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|  | State of HawaiiDepartment of Human ServicesBenefit, Employment and Support Services Division**SEE PROGRAM**1085 S. Beretania Street, #204Honolulu, 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)* |       |
|  |       |  |       |

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

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| --- | --- |
| 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 |

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|  | ***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: |  |  |
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| 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:  |      /      /       |

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| **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:** |