|  |  |  |
| --- | --- | --- |
|  | State of Hawaii  Department of Human Services  Benefit, Employment and Support Services Division  **SEE PROGRAM**  1085 S. Beretania Street, Ste 204  Honolulu, HI 96814  808-792-8551 | New Application |
| Recertification |
| Update Employer Information |
| Former SEE Employer |

**SEE EMPLOYER APPLICATION FORM**

|  |  |
| --- | --- |
| ***Section I: Employer*** | |
| Business Name: |  |
|  | (As registered with the Department of Commerce and Consumer Affairs) |

|  |  |
| --- | --- |
| Doing Business As (dba): |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Business Address: |  | Mailing Address: |  |
|  |  | (if different from business  address) |  |
|  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Phone: |  | Fax: |  | Website Address (URL): |  |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Business Type: |  | | | | | Business Industry: | | |  | | |
|  | (As registered with DCCA) | | | | |  | | | (e.g. Construction, Healthcare, IT, etc.) | | |
| Federal Tax ID No: | |  | | | State Tax ID No: | | | GE- |  | | | |
|  | | | | | | | | | | | | |
| ***Section II: Worksite(s)*** | | | | | | | | | | | |
| **Address Worksite 1**: | | |  | **Employer ID#** | | |  | | | **Service ID#** |  |
| ***(***If not the same as the above business address) | | |  | Mailing Address: | | | | |  | | |
|  | | |  | (If not the same as the  mailing address in section 1) | | | | |  | | |
|  | | |  |  | | | | |  | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Worksite Contact: |  | | | Position Title: | |  | |
|  | (Print First and Last Names) | | |  | |  | |
|  | | | | | | | |
| Worksite Phone: | (808) | Fax: |  | | Mobile: | |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Worksite Email: |  | | Hours of Operation: |  | |
| **(**Include Days and Times) | | | | | |
| Total Number of Employees During Hours of Operation | |  | | |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Address Worksite 2:** |  | **Provider ID#** |  | | **Service ID#** |  |
| (If not the same as the above business address) |  | Mailing Address: | |  | | |
|  |  | (If not the same as the  mailing address in section 1) | |  | | |
|  |  |  | |  | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Worksite Contact: |  | | | Position Title: | |  | |
|  | (Print First and Last Names) | | |  | |  | |
|  | | | | | | | |
| Worksite Phone: | (808) | Fax: |  | | Mobile: | |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Worksite Email: |  | Hours of Operation: | |  |
| (Include Days and Times) | | | | |
| Total Number of Employees During Hours of Operation: | | |  |  |
|  | | | | |

*Please attach a separate sheet for additional worksites.*

|  |
| --- |
| ***Section III: Participation Requirements*** |

A. The above-mentioned employer agrees to:

1. Maintain compliance with applicable federal, state, and county laws that affect its ability to do business in the State of Hawaii for the duration of participation with the SEE Program;

2. Possess all applicable licenses and accreditation related to the nature of the business, required under any applicable federal, state, and county laws;

3. Pay the SEE participant (employee) at a rate that is comparable to other employees in the same position, and provide the same working conditions, entitlements and benefits provided to all other employees in similar positions including but not limited to temporary disability insurance, worker’s compensation, unemployment insurance, health insurance benefits, and sick, vacation, personal and holiday leaves;

4. Receive reimbursement payments through direct deposit into a bank account designated by the employer;

5. Employ no more than ten percent (10%) of the total workforce, per worksite. through the SEE Program at any given time; and

B. Determination of eligibility and approval does not grant the employer any rights or interest in participation with the SEE Program, and the Department is not obligated to refer or place any SEE participants with the employer.

C. The employer may dispute a non-payment or amount of an eligible reimbursement payment through a written request to the Department no later than thirty (30) calendar days from the date of the non-payment notice.

NOTE: The employer may refer to Chapter 17-795, Hawaii Administrative Rules (HAR), for additional SEE Program

policies, eligibility, and participation requirements for SEE employers. Program rules are available through

the Department’s website at <http://humanservices.hawaii.gov/admin-rules-2/admin-rules-for-programs/>.

|  |  |  |  |
| --- | --- | --- | --- |
| ***Authorized Representative*** | | | |
| Employer Representative: |  | Position Title: |  |
|  | (Print First and Last Names) |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Phone: |  | Fax: |  | Mobile: |  |

|  |  |
| --- | --- |
| Email Address: |  |

|  |
| --- |
| I hereby certify that I am  legally authorized  have delegated authority to act and sign on behalf of the above-mentioned employer. By my signature below, I attest to having read the aforementioned requirements and agree with the stated conditions. |

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
| Signature of Authorized Representative |  | Date |