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:
75-5722 Hanama Pl., Ste 1105
Kailua-Kona, HI 96740