State of Hawaii
Dept. of Human Services

Benefit, Employment and Support Services Division
Employment and Child Care Program Office

# REIMBURSEMENT INVOICE
# SUPPORTING EMPLOYMENT EMPOWERMENT (SEE) Program

Employer Name: _____ Payee name (if different) _____

Remittance Address: _____

City: _____ State: _____ Zip Code: _____ Phone Number: _____

| | | |
|---|---|---|
| Report Month(s): | | |
| Name of Employee: | | Employee's SSN: |
| Total Hours Paid in the Report Month--including paid sick/vacation leave and other paid leave, **NOT TO EXCEED 40 HOURS PER WEEK**: | | |
| Total Hours of Unexcused Absences: | | |
| Total Hours of Unpaid Excused Absences: | | |
| **NOTE:** Attach pay stubs for pay periods covered by this invoice | | |
| **Pay Period Start/End Dates** | **Pay Date** | **(Hours Worked) x ( State Minimum Wage)** |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | Subtotal: |
| | | 14% UI, WC, FICA: |
| | | Total Amount Authorized: |
| | | |
| Payroll Personnel Name **(PRINT/TYPE)**: | | Tel #: |
| **Original** Payroll Personnel's Signature: | | Date: |
| **Original** DHS Authorized Representative: | | Date: |

| **FISCAL AGENT USE ONLY:** | |
|---|---|
| *Rec'd By:* | *Date:* |
| *Authorized By:* | *Date Authorized:* |

**PLEASE REMIT INVOICE TO:**
1085 S. Beretania Street, Ste 200
Honolulu, HI 96814

DHS 760 (7/06)