



**Employer Solutions Staffing Group LLC** *New Hire Application*

7301 Ohms Lane / Suite 405  
Edina, MN 55439  
T:952.835.1288 / F:952.835.4881

Personal Data-- PLEASE PRINT LEGIBLY IN INK

Last Name Enriquez First Name Juan Middle Initial C.  
Street Address 294 Guanacaste CT  
City/State/Zip San Jose, CA 95116  
Home Phone \_\_\_\_\_ Cell / Message Phone (916) 509-6809  
Company/Employer Storeroom Solutions

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.

Juan Enriquez Name (Print or type) Juan Enriquez Applicant's Signature 1 July 2014 Date

A copy or facsimile will be considered the same as an original signature.

For ESSG Office Use Only				
DOH _____	NHW _____	I-9 _____	8850 _____	W4 _____
Emergency Contact Info _____	Background Release Form _____	Background Results _____	5 Day Letter (If applicable) _____	ESC Application _____

# 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 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 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/w4](http://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	<u>1</u>
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	<u>1</u>
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	<u>0</u>
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return . . . . .	D	<u>0</u>
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above) . . . . .	E	<u>0</u>
F	Enter "1" if you have at least \$1,900 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.)	F	<u>0</u>
G	<b>Child Tax Credit</b> (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <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	<u>0</u>
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	<u>3</u>

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.

<b>Form W-4</b> Department of the Treasury Internal Revenue Service	<h2>Employee's Withholding Allowance Certificate</h2> <p>▶ 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>	OMB No. 1545-0074 <h1 style="font-size: 2em;">2013</h1>
1 Your first name and middle initial <u>Juan C.</u>		2 Your social security number <u>617-09-9806</u>
Last name <u>Enriquez</u>		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input checked="" 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.
Home address (number and street or rural route) <u>294 Guanacaste CT</u>		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"/>
City or town, state, and ZIP code <u>Sao Jose, CA 95116</u>		5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2) 5 <u>3</u>
6 Additional amount, if any, you want withheld from each paycheck 6 \$ <u>0</u>		7 I claim exemption from withholding for 2013, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> <li>• Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and</li> <li>• This year I expect a refund of all federal income tax withheld because I expect to have no tax liability.</li> </ul> If you meet both conditions, write "Exempt" here . . . . . ▶ <u>7</u>
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.) ▶ <u>Juan C Enriquez</u>		Date ▶ <u>1 July 2014</u>
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)		

**PLEASE READ CAREFULLY  
APPLICATION FORM WAIVER**

In exchange for the consideration of my job application by Employer Solutions Staffing Group LLC, (hereinafter called "the Company"),

I agree that:

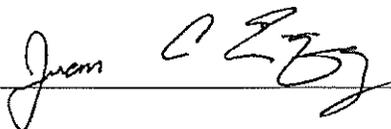
Neither the acceptance of this application nor the subsequent entry into any type of employment relationship, either in the position applied for or any other position, and regardless of the contents of employee handbooks, personnel manuals, benefit plans, policy statements and the like as they may exist from time to time, or other Company practices, shall serve to create an actual or implied contract of employment, or to confer any right to remain an employee of the Company, or otherwise to change in any respect the employment-at-will relationship between it and the undersigned, and that relationship cannot be altered except by a written instrument signed by the Owner/Managing Member of the Company. Both the undersigned and the Company may end the employment relationship at any time, without specified notice or reason. If employed, I understand that the Company may unilaterally change or revise their benefits, policies and procedures and such changes may include reduction in benefits.

I authorize investigation of all statements contained in this application. I understand that the misrepresentation or omission of facts called for is cause for dismissal at any time without any previous notice. I hereby give the Company permission to contact schools, all previous employers (unless otherwise indicated), references and others and hereby release the Company from any liability as a result of such contact.

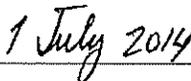
I understand that, in connection with the routine processing of your employment application, the Company may request from a consumer reporting agency an investigative consumer report including information as to my credit records, character, general reputation, personal characteristics and mode of living. Upon written request from me, the Company, will provide me with additional information concerning the nature and scope of any such report requested by it, as required by the Fair Credit Reporting Act.

I further understand that my employment with the Company shall be probationary for a period of ninety (90) days and further that at any time during the probationary period or thereafter, my employment relationship with the Company is terminable at will for any reason by either party.

Signature of applicant



Date:



**DISCLOSURE AND AUTHORIZATION REGARDING PROCUREMENT OF BACKGROUND REPORTS**

It is recognized and understood that the Fair Credit Reporting Act provides that anyone "who knowingly and willfully obtains information on a consumer from a consumer reporting agency under false pretenses" shall be fined not more than \$2,500 or imprisoned not more than a year, or both.

In connection with my application for EMPLOYMENT (including contract for services), I understand that investigative background inquiries are to be made on me which may include criminal convictions, motor vehicle, and other reports. These reports may include information as to my character, work habits, performance, education and experience along with reasons for termination of employment from previous employers. Further, I understand that you will be requesting information from various Federal, State, and other agencies which maintain records concerning my past activities relating to my driving, credit, criminal, civil and other experiences. *If I include a current employer for verification, I may jeopardize my position within that company.* I authorize without reservation, any party or agency contacted to furnish the above mentioned information and release all parties involved from any liability and responsibility for doing so. I hereby consent to obtaining the above information from BACKGROUND SOURCE INT'L and/or any of their licensed agents. This authorization and consent shall be valid in original, fax or copy form. I further authorize ongoing procurement of the above mentioned reports at any time during my employment (or contract).

**Applicant Signature:** Juan C. Ezy **Date:** 4 July 2014

Please PRINT clearly: Position applied for: \_\_\_\_\_

Name: Juan Carlos Enriquez Maiden / AKA: \_\_\_\_\_  
First Middle Last

Soc. Sec. #: 617-09-9806 \*Sex: M \*Race: H \*Date of Birth: 12/06/1977

Current Address: 294 Guanacaste CT County: Santa Clara

City: San Jose State: CA Zip: 95116 How long: 06/01/14 to Present

Previous Address: 5948 Gilman Way, County: Sacramento

City: North Highlands State: CA Zip: 95660 How long: 03/15/14 to 06/01/14

Motor Vehicle Report Fax to: (208)769-7282  
 Name as it appears: \_\_\_\_\_ License #: \_\_\_\_\_ State held: \_\_\_\_\_

\*Responses to these are completely voluntary. You need not respond to have your application considered. However, without this information, we may be unable to distinguish you from another in the event we discover adverse information during our background investigation. 03/06/01

## Background Investigation Information Release Form

Please read this form carefully and be aware that by allowing Employer Solutions Staffing Group LLC to investigate your background with state and federal agencies, you will be waiving and releasing all claims for damages you might sustain arising out of the criminal and driving record background check and review.

I understand that a successful criminal and driving record background investigation is a condition of my employment by Employer Solutions Staffing Group LLC to work at facilities of: Storeroom Solutions Inc.

and, further, that Employer Solutions Staffing Group may, at its discretion, conduct periodic criminal and driving record background investigations on me during the course of my employment with Employer Solutions Staffing Group.

I agree to waive and relinquish all claims I may have against Employer Solutions Staffing Group LLC and its officers, agents, servants and employees as a result of my participation in any criminal and driving record background investigation.

I do hereby fully release and discharge Employer Solutions Staffing Group LLC, its respective officers, agents, servants, and employees from any and all claims from damages that I may have or that may accrue to me on account of the results of any aspect of any criminal and driving record background investigation.

I further agree to indemnify and hold harmless and defend Employer Solutions Staffing Group LLC, its respective officers, agents, servants, and employees from any and all claims resulting from damages sustained by me or arising out of, connected with, or in any way associated with, any of the activities of any criminal and driving record background investigation and review.

I have read and fully understand this Waiver and Release of All Claims.

<u>617-09-9806</u> Social Security Number	<u>B6925276</u> Driver's License No:	<u>CA</u> State
<u>Enriquez</u> Last Name	<u>Juan</u> First Name	<u>C.</u> M.I
<u>Maiden and/or Other Last Names Used</u> <u>294 Guamaeste CT</u> Current Address	<u>San Jose, Santa Clara</u> City and County	<u>CA 95116</u> State and Zip Code
<u>12/06/1977</u> Date of Birth	Circle One: <input checked="" type="radio"/> Male <input type="radio"/> Female	

Signature: Juan C. Enriquez Date: 1 July 2014

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

Name: Juan Enriquez

Address: 294 Guanacaste CT

Home Phone: 916-509-6809

Person(s) to contact in case of an emergency on the job (in order of preference):

1. Name: Fernando Vasquez

Phone (work): \_\_\_\_\_

Phone (home): (408) 401-5209

2. Name: Rosa

Phone (work): \_\_\_\_\_

Phone (home): (408) 775-0402

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

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## PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name <b>Employer Solutions Staffing Group LLC</b>		4. Employer Identification Number (EIN) <b>20-8084369</b>	
5. Employer address <b>7301 Ohms Lane Suite 405</b>		6. Employer phone number <b>952-767-9519</b>	
7. City <b>Edina</b>	8. State <b>MN</b>	9. ZIP code <b>55439</b>	
10. Who can we contact about employee health coverage at this job? <b>ESSG Health Benefits Team</b>			
11. Phone number (if different from above) <b>952-767-9519</b>		12. Email address <b>health@employersolutionsgroup.com</b>	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - All employees.
  - Some employees. Eligible employees are: **Site by site basis, to employees who work 30+ hours/week, 1560+ hours/year**
- With respect to dependents:
  - We do offer coverage. Eligible dependents are: **Dependents of enrolled employees working at sites that have elected insurance**
  - We do not offer coverage.

If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

\*\* Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? **Varies by site** (mm/dd/yyyy) (Continue)

No (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard\*?

Yes (Go to question 15)  No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard\* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? **\$Varies - \$0 - \$55.38**

b. How often?  Weekly  Every 2 weeks  Twice a month  Monthly  Quarterly  Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.\* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? \$

b. How often?  Weekly  Every 2 weeks  Twice a month  Monthly  Quarterly  Yearly

Date of change (mm/dd/yyyy): \_\_\_\_\_

# Employer Solutions Staffing Group Direct Deposit Authorization

If you are applying for direct deposit, please make sure that you are mark whether the account is a savings or checking. Failure to provide this information can result in the deposit being delayed for several days. Please also note that it is possible for your direct deposit to be delayed a day or two the first week that your direct deposit is processed. Every bank is different and, although this doesn't happen frequently, it does happen. If you cannot wait a day or two past pay day for your deposit, then we suggest staying with a paper paycheck.

The time that the money goes into your account on pay day varies by bank.  
Please allow until at least 10 am on your payday for the deposit to show.

Please print

Check one of the following	Effective Date
<input checked="" type="checkbox"/> Start	<input type="checkbox"/> As Soon As Possible
<input type="checkbox"/> Stop	<input type="checkbox"/> Future Paydate
<input type="checkbox"/> Change	____/____/____

Social Security Number <b>617-09-9806</b>
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Name (Last, First Middle Initial) <b>Enriquez Juan C.</b>			
Home Address <b>294 Guanacaste CT</b>	City <b>San Jose,</b>	State <b>CA</b>	Zipcode <b>95116</b>
Date (Mo/Day/Yr) <b>07/01/2014</b>	Employee Signature <b>Juan C Enriquez</b>	Daytime Phone Number <b>(916) 509-6809</b>	

**SUBMISSION OF THIS FORM MEANS YOUR ENTIRE PAYROLL CHECK WILL GO TO THIS FINANCIAL INSTITUTION**

Financial Institution Name (Bank, Savings Institution, Credit Union, etc.) <b>Citibank</b>
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Type of Account <input checked="" type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> Money Market Checking <input type="checkbox"/> Money Market Investment Requires Submission of ACH form from your broker
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I authorize Employer Solutions Staffing Group to direct deposit funds to my account in the financial institution listed above. If funds to which I am not entitled are deposited in my account, I authorize Employer Solutions Staffing Group to initiate a correcting (debit) entry. I understand that the authorization may be rejected or discontinued by Employer Solutions Staffing Group at any time. If any of the above information changes, I will promptly complete a new authorization agreement. If the direct deposit is not stopped before closing an account, funds payable to you will be returned to Employer Solutions Staffing Group for distribution. This will delay payment of funds to you.

✓ **Attach a voided check HERE or photocopy of a check for checking account.**  
**DO NOT ATTACH A DEPOSIT SLIP.**

VSI-IND 219301-EMP

OFFICE USE ONLY

ReHire Date \_\_\_/\_\_\_/\_\_\_

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

**ENROLLMENT FORM - PLAN 2**

USE BLACK or BLUE INK ONLY  
ESC CU(NAV\*SAD) P2 v13.0

Social Security Number 617-09-9806  
 Date of Birth 12/06/1977 Sex  M  F  
 Name Juan Enriquez  
 Street Address 294 Guanacaste CT  
 City San Jose State CA Zip 95116  
 Home Phone 916-509-6806

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 \$4.20 Employee Only
- NO

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 declination of coverage.

Signature Juan C. Enriquez

Date 07/01/2014

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

OMB No. 1545-1500

▶ See separate instructions.

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

Your name Juan Carlos Enriquez Social security number ▶ 617-09-9806  
Street address where you live 294 Guamacaste CT  
City or town, state, and ZIP code Sun Jose, CA 95116  
County Santa Clara Telephone number (916) 509-6809  
If you are under age 40, enter your date of birth (month, day, year) 12/06/1977

- 1  Check here if you are completing this form before August 28, 2009, and you lived in the area impacted by Hurricane Katrina on August 28, 2005. If so, please enter the address, including county or parish and state where you lived at that time.
- 2  Check here if you received a conditional certification from the state workforce agency (SWA) or a participating local agency for the work opportunity credit.
- 3  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 discharged or released from active duty in the U.S. Armed Forces during the past 5 years and, for at least 4 weeks during the past year, I received unemployment compensation.
  - I am at least age 16 but not age 25 or older, and:
    - a During the past 6 months, I have not attended a secondary, technical, or post-secondary school for more than an average of 10 hours per week, not counting periods during which the school was closed for scheduled vacations, and
    - b During the past 6 months, if I was employed, during each consecutive 3-month period within the past 6 months, I earned less than I would have earned if I had worked for the applicable minimum wage 30 hours every week during the 3-month period, and
    - c I do not have a certificate of graduation from a secondary school or a General Education Development (GED) certificate or I have a certificate that was awarded at least 6 months ago and I have not held a job (other than occasionally) or been admitted to a technical or post-secondary school since I received the certificate.
- 4  Check here if you are a veteran entitled to compensation for a service-connected disability and, during the past year, you were:
- Discharged or released from active duty in the U.S. Armed Forces, or
  - Unemployed for a period or periods totaling at least 6 months.
- 5  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 ▶ Juan C. Enriquez

Date 07/01/14

For Employer's Use Only

Employer's name Employer Solutions Staffing Group Telephone no. ( 952 ) 835 - 1288 EIN ▶ \_\_\_\_\_

Street address 7301 Ohms Lane, Suite 405

City or town, state, and ZIP code Edina, MN 55439

Person to contact, if different from above Associated Consultants, Inc. Telephone no. ( 800 ) 925 - 0557

Street address 3730 Washington Boulevard

City or town, state, and ZIP code Indianapolis, IN 46205

If, based on the individual's age and home address, he or she is a member of group 4 or 6 (as described under Members of Targeted Groups in the separate instructions), enter that group number (4 or 6) . . . . . ▶ \_\_\_\_\_

Date applicant:
Gave information \_\_\_\_/\_\_\_\_/\_\_\_\_ Was offered job \_\_\_\_/\_\_\_\_/\_\_\_\_ Was hired \_\_\_\_/\_\_\_\_/\_\_\_\_ Started job \_\_\_\_/\_\_\_\_/\_\_\_\_

Complete Only If Box 1 on Page 1 is Checked

State and county or parish of job \_\_\_\_\_

Check if the individual was not your employee on August 28, 2005, and this is the first time the employee has been hired by you since August 28, 2005.

Under penalties of perjury, I declare that the applicant provided the information on this form on or before the day a job was offered to the applicant and that the information I have furnished is, to the best of my knowledge, true, correct, and complete. Based on the information the job applicant furnished on page 1, I believe the individual is a member of a targeted group. I hereby request a certification that the individual is a member of a targeted group.

Employer's signature ▶ \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Privacy Act and Paperwork Reduction Act Notice

Section references are to the Internal Revenue Code.

Section 51(d)(13) permits a prospective employer to request the applicant to complete this form and give it to the prospective employer. The information will be used by the employer to complete the employer's federal tax return. Completion of this form is voluntary and may assist members of targeted groups in securing employment. Routine uses of this form include giving it to the state workforce agency (SWA), which will contact appropriate sources to confirm that the applicant is a member of a targeted group. This form may also be given to the Internal Revenue Service for administration of the Internal Revenue laws, to the Department of Justice for civil and

criminal litigation, to the Department of Labor for oversight of the certifications performed by the SWA, and to cities, states, and the District of Columbia for use in administering their tax laws. 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 section 6103.

The time needed to complete and file this form will vary depending on individual circumstances. The estimated average time is:

- Recordkeeping . . . . . 3 hrs., 16 min.
Learning about the law or the form . . . . . 46 min.
Preparing and sending this form to the SWA . . . . . 42 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making this form simpler, we would be happy to hear from you. You can write to the Internal Revenue Service, Tax Products Coordinating Committee, SE:W:CAR:MP:T:T:SP, 1111 Constitution Ave. NW, IR-6526, Washington, DC 20224.

Do not send this form to this address. Instead, see When and Where To File in the separate instructions.

Form A (revised 07/09) WORK OPPORTUNITY TAX CREDIT

PLEASE CHECK "YES" OR "NO" AND ANSWER ALL QUESTIONS

Name Juan Enriquez
Address 294 Guanacaste CT
City San Jose State CA Zip 95116 Social Security # 617-09-9806
Date of Birth 12/06/1977 Age 36

Please CHECK ONE ANSWER for each of the following questions, and complete question #5:

- 1. Have you or any family member living with you received Temporary Assistance to Needy Families (TANF) or Aid to Families with Dependent Children (AFDC) during the past 24 months? Yes [X] No [X]
2. Have you or any family member living with you received Supplemental Nutritional Assistance Program (SNAP) (Food Stamps) at any time during the past fifteen (15) months? Yes [X] No [ ]
3. Have you received Supplemental Security Income (SSI) benefits in the past sixty (60) days? Yes [ ] No [X]
4. Are you part of the Ticket to Work program? Yes [ ] No [X]

5. Name of person who received benefits Juan Enriquez
Relationship Self City & State where benefits received San Jose, CA

6. Are you a veteran? Yes [X] No [ ] and Disabled due to service? Yes [ ] No [X]
Service Dates: From: June 1997 To: 30 Sept 2012 Branch: Army

7. Have you been unemployed at any time during the last 12 months? Yes [X] No [ ]
If yes, dates of unemployment: From: Sept 2013 To: Dec 2013
Did you receive unemployment compensation at any point during your unemployment?
If yes, dates received compensation: From: Sept 2013 To: Dec 2013 Yes [X] No [ ]

8. Have you been convicted of a felony or released from prison in the last 12 months?
Date of Conviction: Date of Release: Yes [ ] No [X]
Parole Officer's Name: Parole Officer's Phone #

9. Have you received rehabilitation services from a State approved or Department of Veterans Affairs approved Vocational rehabilitation agency? Yes [ ] No [X]
Name of Agency Phone #
Address of Agency Counselor's Name

10. Have you attended High School, College or Technical School for more than an average of 10 hours per week at any time during the last 6 months? Yes [ ] No [X]

11. Did you receive a high school diploma or GED? If yes, date received: June 1997 Yes [X] No [ ]
Have you been employed or been admitted to technical school or college since then? Yes [ ] No [X]

12. How much in gross wages have you earned TOTAL in the past six months? \$ 400.

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, or the Department of Labor.

NEW HIRE SIGNATURE Juan C [Signature] DATE 07/01/2014

Questions below to be completed by manager

Starting Wage Position
Has employee worked for this company before? If yes, date and location



# 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>Enriquez</i>		First Name (Given Name) <i>Juan</i>		Middle Initial <i>C.</i>	Other Names Used (if any)	
Address (Street Number and Name) <i>294 Guanacaste CT</i>			Apt. Number	City or Town <i>San Jose</i>	State <i>CA</i>	Zip Code <i>95116</i>
Date of Birth (mm/dd/yyyy) <i>12/06/1977</i>	U.S. Social Security Number <i>6117-09-98106</i>	E-mail Address <i>enriquez24@yahoo.com</i>			Telephone Number <i>916509-6809</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):

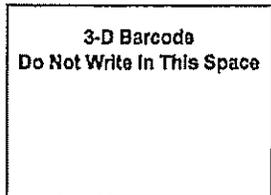
- A citizen of the United States
- A noncitizen national of the United States (See instructions)
- A lawful permanent resident (Alien Registration Number/USCIS Number): \_\_\_\_\_
- An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) \_\_\_\_\_. Some aliens may write "N/A" 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: <i>Juan Enriquez</i>	Date (mm/dd/yyyy): <i>07/01/2014</i>
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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: <i>Juan Enriquez</i>		Date (mm/dd/yyyy): <i>07/01/2014</i>	
Last Name (Family Name) <i>Enriquez</i>		First Name (Given Name) <i>Juan</i>	
Address (Street Number and Name) <i>294 Guanacaste CT</i>		City or Town <i>San Jose</i>	State <i>CA</i> Zip Code <i>95116</i>



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: CALIFORNIA DRIVERS LICENSE		Document Title: SOCIAL SECURITY CARD
Issuing Authority:		Issuing Authority: STATE OF CALIFORNIA		Issuing Authority: SS ADMIN
Document Number:		Document Number: B6925276		Document Number: 617 09 9806
Expiration Date (if any)(mm/dd/yyyy):		Expiration Date (if any)(mm/dd/yyyy): 12/06/2017		Expiration Date (if any)(mm/dd/yyyy): N/A
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) 07/01/2014 (See instructions for exemptions.)

Signature of Employer or Authorized Representative 		Date (mm/dd/yyyy) 07/03/2014	Title of Employer or Authorized Representative RECRUITER	
Last Name (Family Name) WEAVER		First Name (Given Name) KONARD	Employer's Business or Organization Name CMG	
Employer's Business or Organization Address (Street Number and Name) 12000 WASHINGTON ST		City or Town THORNTON	State CO	Zip Code 80241

### 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):
-----------------	------------------	---------------------------------------

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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CALIFORNIA DRIVER LICENSE



DL B6925276

EXP 12/06/2017

LN ENRIQUEZ

FN JUAN C

7818 68TH AVE

SACRAMENTO, CA 95828

DOB 12/06/1977

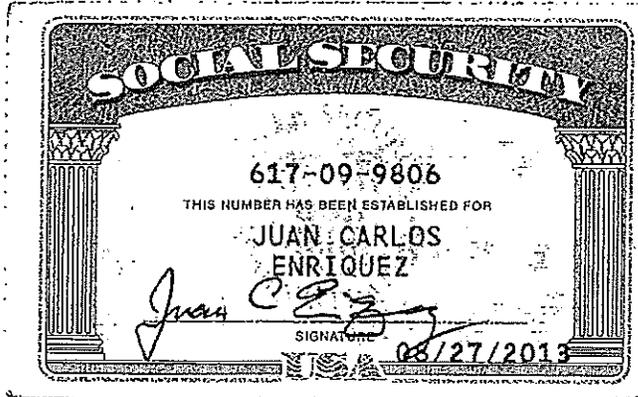
RSTR NONE

CLASS C  
END NONE

12061977

*267*

SEX: M HAIR: BRN EYES: BRN  
HGT: 5'-08" WGT: 176 lb  
DD 07/12/2013 SS 07/19/2013



SOCIAL SECURITY

617-09-9806

THIS NUMBER HAS BEEN ESTABLISHED FOR

JUAN CARLOS  
ENRIQUEZ

*Juan C. Enriquez*  
SIGNATURE

08/27/2013



DEPARTMENT OF DEFENSE/UNIFORMED SERVICES



EXPIRATION DATE  
2014 OCT 01

SERVICE ORGANIZATION  
USA

STATUS/GRADE  
TA-180/EA

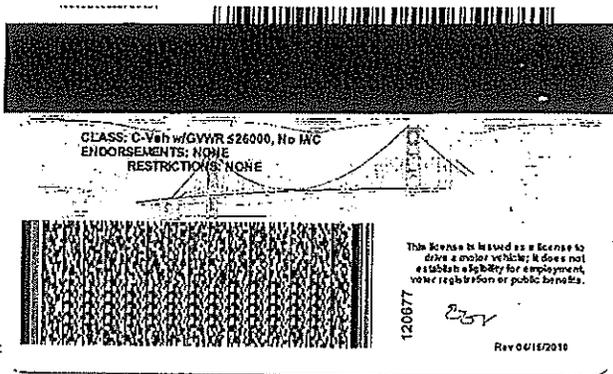
DD ID NUMBER  
1187856163

*Juan C. Enriquez*  
SIGNATURE

AUTHORIZED PATHWAYS  
EXCHANGE  
COMMISSARY

ENRIQUEZ, JUAN CARLOS

IDENTIFICATION AND PRIVILEGE CARD



This card belongs to the Social Security Administration and you must return it if we ask for it.

If you find a card that isn't yours, please return it to:  
Social Security Administration  
P.O. Box 33008, Baltimore, MD 21290-3008

For any other Social Security business/information, contact your local Social Security office. If you write to the above address for any business other than returning a found card you will not receive a response.

Social Security Administration  
Form SSA-3000 (08-2011)

DATE OF BIRTH 1977DEC06	BENEFITS NUMBER 007392609-00			
				
DATE OF ISSUE 2012NOV30	MEDICAL DIRECT: YES	CIVILIAN YES	EFF DATE 2012OCT02	EXP DATE 2013MAR30
				
DD FORM 2765	APR 1998	PROPERTY OF US GOVERNMENT	OUSD(P&R) OCT 2005	