| <input type="checkbox"/> YOUTH OFFENDER | <input type="checkbox"/> TRANSPORTATION | <input type="checkbox"/> HOUSING | <input type="checkbox"/> PLANTS/ANIMALS | <input type="checkbox"/> SELLING |
| <input type="checkbox"/> LIMITED ENGLISH ABILITY | <input type="checkbox"/> ESL TRAINING | <input type="checkbox"/> BASIC SKILLS ED. | <input type="checkbox"/> SERVICE TO OTHERS | |
| <input type="checkbox"/> SUBSTANCE ABUSER | <input type="checkbox"/> SUBSTANCE ABUSE COUNSELING | | <input type="checkbox"/> PHYSICAL ACTIVITY | |
| <input type="checkbox"/> HIGH SCHOOL DROPOUT - HIGHEST GRADE COMPLETED _____ | | | <input type="checkbox"/> OTHER _____ | |
| <input type="checkbox"/> YOUTH NEEDS ADDITIONAL ASSISTANCE | | | | |

WHAT ARE YOUR PLANS FOR SEPTEMBER 2016?

- A. ATTEND SCHOOL/COLLEGE B. ATTEND VOCATIONAL SCHOOL C. LOOK FOR WORK

PRIOR WORK HISTORY: (NOTE ADDITIONAL WORK HISTORY ON BACK OF THIS PAGE)

EMPLOYER NAME: _____ FROM: _____ TO: _____ JOB TITLE: _____

ADDRESS: _____ RATE OF PAY: _____ REASON FOR LEAVING: _____

TASKS PERFORMED: _____

PRIOR TANF/WIA TRAINING/WORK EXPERIENCE:

ACTIVITY: _____

LOCATION: _____

TASKS PERFORMED: _____

APPLICANT TO COMPLETE:

WRITE A SHORT PARAGRAPH OUTLINING ANY INFORMAL WORK EXPERIENCE YOU MAY HAVE HAD SUCH AS BABY-SITTING, YARD WORK, ETC.

X

APPLICANT'S SIGNATURE

COUNSELOR'S SIGNATURE



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Phone # (631) 853-6600

NEW YORK STATE RETIREMENT SYSTEM OPTION

The New York State Retirement and Social Security Law provides that participants enrolled on a part-time or temporary basis in a Work Experience component where a wage is earned are eligible to join the Retirement System. Since you are a Work Experience participant in a Suffolk County Youth Program, you are hereby given the option to join the New York State Retirement System.

Please be advised that if you decide to join the New York State Retirement System, you will be required to contribute 3% of your wages to the Retirement System which will be subtracted from your salary. If you subsequently withdraw from the Retirement System, you may also withdraw your contributions without waiting until age 62 as long as you have not vested or become eligible for any other benefit from the Retirement System.

ACKNOWLEDGMENT

I hereby acknowledge that I have been informed of my rights as an optional member of the New York State Retirement System.

I choose not to join the Retirement System.

I choose to participate in the Retirement System.

Participant Signature

Participant Social Security #

SCDOL Representative

Date

[] Approved

[] Not Approved

Administrative Review

DOL-S155 (rev. 1/15)

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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 <i>(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.)</i>						
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

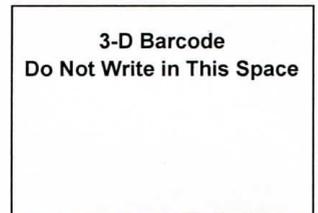
2. Form I-94 Admission Number: _____

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)*



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



Employer Completes Next Page



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:		<div style="border: 1px solid black; padding: 10px; width: fit-content; margin: auto;"> <p>3-D Barcode Do Not Write in This Space</p> </div>		
Issuing Authority:				
Document Number:				
Expiration Date (if any)(mm/dd/yyyy):				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date (if any)(mm/dd/yyyy):				

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 SCDOLLCA	
Employer's Business or Organization Address (Street Number and Name) 725 Veterans Memorial Highway		City or Town Hauppauge	State NY	Zip Code 11788

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):
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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):
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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:
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LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

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
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 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 	OR	<ol style="list-style-type: none"> 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 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. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">For persons under age 18 who are unable to present a document listed above: 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record 	AND	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of Birth Abroad issued by the Department of State (Form FS-545) 3. Certification of Report of Birth issued by the Department of State (Form DS-1350) 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. Native American tribal document 6. U.S. Citizen ID Card (Form I-197) 7. Identification Card for Use of Resident Citizen in the United States (Form I-179) 8. Employment authorization document issued by the Department of Homeland Security

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

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.

Form W-4 (2016)

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 2016 expires February 15, 2017. 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 \$1,050 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 2016. 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: <ul style="list-style-type: none"> • 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	F _____
G	Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> • If your total income will be less than \$70,000 (\$100,000 if married), enter "2" for each eligible child; then less "1" if you have two to four eligible children or less "2" if you have five or more eligible children. • If your total income will be between \$70,000 and \$84,000 (\$100,000 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 2016
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1 Your first name and middle initial	Last name	2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> 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. ▶ <input type="checkbox"/>
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 2016, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> • 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.) Suffolk County Audit & Control, H. Lee Dennison, Hauppauge, NY 11788	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 2016 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1952) of your income, and miscellaneous deductions. For 2016, you may have to reduce your itemized deductions if your income is over \$311,300 and you are married filing jointly or are a qualifying widow(er); \$285,350 if you are head of household; \$259,400 if you are single and not head of household or a qualifying widow(er); or \$155,650 if you are married filing separately. See Pub. 505 for details **1** \$ _____
- 2 Enter: $\left\{ \begin{array}{l} \$12,600 \text{ if married filing jointly or qualifying widow(er)} \\ \$9,300 \text{ if head of household} \\ \$6,300 \text{ if single or married filing separately} \end{array} \right\}$ **2** \$ _____
- 3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" **3** \$ _____
- 4 Enter an estimate of your 2016 adjustments to income and any additional standard deduction (see Pub. 505) **4** \$ _____
- 5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2016 Form W-4* worksheet in Pub. 505.) **5** \$ _____
- 6 Enter an estimate of your 2016 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 \$4,050 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 2016. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2016. 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

Table 2

Table 1				Table 2			
Married Filing Jointly		All Others		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	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 - \$6,000	0	\$0 - \$9,000	0	\$0 - \$75,000	\$610	\$0 - \$38,000	\$610
6,001 - 14,000	1	9,001 - 17,000	1	75,001 - 135,000	1,010	38,001 - 85,000	1,010
14,001 - 25,000	2	17,001 - 26,000	2	135,001 - 205,000	1,130	85,001 - 185,000	1,130
25,001 - 27,000	3	26,001 - 34,000	3	205,001 - 360,000	1,340	185,001 - 400,000	1,340
27,001 - 35,000	4	34,001 - 44,000	4	360,001 - 405,000	1,420	400,001 and over	1,600
35,001 - 44,000	5	44,001 - 75,000	5	405,001 and over	1,600		
44,001 - 55,000	6	75,001 - 85,000	6				
55,001 - 65,000	7	85,001 - 110,000	7				
65,001 - 75,000	8	110,001 - 125,000	8				
75,001 - 80,000	9	125,001 - 140,000	9				
80,001 - 100,000	10	140,001 and over	10				
100,001 - 115,000	11						
115,001 - 130,000	12						
130,001 - 140,000	13						
140,001 - 150,000	14						
150,001 and over	15						

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.

SUFFOLK COUNTY DEPARTMENT OF LABOR, LICENSING & CONSUMER AFFAIRS
APPLICANT/PARTICIPANT MEMORANDUM OF UNDERSTANDING

The following information will provide you with an overview of the services and programs administered by the Suffolk County Department of Labor, Licensing & Consumer Affairs (SCDOLLCA) for which you may be eligible. In addition, this Memorandum serves to advise you that you have certain rights and certain responsibilities as an applicant and participant.

1. **EMPLOYMENT AND TRAINING PROGRAMS**

A. The purpose of programs administered by the SCDOLLCA is to provide services and activities that increase the employment, retention, and earnings of participants, as well as increase their occupational skill level.

B. 1. Programs Include:

Adult, Dislocated Worker and Youth Programs
Displaced Homemaker Program
Public Assistance Programs

2. Services and activities include:

Outreach Orientation to the One-Stop System Use of the Employment Center Skills assessment Supportive service assessment Information regarding filing claims for unemployment Job vacancy listings and job banks Computers, Internet access, and phone banks Job search and placement assistance	Career Counseling Labor Market Information Career Transition Workshops Job Search Workshops On-the-Job Training Education and Training when appropriate and suitable Employer Open Houses and Job Fairs Information on community services Follow-up services
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In addition to the above, youth services also include:

Dropout Prevention Strategies Alternative Schools Summer Employment Opportunities Occupational Skill Training	Leadership Development Opportunities Supportive Services Adult Mentoring Comprehensive Guidance and Counseling As appropriate, paid & unpaid work experience including: internships & job shadowing
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C. You agree to fully comply with the program standards and procedures which govern that activity.

D. You agree to follow the plan developed by you and SCDOLLCA staff.

E. You must agree to seek employment at the conclusion of the program. If you received education and/or training you must seek training related employment at the conclusion of the program.

F. You agree to cooperate with all post-program follow-up efforts conducted by our staff counselors.

2. **UNEMPLOYMENT INSURANCE INFORMATION:** If you are laid-off or fired from a wage paying job, you may be eligible for Unemployment Insurance Benefits. You must apply to the New York State Department of Labor to find out if you qualify.

3. **CHARGING OF FEES:** There is no charge to you for any of the services sponsored by the SCDOLLCA. Should any person attempt to charge you money or request any kind of favor from you, report that person to the SCDOLLCA at (631) 853-6623.

4. **LIMITATIONS ON POLITICAL ACTIVITY:** Participants may neither be involved in political activities during the hours for which they are paid with federal or state funds, nor may they act as a spokesperson for SCDOLLCA Programs at political activities.

5. **LIMITATIONS ON WORK AT RELIGIOUS OR SECTARIAN FACILITIES:** As part of their SCDOLLCA funded activity, participants may not be employed or involved in the construction, operation or maintenance of any portion of any facility used or to be used for sectarian instruction or as a place of religious worship.
6. **DISCRIMINATION COMPLAINT PROCEDURES:** No individual will be excluded from participation in, denied the benefits of, subjected to discrimination, or denied employment in connection with any programs because of race, color, religion, sex, national origin, age, disability, political affiliation or belief or your status as a participant in SCDOLLCA programs. Participation in SCDOLLCA programs and activities shall be available to citizens and nationals of the United States, lawfully admitted permanent resident aliens, refugees, asylees, and parolees, and other immigrants authorized by the Attorney General to work in the United States. An individual has the right to file at the local, state and federal levels. All complaints of discrimination based on the preceding should be filed within 180 days of the occurrence directly with the Suffolk County Department of Labor, Licensing & Consumer Affairs Equal Opportunity Officer by phoning (631) 853-6623 or in writing to Suffolk County Department of Labor, Licensing & Consumer Affairs, P.O. Box 6100, Hauppauge, NY 11788. An individual will be offered the choice of resolving the complaint through the customer discrimination complaint procedure or an Alternative Dispute Resolution through Mediation Process.

A complainant may file a written complaint at:

the state level directly with:

Director
 Division of Equal Opportunity Development
 New York State Department of Labor
 State Office Building Campus
 Building 12, Room 540
 Albany, New York 12240

or at the federal level directly with:

Director
 Civil Rights Center
 United States Department of Labor
 200 Constitution Avenue NW
 Room N4123
 Washington, DC 20210

7. **COMPLAINTS OF CRIMINAL ACTIVITY:** All information and complaints involving fraud, abuse, or other criminal activity shall be reported directly to:

Office of Inspector General
 United States Department of Labor
 Room S-5506
 200 Constitution Avenue, N.W.
 Washington, D.C. 20210
 The telephone hotline number is 1-800-347-3756

8. **ALL OTHER COMPLAINTS:** Complaints regarding disciplinary action, working conditions, payment of wages or other training related matters should be directed to the SCDOLLCA EO Officer at (631) 853-6623. All non-criminal complaints must be made within one (1) year of the alleged occurrence.
Note: If necessary, SCDOLLCA will provide assistance to understand and participate in any complaint process to individuals with special needs (e.g. hearing impaired, Spanish speaking, etc.).
9. **CUSTOMER SATISFACTION:** The Suffolk County Department of Labor, Licensing & Consumer Affairs is committed to achieving superior standards in the areas of Customer Waiting Intervals, Services Provided, and Quality of Service. Accordingly, you will be surveyed, by phone or mail, and asked to provide comments regarding your experiences with us. Your responses will be used to help us measure our levels of success and to maintain and improve services to our customers.
10. **PUBLIC INFORMATION:** In an effort to inform the general public of the efforts and success of the Suffolk County Department of Labor, Licensing & Consumer Affairs Programs, you may, in the course of your activities with us, be asked to have your photograph taken. By checking yes, you grant the Suffolk County Department of Labor, Licensing & Consumer Affairs permission to use your experience and photograph for promotional purposes. Yes No
11. **ACKNOWLEDGEMENT:** My signature acknowledges that I have received a copy of this Memorandum of Understanding, understand the information provided, and agree to comply with program requirements in order to continue receiving services.

DATE: _____ **PRINT NAME:** _____ **SIGNATURE:** _____

Auxiliary aids and services available upon request to individuals with disabilities. Equal Opportunity Employer Program