Application for Certification*

Tax Credit Program for Employers of Employees with Impairments
Impacted by Increase in Minimum Wage under P.L. 2019, c. 32 (C.34:11-56a4.9 et seq.)

Legal Business Name	Federal Employer ID (FEIN)
Business Location Address	Mailing Address (if different)

Number of *employees with an impairment* for whom the employer is seeking the tax credit _____

"**Employee with an impairment**" means an employee earning at least the minimum wage on February 4, 2019, whose work capacity is significantly impaired by age or physical or mental deficiency or injury and who, based on a determination by the State, is found eligible for personal assistance services or prescribed drugs because without such services or drugs the individual would be unable to perform the essential functions of the employment position that the individual holds.

For each employee with an impairment, an Attachment A must be submitted.

☐ I certify that each employee for whom I am seeking this tax credit and for whom I am submitting an Attachment A to this form is an "employee with an impairment," as that term is defined above.

☐ I certify that upon request I will produce records to demonstrate that each employee for whom I am seeking this tax credit is an "employee with an impairment," as that term is defined above.

☐ I certify that each "employee with an impairment" for whom I am seeking this tax credit received an increase in wages during the tax year for which I am seeking the tax credit, compared to the wages received by that employee during the last preceding calendar year, and that this increase in wages was caused by the increase in the minimum wage under N.J.S.A. 34:11-56a4.9 et seq.

☐ I understand that, under the law, if I have knowingly made a false representation that an employee is an "employee with an impairment," this will be considered a violation of the applicable State tax law and I will be subject to **three times** the amount of penalties otherwise provided; and further, that for the particular violation(s), the penalty will not be waived, including during tax years 2019 and 2020.

Responsible Officer's Name	E-Mail
Responsible Officer's Signature	Date

*This form is subject to change, including through subsequent rulemaking in accordance with N.J.S.A. 34:11-56a41.

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ATTACHMENT A
EMPLOYEE INFORMATION

Employee Name	Employee Social Security Number
Employee Home Address	Employee Mailing Address (if different)
Tax Year Applied For	Current Hourly Rate
Business Name	FEIN

Hourly Rate Increase

Amount of Increase	Date(s) of Increase

		Q1	Q2	Q3	Q4
Hours Worked*	by quarter for Tax Year applied for				
	by quarter in previous Calendar Year				
Gross Wages	Paid for Tax Year applied for				
	Paid in previous Calendar Year				
Hourly Rate	Paid for Tax Year applied for				
	Paid in previous Calendar Year				
UI/DI Contribution Rate	Paid for Tax Year applied for				
	Paid in previous Calendar Year				

* "Hours Worked" means the time the employee is required to be at their place of work or on duty. Hours worked does not include hours the employee is not required to be at their place of work because of holidays, vacation, lunch hours, illness and similar reasons. See N.J.A.C. 12:56-5.2.

HOW TO FILE

Application and attachment(s) must be submitted together.
Send your completed materials by mail:

Attn: Renee Montague
Division of Employer Accounts
NJ Dept. of Labor and Workforce Development
P.O. Box 947
Trenton, NJ 08625-0947

or fax: 609-292-7801 **or email:** *Renee.Montague@dol.nj.gov*