|  |  |  |
| --- | --- | --- |
|  | State of Hawaii  Department of Human Services  Benefit, Employment and Support Services Division  **SEE PROGRAM**  1085 S. Beretania Street, #204  Honolulu, Hawaii 96814 | Employer ID No: |
| Service ID No: |
|  |

**SEE EMPLOYER INVOICE FOR REIMBURSEMENT CLAIM**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Employer Name: |  | | | |
|  | *(as registered with DCCA / Business Registration Division)* | | | |
| Business Address: |  |  | Mailing Address: |  | |
|  |  |  | *(if different from Business Address)* |  | |
|  |  |  |  | |

|  |  |  |  |
| --- | --- | --- | --- |
| Employee Name: |  | Employee SSN *(last 4-digits)*: | XXX – XX – |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Report Month(s): | |  | | | | | | | |
| Total Hours Paid in Report Month, including paid sick/vacation and other paid leave, **not to exceed 40 hours per week**: | | | | | | | | | |
| Total Hours of Unexcused Absences: | | | |  | | Total Hours of Unpaid Excused Absences: | | |  |
| Pay Schedule: | Weekly | | Bi-weekly | | Semi-monthly | | Monthly | Every 4 weeks | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | ***NOTE:*** *Pay statements must be attached for each pay date listed below.* | | | |  |
|  | **Pay Period Start/End Dates** | **Pay Date** | **Hourly Wage Paid** | **Hours Worked** |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| Subtotal: | | | |  |  |
| 14% of Subtotal: | | | |  |  |
| Monthly Transportation Assistance: | | | |  |  |
| Total Reimbursement Claim: | | | |  |  |
|  | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| I hereby certify that all the information contained on this form is true and correct to the best of my knowledge. I understand, the Department may recuperate any reimbursement payment(s) that above-mentioned employer is not entitled to receive and the employer will be responsible to repay the overpayment amount. *Auth: HAR §§17-795-46 to 62* | | | | | | |
| Auth Personnel *(print name)*: |  | Ph #: |  | Email: |  | |
|  |  |  |  |  |  | |
| Auth Signature ***(Original)***: |  | | | | Date: | /      / |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **DEPARMENT USE ONLY:** | | | | | |
| Date Invoice Received: | | Reimbursement Claim  Approved  Not Approved | | Authorized By: | |
| Reason for Non-Payment: | | | | Date Authorized in HANA |  |
| Approved Wage Subsidies: | 14% of Wage Subsidies: | | Transportation Assistance: | **Total Payment Approved:** | |