



# New Hire Application

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

Last Name DiCillo First Name MARK Middle Initial \_\_\_\_\_  
 Street Address 291 MICHAEL AVE. Apt/Ste \_\_\_\_\_  
 City/State/Zip SLOAN NY 14212  
 Phone Number 716 896 7622 Email Address MARKDISILLY @AOL.COM  
 Staffing Agency/Recruitment Partner CORPORATE MANAGEMENT GROUP

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.

MARK DICILLO *Mark DiCillo* 7-21-15  
 Name (Print or type) Applicant's Signature Date

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 _____	W4 _____
Emergency Contact Info _____	Background Release Form _____	Background Results _____	Unemployment Letter (If applicable) _____	ESC Application _____
For ESSG Client Use				
DOH _____	ROP _____	Work Site Loc. _____	WC Code _____	

# Form W-4 (2015)

**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 2015 expires February 16, 2016. 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 2015. 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](http://www.irs.gov/w4).

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

<b>A</b>	Enter "1" for yourself if no one else can claim you as a dependent . . . . .	<b>A</b> _____
<b>B</b>	Enter "1" if: { • 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>B</b> _____
<b>C</b>	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.) . . . . .	<b>C</b> _____
<b>D</b>	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return . . . . .	<b>D</b> _____
<b>E</b>	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above) . . . . .	<b>E</b> _____
<b>F</b>	Enter "1" if you have at least \$2,000 of child or dependent care expenses for which you plan to claim a credit . . . . . (Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	<b>F</b> _____
<b>G</b>	<b>Child Tax Credit</b> (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than \$65,000 (\$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 \$65,000 and \$84,000 (\$100,000 and \$119,000 if married), enter "1" for each eligible child . . . . .	<b>G</b> _____
<b>H</b>	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.) ▶	<b>H</b> _____

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.

<b>Form W-4</b> Department of the Treasury Internal Revenue Service		<b>Employee's Withholding Allowance Certificate</b> ▶ 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 <b>2015</b>
1 Your first name and middle initial <b>MARK</b>		Last name <b>DICILLO</b>		2 Your social security number <b>101 52 7915</b>
Home address (number and street or rural route) <b>291 MICHAEL AVE.</b>		3 <input type="checkbox"/> Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Married, but withheld 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 <b>SLOAN NY 14213</b>		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 <b>0</b>		
6 Additional amount, if any, you want withheld from each paycheck		6 \$		
7 I claim exemption from withholding for 2015, 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 . . . . . ▶		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.) ▶ <b>Mark D'icillo</b>		Date ▶ <b>7-21-15</b>		
8 Employer's name and address (Employer. Complete lines 8 and 10 only if sending to the IRS.)		9 Office code (optional) 9 Office code (optional)		10 Employer identification number (EIN)
8 Employer's name and address (Employer. Complete lines 8 and 10 only if sending to the IRS.)		9 Office code (optional)		10 Employer identification number (EIN)



# Employee's Withholding Allowance Certificate

# IT-2104

New York State • New York City • Yonkers

First name and middle initial <b>MARK</b>	Last name <b>DICILLO</b>	Your social security number <b>101 52 7915</b>
Permanent home address (number and street or rural route) <b>291 MICHAEL AVE.</b>		Apartment number
City, village, or post office <b>SLOAN</b>	State <b>NY</b>	ZIP code <b>14212</b>
Are you a resident of New York City? ..... Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Are you a resident of Yonkers? ..... Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
Complete the worksheet on page 3 before making any entries.		
1 Total number of allowances you are claiming for New York State and Yonkers, if applicable (from line 17) .....	1	<b>0</b>
2 Total number of allowances for New York City (from line 28) .....	2	
Use lines 3, 4, and 5 below to have additional withholding per pay period under special agreement with your employer.		
3 New York State amount .....	3	
4 New York City amount .....	4	
5 Yonkers amount .....	5	

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

Employee's signature <i>Mark Dicillo</i>	Date <b>7-21-15</b>
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Penalty - A penalty of \$500 may be imposed for any false statement you make that decreases the amount of money you have withheld from your wages. You may also be subject to criminal penalties.

Employee: detach this page and give it to your employer; keep a copy for your records.

Employer: Keep this certificate with your records.

Mark an X in box A and/or box B to indicate why you are sending a copy of this form to New York State (see instructions):

A Employee claimed more than 14 exemption allowances for NYS ..... A

B Employee is a new hire or a rehire ... B  First date employee performed services for pay (mm-dd-yyyy) (see instr.):

Are dependent health insurance benefits available for this employee? ..... Yes  No

If Yes, enter the date the employee qualifies (mm-dd-yyyy):

Employer's name and address (Employer complete this section only if you are sending a copy of this form to the NYS Tax Department.)	Employer identification number
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## Instructions

### Changes effective for 2015

Form IT-2104 has been revised for tax year 2015. The worksheet on page 3, the charts beginning on page 4, and the additional dollar amounts in the instructions on page 2, used to compute withholding allowances or to enter an additional dollar amount on line(s) 3, 4, or 5, have been revised. If you previously filed a Form IT-2104 and used the worksheet, charts, or additional dollar amounts, you should complete a new 2015 Form IT-2104 and give it to your employer.

### Who should file this form

This certificate, Form IT-2104, is completed by an employee and given to the employer to instruct the employer how much New York State (and New York City and Yonkers) tax to withhold from the employee's pay. The more allowances claimed, the lower the amount of tax withheld.

If you do not file Form IT-2104, your employer may use the same number of allowances you claimed on federal Form W-4. Due to differences in tax law, this may result in the wrong amount of tax withheld for New York State, New York City, and Yonkers. Complete Form IT-2104 each year

and file it with your employer if the number of allowances you may claim is different from federal Form W-4 or has changed. Common reasons for completing a new Form IT-2104 each year include the following:

- You started a new job.
- You are no longer a dependent.
- Your individual circumstances may have changed (for example, you were married or have an additional child).
- You moved into or out of NYC or Yonkers.
- You itemize your deductions on your personal income tax return.
- You claim allowances for New York State credits.
- You owed tax or received a large refund when you filed your personal income tax return for the past year.
- Your wages have increased and you expect to earn \$106,200 or more during the tax year.
- The total income of you and your spouse has increased to \$106,200 or more for the tax year.
- You have significantly more or less income from other sources or from another job.
- You no longer qualify for exemption from withholding
- You no longer qualify for exemption from withholding



# 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) <b>DICILLO</b>		First Name (Given Name) <b>MARK</b>		Middle Initial	Other Names Used (if any)	
Address (Street Number and Name) <b>291 MICHAEL AVE</b>			Apt. Number	City or Town <b>SLOAN</b>	State <b>NY</b>	Zip Code <b>14212</b>
Date of Birth (mm/dd/yyyy) <b>7-31-69</b>	U.S. Social Security Number <b>101-52-7913</b>		E-mail Address		Telephone Number <b>714 896 7622</b>	

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):

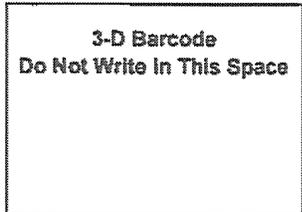
- A citizen of the United States
- A noncitizen national of the United States (See instructions)
- A lawful permanent resident (Alien Registration Number/USCIS Number): \_\_\_\_\_
- An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) \_\_\_\_\_. Some aliens may write "N/A" 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: <i>Mark Dicillo</i>	Date (mm/dd/yyyy): <b>07-21-2015</b>
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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: DiCillo, Mark

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title: <u>Driver's License</u>		Document Title: <u>Social Security Card</u>
Issuing Authority:		Issuing Authority: <u>New York</u>		Issuing Authority: <u>Social Security Administration</u>
Document Number:		Document Number: <u>541 705 030</u>		Document Number: <u>101 - 52 - 7915</u>
Expiration Date (if any)(mm/dd/yyyy):		Expiration Date (if any)(mm/dd/yyyy): <u>N/A</u>		Expiration Date (if any)(mm/dd/yyyy): <u>N/A</u>
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date (if any)(mm/dd/yyyy):				
Document Title:				
Issuing Authority:				
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): 07/21/2015 (See instructions for exemptions.)

Signature of Employer or Authorized Representative <u>Caitlin Scholl</u>		Date (mm/dd/yyyy) <u>07/24/2015</u>	Title of Employer or Authorized Representative <u>Administrative Assistant</u>	
Last Name (Family Name) <u>Scholl</u>		First Name (Given Name) <u>Caitlin</u>		Employer's Business or Organization Name <u>EMPLOYER SOLUTIONS STAFFING GROUP LLC</u>
Employer's Business or Organization Address (Street Number and Name) <u>7301 OHMS LANE SUITE 405</u>		City or Town <u>EDINA</u>		State <u>MN</u>
				Zip Code <u>55439</u>

### 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:	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:

**NEW YORK STATE**  
Department of Motor Vehicles

**DRIVER LICENSE**  
ID: 541 705 630 CLASS D



DICILLO  
MARK  
291 MICHAEL AV  
SLOAN NY 14212  
DOB: 07-31-69  
SEX: M EYES: GR HT: 5-08  
NONE  
NONE  
ISSUED: 07-27-11

*Mark D'illo*

CPW2015708

**SOCIAL SECURITY**

101-52-7915

MARK DICILLO

*Mark D'illo*

**SENSITIVE BUT UNCLASSIFIED**

**Department of Homeland Security**  
**E-Verify**

**Report Prepared: 07/24/2015**  
**Page: 1 of 1**

**Case Verification Number: 2015205114026JU**

**Case Information:****Employee Information:**

Last Name:	DiCillo	First Name:	Mark
Middle Initial:		Other Names Used:	
Social Security Number:	*** ** 7915	Date of Birth:	07/31/1969
Citizenship Status:	A citizen of the United States	Email Address:	

**Document Information:**

List B Document:	Driver's license or ID card issued by a U.S. state or outlying possession	List C Document:	Social Security Card
Document Name:	Driver's license	Document State:	New York
Driver's License or ID Card Number:		Document Expiration Date:	This document has no expiration date
Alien Number:		I-94 Number:	

**Additional Information:**

Hire Date:	07/21/2015	Employer Case ID:	
Three-Day Rule Reason:		Three-Day Rule - Other:	
Submitted By:	CSCH4411	Submitted On:	07/24/2015

**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:		First Name:	
Middle Initial:		Other Names Used:	
Social Security Number:		Date of Birth:	
Resubmitted By:		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:

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

Referred By:

Referred On:

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

Case Result:

Response Date:

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**Case Closure:**

Closure Statement:

Closed By:

Closed On:

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**SENSITIVE BUT UNCLASSIFIED**

# EMERGENCY CONTACT INFORMATION

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

Employee Name: MARK DICILLO

Address: 291 MICHAEL AVE SLOAN NY 14212

Home Phone: 716 896 7622

### EMERGENCY CONTACTS

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

Contact #1	Contact #2
Name: <u>LISA DICILLO</u>	Name: <u>RYAN DICILLO</u>
Relationship: <u>WIFE</u>	Relationship: <u>SON</u>
Home Phone: <u>716 896 7622</u>	Home Phone: <u>716 896 7622</u>
Cell Phone: <u>716 480 5126</u>	Cell Phone: <u>716 730 9050</u>
Work Phone: <u>716 89862 1866</u>	Work Phone:

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

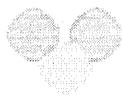
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# employer solutions staffing group

Leveraging Resources in a Changing Market

## Direct Deposit/Payroll Debit Card Authorization

Employees have the option of receiving wages by Direct Deposit and/or Payroll Debit Card.  
If you do not provide a written election, wages will be paid by Payroll Debit Card.

### SECTION 1 BASIC INFORMATION

Employee Name <b>MARK DICILLO</b>	SSN# (last 4 digits) <b>101 52 7915</b>	Effective Date <b>7-21-15</b>
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### SECTION 2 PAYROLL ELECTION

**Direct Deposit** (Please complete Sections 3 and 5 below)  
 **Payroll Debit Card** (Please complete Sections 4 and 5 below)

### SECTION 3 DIRECT DEPOSIT

Update Bank Account

Bank Name: **FIRST NIAGARA**

Routing#: **222370440**

Account#: **7803822167**

Account Type:  Checking  Savings  Other

I understand and acknowledge that if I do not provide a voided check with this direct deposit form, I am responsible for any delays in payroll or extra costs incurred if the account number that I provide is incorrect.

Initial **MD** Date **7-21-15**

- To help us avoid making an error, please attach a copy of a voided check. (a deposit slip will not work)
- If you change banks, do not close your old bank account until your direct deposit has started at the new bank, which may take 2 pay periods.

### SECTION 4 PAYROLL DEBIT CARD (GLOBAL CASH CARD)

Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. In order to request a Payroll Debit Card for you, we must provide all of the following information that will enable the financial institution to identify you. If you do not submit a Direct Deposit/Payroll Debit Card Authorization, ESSG will provide the necessary information and issue you a Payroll Debit Card to pay your wages. For your protection, the financial institution may ask you to provide them additional identification information so they can verify your identity.

Except for the routing and account number, ESSG does not have access to any information regarding your Payroll Debit Card account or transactions. On your first payday, you will receive your new Payroll Debit Card, and a packet containing all of the terms and conditions. You will then sign acknowledging that you received the Payroll Debit Card and packet. Your Payroll Debit Card will be reloaded on each payday you receive wages.

#### CARDHOLDER INFORMATION (as you want your Payroll Debit Card to be issued)

First Name	M.I.	Last Name	Date of Birth
Street Address (PO BOX NOT ACCEPTABLE)			Social Security#
City	State	Zip	Cell Phone (mobile)

#### RECEIPT OF PAYROLL DEBIT CARD (to be completed when you pick up your Payroll Debit Card)

Payroll Debit Card Routing # <b>073972181</b>	Payroll Debit Card Account #
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I have received my Payroll Debit Card, welcome brochure, program fees, program terms, conditions, and disclosures. By activating my Payroll Debit Card, I am agreeing to the program terms, conditions, and disclosures that are included or made available to me from time to time from the financial institution. I authorize the financial institution to debit my Payroll Debit Card account for the fees described in the fee schedule that is part of the program terms, conditions, and disclosures.

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### SECTION 5 AUTHORIZATION

I authorize ESSG to directly deposit my periodic wages/compensation payments, net of required tax withholdings, other required withholdings or authorized deductions, into my account(s) as designated above and to initiate, if necessary, debit entries and adjustments for any credit entries made in error to my account(s). **\* E-mail is required for pay stub information.**

\*E-mail: **MARK DICILLO @ AOL.COM**  
 this information will only be used to send your paystubs electronically

Employee's Signature: **Mark Dicillo** Date: **7-21-15**



employer solutions staffing group  
Leveraging Resources in a Changing Market

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**STATEMENT OF CONFIDENTIALITY**

This agreement made this 21 day of July, 2015, between Employer Solutions Staffing Group LLC, hereinafter referred to as "employer", and MARK DICILLO 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

▶ See separate instructions.

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

Your name MARK DICILLO Social security number ▶ 101 52 7915

Street address where you live 291 MICHAEL AVE.

City or town, state, and ZIP code SLOAN NY 14212

County ERIE Telephone number 716 896 7622

If you are under age 40, enter your date of birth (month, day, year) \_\_\_\_\_

- 1  Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.
  
- 2  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.
  
- 3  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.
  
- 4  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.
  
- 5  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.
  
- 6  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 on 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 7-21-15

**EMPLOYER SECTION:**

ESG FEIN#:	ESG Client Name & State:	
Hiring Manager:	Position:	Starting Wage: \$

**EMPLOYEE SECTION:**

Employee Name: <u>MARK DICILLO</u>	Street Address: <u>291 MICHAEL AVE</u>	City/State: <u>SLOAN NY</u>	Zip: <u>14212</u>
SS#: <u>101-52-7915</u>	Date of Birth: <u>7/31/69</u>	Age: <u>46</u>	Have you worked for this company before? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
			If yes, location:

Please complete all questions, and sign and date the form.

	Yes	No
<b>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.)</b> Name of the person receiving benefits: _____ Relationship to you: _____ City: _____ County: _____ State: _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>2. Have you or has anyone living with you received Food Stamps (SNAP) at any time during the past 15 months? (If yes, please provide information below.)</b> Name of the person receiving benefits: _____ Relationship to you: _____ City: _____ County: _____ State: _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>3. Have you received Supplemental Security Income (SSI) at any time within the past 3 months? 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.</b>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>4. Have you received any type of vocational rehabilitation services within the past two years? If yes, please indicate which type of agency you worked with and provide their location information below:</b> <input type="checkbox"/> Vocational Rehabilitation Agency <input type="checkbox"/> Dept. of Veterans Affairs <input type="checkbox"/> 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.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>5. Are you a Veteran of the U.S. Military? *If yes, please provide a copy of your DD-214 and letter of separation. (If yes, please provide information below. If no, please continue to question #6.)</b> Dates of Service - From: ____/____/____ To: ____/____/____ Branch of Service: _____ Are you entitled to or are you receiving compensation for a service-connected disability? <input type="checkbox"/> Have you been unemployed at any time during the last 12 months? <input checked="" type="checkbox"/> If yes, dates of unemployment - From: <u>7/15/15</u> To: <u>7/27/15</u> Did you receive unemployment compensation at any point during your unemployment? <input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>6. Have you been convicted of a felony or released from prison for a felony conviction in the past 12 months?</b> Conviction Date: ____/____/____ Release Date: ____/____/____ Was this a <input type="checkbox"/> Federal or <input type="checkbox"/> State conviction? If State - County: _____ State: _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>

**Additional Tax Credits**

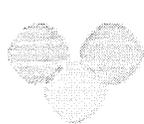
<b>IEC (Native American):</b> Are you or your spouse a member of a Native American Tribe? *If you checked yes please provide a copy of your CDIB card.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<b>CA Residents:</b> <input type="checkbox"/> Are you the child of foster parents? <input type="checkbox"/> Do you receive CalWorks? <input type="checkbox"/> Workforce Investment Act? <input type="checkbox"/> Are you a migrant or seasonal farm worker? <input type="checkbox"/> Have you ever been convicted of a misdemeanor?		
<b>SC Residents:</b> <input type="checkbox"/> 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. and Retrotax, or the Department of Labor.

New Employee Signature: M. A. T. G. M.

Date: 7-21-15



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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.

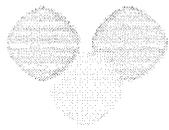
Notify your employer immediately of any new injuries or conditions that impact your physical condition.

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: Mark D. Cicillo

Printed Name: MARK DICILLO



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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): MARK DICILLO

Signature/Firma: Mark D'icillo

ENROLLMENT FORM

REQUIRED EMPLOYEE INFORMATION

PRINT USING BLACK or BLUE INK (Must Be Filled Out)

Social Security Number 101-52-7915

Date of Birth 07/31/1969 Sex M F

Name MARK DICILLO

Street Address 291 MICHAEL AVE

City SLOAN State NY Zip 14212

Home Phone 714-896-7622

Do you or any dependents have Medicare?

Yes No If Yes: [X] No

Medicare Health Insurance Claim Number (HICN)

Medicare Effective Date

Names of Covered Person(s)

- 1. 2. 3.

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

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.

OPTION 1 FIXED INDEMNITY PLAN Weekly Rates

You MUST enroll in the Indemnity Medical Insurance Plan before adding any additional Indemnity benefits, except Dental. Your coverage level for the Term Life will be identical to your medical plan selection.

FIXED INDEMNITY MEDICAL

- \$20.91 Employee Only \$42.44 Employee + 1 \$56.67 Employee + Family NO to all Indemnity benefits.

This coverage is not available to residents of New Hampshire, Hawaii, or Puerto Rico.

DENTAL

- \$5.99 Employee Only \$11.98 Employee + 1 \$19.77 Employee + Family NO

TERM LIFE

- YES \$0.60 Employee Only \$0.90 Employee + 1 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.

OPTION 2 MEC WELLNESS/PREVENTIVE PLAN Monthly Rates

- \$58.87 Employee Only \$87.73 Employee+ 1 \$186.99 Employee + Family NO to MEC Wellness/Preventive Plan

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 declination of coverage.

Signature Mark Dicillo

Date 07/21/2015

Ordered 7/21

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

Mark DiCillo

\_\_\_\_\_, or any of its subsidiaries may obtain information about you from a consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" conducted by a consumer reporting agency which may include information about your character, general reputation, personal characteristics, and/or mode of living and which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may contain information regarding your credit history, criminal history (State and Federal records), social security verification, address trace, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any report conducted by a consumer reporting agency. Please be advised NationSearch.com, LLC (NationSearch)—11184 Huron St. Suite 13; Northglenn, CO 80234; (800)-827-9550—will be the consumer reporting agency conducting the background investigation. The scope of this notice and authorization is all encompassing, however, allowing the Company to obtain from any outside organization all manners of consumer reporting now and throughout the course of your employment to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any report conducted by a consumer reporting agency.

**ACKNOWLEDGEMENT AND AUTHORIZATION**

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" by the Company at any time after receipt of this authorization and throughout my employment, if applicable. I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, credit reporting agency, employer, to provide any and all background information requested by NationSearch.com, LLC—11184 Huron St. Suite 13; Northglenn, CO 80234 (800)-827-9550—another outside organization acting on behalf of the Company, and/or the Company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

**Notice to California Applicants:** Notice to California Applicants: Under section 1786.22 of California Civil Code, you have the right to request from NationSearch, upon proper identification, the nature and substance of all information in files pertaining to you, including the sources of information, and recipients of any reports on you, which NationSearch has previously furnished within the two-year period preceding your request. You may view the file maintained on you by contacting NationSearch during normal business hours. You may also obtain a copy of this report(s) upon submitting proper identification. Upon making a written request, you may receive a summary of your report.  
**New York applicants or employees only:** You have the right to inspect and receive a copy of any report conducted by a consumer reporting agency and requested by the Company by contacting the consumer reporting agency identified above directly.  
**Notice to Maine Applicants:** Under Chapter 210 Section 1314 of Maine revised Statutes, you have the right, upon request, to be informed within 5 business days of such a request to whether or not a consumer report was requested. If such report was obtained, you may contact the consumer reporting agency, NationSearch, and request a copy of the report(s) compiled.  
**Minnesota and Oklahoma applicants or employees only:** Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company.

Last Name: DiCillo	First Name: Mark	Middle Name:
Other Names Used:	SSN: 101527915	Date of Birth: (For Employment Purposes Only) 7-31-69
Motor Vehicle Number & State of Issue: (Driver's License Number) NYS 541705630	Current Address: 291 Michael Ave Sloan, NY 14212	

Signature: Mark DiCillo  
Mark DiCillo (Jul 21, 2015)

Date: Jul 21, 2015

Please initial this box in affirmation that you have been advised of your rights as it pertains to this consumer report, and are aware of the consumer reporting agency conducting the background investigation:

MD

# Background Authorization Form

Adobe Document Cloud Document  
History

July 21, 2015

Created:	July 21, 2015
By:	Caitlin Scholl (Caitlin@corpmgmtgroup.com)
Status:	SIGNED
Transaction ID:	XQ9BGRL7XG2TM4D

## “Background Authorization Form” History

-  Document created by Caitlin Scholl (Caitlin@corpmgmtgroup.com)  
July 21, 2015 - 11:11 AM MDT - IP address: 71.211.151.144
-  Document emailed to Mark DiCillo (markdisilly@aol.com) for signature  
July 21, 2015 - 11:11 AM MDT
-  Document viewed by Mark DiCillo (markdisilly@aol.com)  
July 21, 2015 - 12:59 PM MDT - IP address: 72.88.53.128
-  Document e-signed by Mark DiCillo (markdisilly@aol.com)  
Signature Date: July 21, 2015 - 1:03 PM MDT - Time Source: server - IP address: 72.88.53.128
-  Signed document emailed to Mark DiCillo (markdisilly@aol.com) and Caitlin Scholl (Caitlin@corpmgmtgroup.com)  
July 21, 2015 - 1:03 PM MDT