



employer solutions staffing group.  
Leveraging Resources in a Changing Market

7301 Ohms Lane Suite 405  
Edina, MN 55439  
Tel: 952.835.1288 • Fax: 952.835.1255  
www.esgstaffingsolutions.com

# New Hire Application

**Personal Data-- PLEASE PRINT LEGIBLY IN INK**

Last Name Persichetti First Name Scot Middle Initial A  
 Street Address 29738 WCR 16 1/2 Keenesburg Apt/Ste \_\_\_\_\_  
 City/State/Zip Keenesburg / CO / 80643  
 Phone Number (303)-887-7738 Email Address Scot.Persichetti23 @ gmail.com  
 Company/Employer BASF

All offers of employment are conditional upon satisfactory proof of identity and legal ability to work in the U.S.A.

Are you legally authorized to work in the United States of America?  YES  NO

### Applicant Certification and Authorization

I authorize Employer Solutions Staffing Group (ESSG) to use the information and statements contained in this application to determine my qualifications for employment. I authorize ESSG to make inquiries of my former employers, except as indicated in this application, regarding my previous duties, responsibilities, performance, compensation and eligibility for rehire.

I understand that a comprehensive background check may be conducted to determine my eligibility for hire by certain clients of ESSG. This may include but is not limited to, investigations of criminal and/or conviction records, driving records and/or a drug screen test as required by clients, government regulations or by ESSG policies.

I release ESSG and other persons or entities from any claims that might be based on ESSG's decision to conduct a background check.

I certify that all statements made in my application are true and accurate and that I have not omitted any material information or provided false or misleading information. I understand that any material omission or misrepresentation will result in my disqualification from consideration for employment or, if discovered after I begin employment, will result in my termination.

If hired, I agree to abide by the policies and procedures of ESSG.

Name (Print or type) Scot Persichetti Applicant's Signature  Date 4/25/2014

**A copy or facsimile ("fax") will be considered the same as an original signature. Email will ONLY be used for employment correspondence**

For ESSG Office Use Only			
DOH _____	NHW _____	I-9 _____	8850 _____
Emergency Contact Info _____	Background Release Form _____	Background Results _____	Unemployment Letter (if applicable) _____
For ESSG Client Use			
DOH _____	ROP _____	Work Site Loc. _____	WC Code _____

# Form W-4 (2013)

**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 2013 expires February 17, 2014. 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).

**Basic instructions.** If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on pages 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 2013. 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/W-4](http://www.irs.gov/W-4).

## Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent . . . . .	A	1
B	Enter "1" if: <ul style="list-style-type: none"> <li>• You are single and have only one job; or</li> <li>• You are married, have only one job, and your spouse does not work; or</li> <li>• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.</li> </ul>	B	1
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	1
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return . . . . .	D	1
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above) . . . . .	E	1
F	Enter "1" if you have at least \$1,900 of child or dependent care expenses for which you plan to claim a credit . . . . .	F	1
G	<b>Child Tax Credit</b> (including additional child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.) <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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 . . . . .</li> </ul>	G	1
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	1

**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 \$40,000 (\$10,000 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.

OMB No. 1545-0074

# 2013

## Employee's Withholding Allowance Certificate

Form **W-4**  
Department of the Treasury  
Internal Revenue Service

▶ 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.

<p>1 Your first name and middle initial <b>Seot A</b></p> <p>Home address (number and street or rural route) <b>29738 WCK 161/2</b></p> <p>City or town, state, and ZIP code <b>Kenesburg, CO, 80643</b></p>	<p>Last name <b>Peschette</b></p> <p>2 Your social security number <b>523-85-1218</b></p>	<p>3 <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. <b>Note.</b> If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.</p> <p>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"/></p>	<p>5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2) <b>5</b></p> <p>6 Additional amount, if any, you want withheld from each paycheck <b>1</b></p> <p>7 I claim exemption from withholding for 2013, 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. . . . .</p> <p>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.</p>
<p>Employee's signature (This form is not valid unless you sign it.) ▶ </p>		<p>Date ▶ <b>4/25/2014</b></p>	
<p>8 Employer's name and address (Employer. Complete lines 8 and 10 only if sending to the IRS.)</p>		<p>9 Office code (optional)</p>	
<p>10 Employer identification number (EIN)</p>		<p>11</p>	



employer solutions staffing group LLC

Leveraging Resources in a Changing Market

**Notification of Colorado Law Requirement –  
Unemployment Acknowledgement**

According to Colorado Statutes section 8-73-105.3. A temporary employee who is given a notice that the employee is required to contact or notify the employer upon completion of an assignment and to be available to work, as agreed upon at the time of hire, during a specified period of time, on specified dates, or upon call by the employer on an as-needed basis and who does not contact or notify the employer upon completion of an assignment in compliance with the notice and is not available to work at the agreed-upon times is deemed to have voluntarily terminated employment for the purpose of determining benefits pursuant to section 8-73-108 (5) (e). Also, a temporary employee who agrees to work on an as-needed basis and refuses all work within three separate pay periods when contacted by the employer is deemed to have voluntarily terminated employment for reasons that may or may not allow an award of benefits pursuant to section 8-73-108.

It is your responsibility to contact or notify ESSG (For example, by calling 303-920-1425, or using another means of contact) once your assignment ends. If you fail to do so, it may affect your unemployment benefits.

I understand by signing this form that I am responsible to contact or notify ESSG once an assignment ends. I also acknowledge that I have received a separate copy of this form. SE (Initial)

Employee Signature:  Date: 4/25/2014

Scott Persichetti  
Employee (please print your name here)

**EMPLOYEE INFORMATION**  
(Must Be Filled Out)


**ENROLLMENT FORM - PLAN 2**

Social Security Number 5 2 3 - 8 5 - 1 0 4 8  
Date of Birth 0 4 / 1 1 / 1 9 9 2 Sex  M  F  
Name Scott Persichette  
Street Address 29738 WCR 16 1/2  
City Kearneysburg State CO Zip 8 0 6 4 3  
Home Phone 3 0 3 - 8 8 7 - 7 7 3 8

Do you or any dependents have Medicare?  
 Yes  No If Yes:  
Medicare Health Insurance Claim Number (HICN)  
\_\_\_\_\_  
Medicare Effective Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Names of Covered Person(s)  
1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_

**BENEFIT SELECTION**

Weekly Rates

- MEDICAL** 
- \$20.91 Employee Only
- \$42.44 Employee + One
- \$56.67 Employee + Family
- NO to MEDICAL, TERM LIFE, and STD benefits.

**DENTAL**



- \$ 5.99 Employee Only
- \$11.98 Employee + One
- \$19.77 Employee + Family
- NO

**TERM LIFE**



- YES \$0.60 Employee Only
- YES \$0.90 Employee + One
- NO \$1.80 Employee + Family

**SHORT-TERM DISABILITY**



- YES
- NO \$4.20 Employee Only

Short-Term Disability is not available to persons who work in California, Hawaii, New Jersey, New York, or Rhode Island.

You **MUST** enroll in the Medical Insurance Plan before adding Term Life or STD. Your coverage level for Term Life will be identical to your medical plan selection.

**REQUIRED DEPENDENT INFORMATION**

Name \_\_\_\_\_

Social Security Number \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex  M  F

Relationship:  Spouse  Child  Domestic Partner

Name \_\_\_\_\_

Social Security Number \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex  M  F

Relationship:  Spouse  Child  Domestic Partner

Name \_\_\_\_\_

Social Security Number \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex  M  F

Relationship:  Spouse  Child  Domestic Partner

**BENEFICIARY INFORMATION**

For Term Life / Accidental Death & Dismemberment, please write in your beneficiary information.

NAME OF BENEFICIARY \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_

Accidental Death & Dismemberment is part of the Term Life Benefit.

I have read the benefit packet and understand its limitations. I understand that open enrollment is only available for a limited time and I understand that making no benefit selection is a declaration of coverage.

Signature

*SR*

Date 04/25/2014





# 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) <i>Persichette</i>		First Name (Given Name) <i>Scott</i>		Middle Initial <i>A</i>	Other Names Used (if any)	
Address (Street Number and Name) <i>29738 WICK 16 1/2</i>				Apt. Number	City or Town <i>Keenesburg</i>	State <i>CO</i>
Date of Birth (mm/dd/yyyy) <i>4/11/1992</i>	U.S. Social Security Number <i>523-75-1048</i>		E-mail Address <i>ScotPersichette23@gmail.com</i>		Zip Code <i>80643</i>	Telephone Number <i>(303)-887-7738</i>

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: *[Signature]* Date (mm/dd/yyyy): *4/25/2014*

**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:

Document Title:	Document Number:	Expiration Date (if any)(mm/dd/yyyy):
Driver License	08-025-0316	4.11.18
Birth Certificate	1051992015505	

Document Title:	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): 4.30.18 (See instructions for exemptions.)

Signature of Employer or Authorized Representative <i>[Signature]</i>	Date (mm/dd/yyyy) <u>4.28.14</u>	Title of Employer or Authorized Representative <u>Acct Mgr</u>
Last Name (Family Name) <u>Wool</u>	First Name (Given Name) <u>Tina</u>	Employer's Business or Organization Name EMPLOYER SOLUTIONS STAFFING GROUP LLC
Employer's Business or Organization Address (Street Number and Name) 7301 OHMS LANE SUITE 405		City or Town EDINA
	State MN	Zip Code 55439

### 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:
	Document Title:	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:

CERTIFICATION OF VITAL RECORD

STATE OF COLORADO

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT  
HOLD TO LIGHT TO VIEW WATERMARK

STATE FILE NUMBER

1051992015505

DATE FILED

APRIL 29, 1992

NAME OF REGISTRANT

SCOT ANTHONY PERSICHETTE

DATE AND TIME OF BIRTH

APRIL 11, 1992 02:39 P.M.

CITY OF BIRTH

DENVER

SEX

MALE

COUNTY OF BIRTH

DENVER

FATHER'S NAME

MARION JOHN PERSICHETTE

MOTHER'S MAIDEN NAME

LISA ANN OWENS

MOTHER'S PLACE OF BIRTH

COLORADO

FATHER'S PLACE OF BIRTH

COLORADO

MOTHER'S AGE

24

FATHER'S AGE

27



THIS IS A TRUE CERTIFICATION OF NAME AND BIRTH FACTS AS RECORDED IN THIS OFFICE.

DATE ISSUED

MAY 25, 2007

*Ronald S. Hyman*

RONALD S. HYMAN  
STATE REGISTRAR

Do not accept unless prepared on security paper with engraved border displaying the Colorado state seal and signature of the Registrar. PENALTY BY LAW, Section 25-2-118, Colorado Revised Statutes, 1982, if any person alters, uses, attempts to use or furnishes to another for deceptive use any vital statistics record. NOT VALID IF PHOTOCOPIED.

REV 07/93

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

880198501



SCOTT ANTHONY FERSICHETTE  
28739 WEST 16 1/2  
KEENE SPRING, CO 80639

Colorado ★  
Driver License

08-025-0318 Expires 04-11-2018

Class: R  
Ends:  
Race:  
Ht: 6'00" Wt: 205 Eyes: HAZ Hair:  
Voter:

Issued: 07-12-2013  
DOB: 04-11-1977  
Previous Type: P

# EMERGENCY CONTACT INFORMATION

## EMPLOYER SOLUTIONS STAFFING GROUP IN CASE OF AN EMERGENCY - NOTIFICATION INFORMATION

Employee Name: Scott Persichetti

Address: 29738 WCR 16 1/2 Kanesburg CO 80643

Home Phone: (303) 887-7738

### EMERGENCY CONTACTS

Please list two people (in priority order) who could be contacted in case of an emergency

<b>Contact #1</b> Name: <u>John Persichetti</u> Relationship: <u>Father</u>	Home Phone: <u>(303) 732-4976</u> Cell Phone: <u>(303) 501-2919</u> Work Phone:
<b>Contact #2</b> Name: <u>LISA Persichetti</u> Relationship: <u>Mother</u>	Home Phone: <u>(303) 732-4976</u> Cell Phone: <u>(303) 319-8207</u> Work Phone:

Additional information you want Employer Solutions Staffing Group and our clients to know in the event of an emergency:

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employer solutions staffing group LLC  
Leveraging Resources in a Changing Market

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**STATEMENT OF CONFIDENTIALITY**

This agreement made this 4 day of 25, 2014, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and Seal Pecsichette hereafter referred to as "employee".

**WITNESSETH:**

For the duration of my employment and after resignation or termination of this employment with employer, for any reason whatsoever, the employee shall not use or disclose to any other person or company, and confidential or proprietary information or know-how related to the business of the employer.

In view of the difficulty of determining the amount of damages which may result to the employer from a violation of any of the provisions hereof, the employee agrees to pay to the employer the sum of \$10,000 as liquidated damages for every such violation; provided, however, that the payment of such amount as liquidated damages shall not be construed as a release or waiver by the employer of the right to prevent any such violation in equity or otherwise.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Employer Solutions Staffing Group LLC, Representative

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

Department of the Treasury  
Internal Revenue Service

▶ See separate instructions.

**Job applicant: Fill in the lines below and check any boxes that apply. Complete only this side.**

Your name Scot Persichette Social security number ▶ 523-85-1048

Street address where you live 29738 WCK 16 1/2

City or town, state, and ZIP code Keenesburg / CO / 80643

County WELD Telephone number (303) 887-7738

If you are under age 40, enter your date of birth (month, day, year) 4/11/1992

Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.

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.

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.

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.

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.

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 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 4/25/2014

TAX CREDIT QUESTIONNAIRE



**EMPLOYER SECTION:**

ESSG FEIN#: \_\_\_\_\_ ESG Client Name & State: \_\_\_\_\_

Hiring Manager: \_\_\_\_\_ Position: \_\_\_\_\_ Starting Wage: \$ \_\_\_\_\_

**EMPLOYEE SECTION:**

Employee Name: Scott Pesschke Street Address: 29738 WCR 16 1/2 City/State: Keenesburg CO Zip: 80643

SS#: 523 - 85 - 1048 Date of Birth: 4 / 11 / 1992 Age: 22 Have you worked for this company before?  Yes  No

If yes, location: \_\_\_\_\_

Please complete all questions, and sign and date the form. Yes No

1. Have you or has anyone living with you received Temporary Assistance to Needy Families (TANF) at any time since August 5, 1997? (If yes, please provide information below.)  Yes  No  
 Name of the person receiving benefits: \_\_\_\_\_ Relationship to you: \_\_\_\_\_  
 City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_
2. Have you or has anyone living with you received Food Stamps (SNAP) at any time during the past 15 months?  Yes  No  
 (If yes, please provide information below.)  
 Name of the person receiving benefits: \_\_\_\_\_ Relationship to you: \_\_\_\_\_  
 City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_
3. Have you received Supplemental Security Income (SSI) at any time within the past 3 months?  Yes  No  
 Please note, this is not the same as Social Security benefits (SS) or Social Security Disability (SSDI) benefits.  
*\*If you checked yes please provide a copy of your SSI documentation.*
4. Have you received any type of vocational rehabilitation services within the past two years?  Yes  No  
 If yes, please indicate which type of agency you worked with and provide their location information below:  
 Vocational Rehabilitation Agency  Dept. of Veterans Affairs  Employment Network (Ticket to Work Program)  
 Name of Agency: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_  
*\*If you checked yes please provide a copy of your active Individual Work Plan and Ticket to Work documentation.*
5. Are you a Veteran of the U.S. Military? *\*If yes, please provide a copy of your DD-214 and letter of separation.*  Yes  No  
 (If yes, please provide information below. If no, please continue to question #6.)  
 Dates of Service - From: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Branch of Service: \_\_\_\_\_  
 Are you entitled to or are you receiving compensation for a service-connected disability?  Yes  No  
 Have you been unemployed at any time during the last 12 months?  Yes  No  
 If yes, dates of unemployment - From: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Did you receive unemployment compensation at any point during your unemployment?  Yes  No
6. Have you been convicted of a felony or released from prison for a felony conviction in the past 12 months?  Yes  No  
 Conviction Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Release Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Was this a  Federal or  State conviction? If State - County: \_\_\_\_\_ State: \_\_\_\_\_

Additional Tax Credits

IEC (Native American): Are you or your spouse a member of a Native American Tribe?  Yes  No  
*\*If you checked yes please provide a copy of your CDIB card.*

CA Residents:  Are you the child of foster parents?  Do you receive CalWorks?  Workforce Investment Act?  Yes  No  
 Are you a migrant or seasonal farm worker?  Have you ever been convicted of a misdemeanor?

SC Residents:  Do you receive Family Independence Benefits?

PLEASE READ, SIGN, AND DATE:

Under penalties of perjury, I declare the information above to be true and accurate to the best of my knowledge, and I hereby authorize any agency, organization, or individuals to supply such verification or information that may be needed to determine tax credit eligibility to my employer, employer representative (Associated Consultants, Inc. dba RetroTax), or the Department of Labor.

New Employee Signature: St D Date: 4/25/2014



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## **INJURY MANAGEMENT PROGRAM**

### **Injured Worker's Responsibilities**

As your employer, we are concerned about your full recovery. Reasonable and necessary medical care will be paid for any compensable work injury. Medically authorized time away from work will be reimbursed in accordance with the **State of Minnesota workers' compensation laws**. Wherever possible light duty restrictions imposed as a result of your injury will be accommodated.

### **RESPONSIBILITIES OF THE INJURED WORKER:**

Minnesota Rule Sec. 5221.0430, Subp. 1 requires that you choose one primary health care provider. Subpart 2 places limitations on your right to change primary health care providers. Discuss with your employer any change in health care provider.

Attend all scheduled appointments. While on physical limitations, visits should be a minimum of once every two weeks. Failure to have current medical support for disability may result in termination of benefits. Schedule your next appointment immediately after your doctor visit, before you leave the clinic if possible.

Obtain a Report of Workability from your physician at every appointment, a minimum of once every two weeks. M.R. 5221.0420 requires that your physician cooperate with return to work planning and that you be released to return to work at the earliest appropriate time.

Immediately following your appointment, provide a copy of the report to the designated employer representative. You should deliver this in person so that changes in work restrictions may be addressed and any questions answered.

Follow all physical restrictions at home and at work.

Report to work and perform physically suitable tasks as assigned. These may or may not be in your regular department. The work may or may not be on your usual shift.

Maintain regular, weekly, communication with your employer if you are unable to return to work. Contact your employer a minimum of after every visit with your primary health care provider. Keep the claims representative advised of your status.

Notify your employer immediately of any new injuries or conditions that impact your physical condition.

If it is necessary to miss scheduled work due to a work injury, you must be seen by your primary health care provider the same day in order to receive compensation for the time away from work. The physician must complete a Report of Workability.

**I have read my responsibilities and agree to abide by these guidelines.**

**Signed:**



**Printed Name:**

Scot Persichette



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## Important/Importante

### LOST OR STOLEN PAYCHECKS

If a paycheck is **lost** (*missing, misplaced, destroyed, lost in the mail, etc.*), you must notify your staffing recruiter that the check cannot be found. If it can be verified that the check has not been cashed, ESSG will stop payment on the check and re-issue the check to you, deducting a fee of between \$25-\$35.

If your paycheck was **stolen**, you must first file a police report before we can re-issue the check. Once you have done so, you must provide a copy of the policy report to your staffing recruiter that the check was stolen. If the check has not been cashed and if the loss of the check was not your fault, ESSG will issue a new check and no fee will be deducted.

### CHEQUES DE PAGO PERDIDOS O ROBADOS

Si un cheque de pago se pierde (que falta, fuera de lugar, destruido, perdido en el correo, etc), usted debe notificar a su reclutador de personal que el cheque no se puede encontrar. Si se puede verificar que el cheque no ha sido cobrado, ESSG se detendrá el cheque de pago y reemitir el cheque a usted, descontando un cargo de entre \$ 25 - \$ 35.

Si su cheque de pago fue robado, primero debe denunciar el robo a la policía antes de que podamos volver a emitir el cheque. Una vez hecho esto, usted debe proporcionar una copia de la denuncia a su reclutador de personal que el cheque fue robado. Si el cheque no ha sido cobrado y si la pérdida del cheque no fue su culpa, ESSG emitirá un nuevo cheque y no hay cuota se deducirá.

AGREED/SE ACUERDA—

Name/Nombre (con letra de molde): Scot Persichetti

Signature/Firma: 

SENSITIVE BUT UNCLASSIFIED

Department of Homeland Security  
E-Verify

Report Prepared: 04/28/2014  
Page: 1 of 1

Case Verification Number: 2014118112916HX

**Case Information:**

**Employee Information:**

Last Name: Pensichette  
Middle Initial:  
Social Security Number: \*\*\* \*\* 1048  
Citizenship Status: A citizen of the United States

First Name: Scot  
Other Names Used:  
Date of Birth: 04/11/1992  
Email Address:

**Document Information:**

List B Document: Driver's license or ID card issued by a U.S. state or outlying possession  
Document Name: Driver's License  
Driver's License or ID Card Number:  
Alien Number:

List C Document: U.S. birth certificate (original or certified copy)  
Document State: Colorado  
Document Expiration Date: 04/11/2018  
I-94 Number:

**Additional Information:**  
Hire Date: 04/28/2014  
Three-Day Rule Reason:  
Submitted By: CKRO8357

Employer Case ID:  
Three-Day Rule - Other:  
Submitted On: 04/28/2014

**Initial Case Result:**

Case Result: Employment Authorized

**Employee Referred to SSA:**

Referred By:

Referred On:

**Case Result from SSA (after SSA Tentative Nonconfirmation):**

Case Result:

Response Date:

**Resubmitted to SSA (after Review and Update Employee Data):**

Last Name:  
Middle Initial:  
Social Security Number:  
Resubmitted By:

First Name:  
Other Names Used:  
Date of Birth:  
Resubmitted On:

**Case Result from SSA (after Resubmission):**

Case Result:

**Request Name Review:**

Comments:  
Submitted By:

Submitted On:

**Case Result from DHS (after DHS Verification in Process):**

Case Result:

Response Date:

**Employee Referred to DHS:**

Referred By:

Referred On:

**Case Result from DHS (after DHS Tentative Nonconfirmation):**

Case Result:

Response Date:

**Photo Matching Results:**

Determination:

**Employee Referred to DHS (Additional):**

Referred By:

Referred On:

**Case Result from DHS (after Additional DHS Tentative Nonconfirmation):**

Case Result:

Response Date:

**Case Closure:**

Closure Statement:

Closed By:

Closed On:

**SENSITIVE BUT UNCLASSIFIED**