

EMPLOYER APPLICATION FOR REFUND OF TAXES PAID TO THE STATE OF TEXAS

Temporary Assistance for Needy Families (TANF)

2. ■

NOTE: Complete a separate form for each eligible employee, to be filed ONLY on or after January 1, 2010 and before April 1, 2010 (for wages paid in 2009).

1. T code ■ 58100


TWC #1098

EMPLOYER INFORMATION

3. Texas taxpayer number ■		Period of claim m m d d y y		4. Begin date ■		5. End date ■	
6. Taxpayer name				8. Blacken this box if your address has changed..... <input type="checkbox"/> 1 ■ FM			
7. Address				9. FOR COMPTROLLER USE ONLY			
City		State		ZIP Code		<input type="checkbox"/> 2 ■ INV <input type="checkbox"/> 3 ■ SD	
Contact person				Telephone (Area code and number)			
Contact person street address (if different from above)				City		State	
				State		ZIP Code	

NOTE: If this form is being completed by an agent of the taxpayer, a power of attorney must be attached to this form.

EMPLOYEE INFORMATION / RELEASE AUTHORIZATION


10. Name (Last) ■		11. First ■		12. Middle initial ■		13. Social Security number ■	
14. Employment start date ■				15. Employment termination date (if applicable)			
I hereby give my permission to the Texas Workforce Commission to certify to this employer or to the Texas Comptroller of Public Accounts that I was a recipient of financial assistance under TANF or MEDICAID any month within 6 months of my beginning date of employment.							
 16. Employee's signature						17. Date	

REFUND CALCULATION

18. Total Wages paid DURING Claim Period in Items 4 and 5 above 18. ■ _____
19. Eligible Wages [Multiply Item 18 by 20% (.20)] 19. _____
20. Maximum Claim allowed per employee 20. **\$2,000.00**
21. Refunds previously claimed for this employee 21. _____
22. Maximum eligible refund for employee (Item 20 minus Item 21) 22. _____
23. Refund claimed for 2009 (Enter the smaller of Item 19 or Item 22) 23. ■ _____


NOTE: The refund issued for all employees will not exceed net taxes paid and postmarked for state sales and use, franchise, boat and boat motor, inheritance, PUC gross receipts, hotel and/or manufactured housing after any applicable credits, in the calendar year that this claim covers.

EMPLOYER'S STATEMENT REGARDING INSURANCE

24. I certify that this taxpayer/employer provides to and pays for the benefit of this employee a part of the cost of health insurance provided under: Check all that apply: <input type="checkbox"/> HMO Plan <input type="checkbox"/> Self-Funded or Self-Insured ERISA Plan <input type="checkbox"/> Health Plan approved by Commissioner of Insurance			
HEALTH INSURANCE PROVIDER			
25. Name		27. Group no.	
26. Street address		28. Policy no. and effective date	
City, State, ZIP Code		29. Telephone (Area code and number)	
I further certify under penalty of perjury that the information I have provided on this application is true and complete to the best of my knowledge and belief.			
 30. Employer or authorized person			Date

ALL RECORDS ARE SUBJECT TO AUDIT REVIEW. Employer must maintain records to support all information. If supporting documentation is needed to verify your claim, you will be contacted.

TWC CERTIFICATION

I hereby certify that the above named individual was a recipient of TANF or Medicaid any month within 6 months of the start date.	
 31. Authorized TWC Employee	Date

