Local LISC Office: ____________

LISC AmeriCorps New Member Enrollment Checklist

Placement Site			
Site Supervisor Name:		Email:	
Member Name:		Email:	
Member Term of Service (# hrs.):			
Service Dates:	Start:	End:	

Enrollment Documents

Document Name	1,700	900	450	300
Service Description	❑	❑	❑	❑
CORI Part I: Sex Offender Check – free at www.nsopr.gov	❑	❑	❑	❑
CORI Part II: State Check	❑	❑	❑	❑
CORI Part III: FBI Check – if applicable	❑	❑	❑	❑
Commitment Letter to Member	❑	❑	❑	❑
LISC AmeriCorps Application	❑	❑	❑	❑
CNCS Enrollment Form	❑	❑	❑	❑
I-9 Form & Documentation ❑ US Passport and/or Certificate of Naturalization ❑ Birth Certificate & State Driver License ❑ Birth Certificate & State Non-Driver License ❑ Resident Alien card with Work Authorization ❑ Foreign VISA with a valid form 1-94 & Form I-551	❑	❑	❑	❑
Request for Employee (RFE)	❑	❑	n/a	n/a
W-4	❑	❑	n/a	n/a
Direct Deposit *(optional)*	❑	❑	n/a	n/a
Photo Release	❑	❑	❑	❑
Drug Free Workplace	❑	❑	❑	❑
Health Care and Childcare Enrollment/ Waiver	❑	n/a	n/a	n/a
Member Agreement *(signed and dated prior to member's start date)*	❑	❑	❑	❑
Parental Consent (if member is under 17 at the start of service)	❑	❑	❑	❑

Other Required Documents

Document Name	1,700	900	450	300
Member Performance Measurement Worksheets	❑	❑	❑	❑
Six Month Appraisal *(required for members serving 12 month periods)*	❑	❑	n/a	n/a
Final Performance Appraisal *(required for all members)*	❑	❑	❑	❑
Grant Agreement *(generated in Grants Department via PA System)*	❑	❑	n/a	n/a
Placement Site Agreement *(generated in NY in AmeriCorps department)*	❑	❑	❑	❑

Exit Documents

Document Name	1,700	900	450	300
CNCS Member Exit Form	❑	❑	❑	❑
Member Exit Survey	❑	❑	❑	❑

Updated 08.01.11

LISC *Helping neighbors build communities*

LISC AmeriCorps Application

I. PARTICIPANT PROFILE

1. Name: Last_______________ First_______________ Mi_______________
2. Date of Birth (Month/Day/Year)_______________
3. Current Address_______________
   City_______________ State_______________ Zip_______________
4. Permanent Address_______________
   City_______________ State _______________ Zip_______________
5. Telephone Number: Daytime _(___)_______________ Evening (___)_______________
6. Are you a U.S Citizen Yes No or Permanent Resident Alien? Yes No
7. Date of Availability: Month _______________ Year_______________
8. Geographic Preference: Eastern USA Midwest USA West Pacific/Northwest
9. What High School did you graduate from (Name/City/State)? _______________
10. Have you served previously with AmeriCorps or any other National Service program, i.e., Public Allies, NCCC, Learn & Serve, etc? If yes, please provide the following information:

Name of Program	Location	From	To

II. EMPLOYMENT HISTORY

Please include any self-employment, home management, military service, full or part-time, salaried employment. Start with your current or most recent experience. Photocopy this page if additional sheets are necessary. You may include a resume in place of completing this section.

A. Employer	Title	Phone	
Address			
Name of Supervisor			
Responsibilities	Hours per week	From	To
	Reason for leaving:		

B. Employer	Title	Phone	
Address			
Name of Supervisor			
Responsibilities	Hours per week	From	To
	Reason for leaving:		

B. Employer	Title	Phone	
Address			
Name of Supervisor			
Responsibilities	Hours per week	From	To
	Reason for leaving:		

Last updated 08.05.11

III. PERSONAL STATEMENT

Please answer the following questions on an attached sheet. Each reponse should not exceed 500 words.

- Please describe why you are interested in AmeriCorps and what you hope to contribute to the program and the community you will be serving. You may address specific skills you have and practical experiences you have had that can be applied to your service and how they relate to the specific area(s) of interest you would like taken into consideration during your placement (i.e. youth, education, community beautification, or housing).

VI. COMMUNITY ACTIVITIES & SKILLS

- Please describe any service work you have performed in your community, the challenges, if any, that you experienced, and how you address such challenges. Describe the types of service and the dates of involvement. Include social, school, professional, and neighborhood projects and programs. If you have not undertaken any service work, please describe a situation where you demonstrated commitment to collaborate with others to achieve a common goal.

VII. REFERENCES

Please list three individuals whom we may contact as references. We encourage you to list people who know you well, such as employers, teachers, representatives of volunteer organizations, or community members. Do not include the name of a relative.

1.Name
Address
City, State, Zip
Telephone Number ( )
Relationship
2.Name
Address
City, State, Zip
Telephone Number ( )
Relationship
3.Name
Address
City, State, Zip
Telephone Number ( )
Relationship

VIII. EDUCATIONAL BACKGROUND

1. Graduate/Professional degree
2. Graduate/Professional study
3. College graduate
4. Some college
5. Technical school/Apprenticeship
6. Associate degree
7. High school graduate
8. GED
9. Less than high school completed
10. Other, specify________________

IX. OPTIONAL INFORMATION

Providing the information in this section is optional and will not affect your selection.

1. Describe your ethnic background:
   - American Indian or Alaska Native
   - Native Hawaiian or Other Pacific Islander
   - Black or African American
   - White non-Hispanic
   - Hispanic/Latino
   - Asian
   - ____________________

2. Do you have any special needs that require accommodations: Yes No

   If yes, please specify____

Last updated 08.05.11

X. LEGAL

Existence of a criminal conviction/adjudication may or may not, depending on the circumstances, disqualify you from consideration. However, misrepresentation of that record – lying or not telling the whole truth – will disqualify you. Answer the following questions fully. We reserve the right to run background/security checks as needed.

1. Have you ever been convicted, or adjudicated as a juvenile offender, of any criminal offense by a civilian or military court? Do not include minor traffic violations (if no, skip to section X)

   Yes (If you answered yes then complete Questions 2 through 4.)
   No

2. Are you now under charges for any offenses or are any civil suits or judgement pending against you? (Do not include charges for minor traffic offenses.)

   Yes
   No (if you answered no, skip to Section X.

   Date: ______________________ Place: ______________________

3. ARE YOU NOW ON PROBATION OR PAROLE? Yes No

4. Provide the name, address and phone number of the court, probation officer, or parole officer who we can contact to verify the above information.

   Name: ______________________ Title: ______________ Phone No. ______________

   Address: ____

It is the intention of the LISC AmeriCorps program to provide all individuals that apply for a LISC AmeriCorps position an equal opportunity to be selected for service. It is also important in the interest of fairness to all applicants and potential applicants that providing such opportunities not create situations where a conflict of interest could arise. This policy is intended to minimize the potential for conflicts of interest in the application and selection process.

Please disclose if you can be considered an immediate relation to: (1) a current LISC employee; (2) an employee of this organization (placement site); (3) a member of the board of directors of this organization (placement site); (4) a LISC local advisory committee member; or (5) any person who has a consultant relationship with either LISC or the organization.

Yes, I am an immediate relation (indicate relationship) ______________________________

No, I am not an immediate relation.

XI. CONSENT FOR CRIMINAL BACKGROUND CHECK & CERTIFICATION

To the extent permitted by state and local law in the jurisdiction where the Member is placed in service, the Member hereby agrees to allow LISC or the placement site conduct a criminal history record check on him/her. Applicants/Members have the right to be treated fairly and have their privacy respected. Applicants/Members will be given the opportunity to challenge the accuracy of information that LISC and/or the placement site receives.

All applications must be signed by the applicant. By signing this application, you are stating that all of the information provided is true to the best of your knowledge.

Signature ______________________________ Date ______________________

Last updated 08.05.11

National Service Trust Enrollment Form

Corporation for NATIONAL & COMMUNITY SERVICE

Completion of this form is required to enroll a serving member in the National Service Trust, making the member eligible for an education award upon successful completion of his or her term of service. It also provides the Corporation for National and Community Service with basic demographic data.

PART 1 — Member: Please Complete and Sign

1. Name ______________________ Last ______________________ First ______ MI

2. Date of Birth ________ Month ______ Day ______ Year   3. Social Security Number ____________________

4. Citizenship Status ☐ I am a U.S. Citizen or National * ☐ I am a Lawful Permanent Resident Alien of the United States **

*Citizens of the US include persons born in Puerto Rico, Guam, the US Virgin Islands, and the Northern Mariana Islands. Nationals of the US include persons born in America Samoa, including Swains Island.

**Generally, you are a Lawful Permanent Resident Alien of the US if you are a US permanent resident with (i) a Permanent Resident Card, INS Form I-551; (ii) an Alien Registration Receipt Card, INS Form I-551, (iii) a passport indicating that the INS has approved it as temporary evidence of lawful admission for permanent residence; or (iv) an I-94 indicating that the INS has approved it as temporary evidence of lawful admission for permanent residence. NOTE: A student visa does not confer eligibility to enroll in an AmeriCorps program.

5. School Status ☐ I have received a high school diploma or its equivalent

☐ I agree to obtain a high school diploma or its equivalent before using my educational award, and I did not drop out of elementary school or secondary school to enroll in the program.

6. Current Address (All information will be sent to you at this address until you notify the Corporation of a change of address.)

Number and Street ____________________

City ____________________ State ________ Zip Code ________ ________

Email Address ____________________

Home Phone ____________________ Business Phone ____________________ Ext ________

7. Permanent Address (Name and address of person through whom you can always be reached once you leave the program.)

Last ____________________ First ____________________ MI ______

Number and Street ____________________

City ____________________ State ________ Zip Code ________ ________

Email Address ____________________

Home Phone ____________________ Business Phone ____________________ Ext ________

8. Have you previously enrolled in an AmeriCorps, Silver Scholar, or Serve America Fellow Program? No ☐ Yes ☐ How many times?

9. Have you ever been released 'for cause' by any AmeriCorps, Silver Scholar, or Serve America Fellow program? No ☐ Yes ☐.

10. Education Award Limitations. I understand that I may not receive more than the aggregate value of two full-time education awards and that upon successful completion of the term of service, I will receive only that portion of the education award for which I am eligible, which may be all or a part of an education award, or no education award, pursuant to 45 CFR § 2526.55

PART 2 — Member Enrollment Certification

By signing this enrollment form I agree, if asked, to provide documentation to verify the accuracy of the information I have provided in this form. I understand that a knowing and willful false statement on this form can be punished by one or more of the following: a fine or imprisonment or both under Section 1001 of Title 18, U.S.C., exclusion from participation in federal programs, and forfeiture of benefits I may receive as a result of my enrollment or other actions authorized by the Civil Fraud Remedies Act, 31 USC 3801-3812.

Member's Signature ______________________________ Date ______________

PART 3 — Member: Please Answer the Following Questions

1. What is your gender?

☐ Female ☐ Male

2. Are you registered to vote?

☐ Yes
☐ No
☐ Not sure
☐ Not eligible
☐ Prefer not to respond

3. Which of the following categories best describes your racial (mark one or more) or ethnic origins (mark one)

A. Race

☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American
☐ White
☐ Asian
☐ Other

B. Ethnicity

☐ Hispanic or Latina/o
☐ Not Hispanic or Latina/o

4. What is the highest level of education you have completed?

☐ Less than high school completed
☐ GED
☐ High school graduate
☐ Technical school/apprenticeship/vocational
☐ Some college
☐ Associates degree (AA)
☐ College graduate
☐ Some graduate school
☐ Graduate degree
☐ Professional degree (medical, law)

5. Are you a veteran of the United States Armed Forces?

☐ Yes ☐ No

6. What are the two most important reasons why you decided to join this program?

☐ To get an education award
☐ To help other people/perform a community service
☐ To be part of a national movement
☐ To get a job/earn money
☐ Friends have joined
☐ To make friends
☐ To learn about or work with different ethnic/cultural groups
☐ Parents/teachers wanted me to join
☐ To explore future job/education interests
☐ To get involved in health issues
☐ To get involved in education issues
☐ To get involved in environment issues
☐ To get involved in public safety issues
☐ Other (Specify: ______________________)

7. How did you hear about this program? (Mark all that apply.)

☐ Article
☐ Advertisement in a newspaper/magazine
☐ Guidance counselor/teacher
☐ Parent/relative
☐ Current or former AmeriCorps Member
☐ Friend told me/friend applied
☐ TV commercial
☐ Radio commercial
☐ The Internet
☐ AmeriCorps recruiter/representative
☐ Received information in the mail
☐ AmeriCorps program poster
☐ Other (Specify: ______________________)

8. Privacy Act Information Release

☐ Yes, I give the Corporation for National and Community Service permission to release my name, address, email and telephone number to the AmeriCorps Alumni Association.

Public reporting burden -- Estimated time to complete this form, including time for reviewing instructions and gathering and providing the information needed to complete the form, is 3 minutes for the Member section and 4 minutes for the Certifying Official section. Send comments regarding this burden or the content of this form to: Corporation for National and Community Service, National Service Trust, 1201 New York Avenue, NW, Washington, DC 20525. The Corporation informs the potential persons who are to respond to this collection of information that such persons are not required to respond to the collection of information unless it displays a currently valid OMB control number on this page of the form (see 5CFR 1320.5(b)(2)(1))

Privacy Statement -- In compliance with the Privacy Act of 1974, the following information is provided: The collection of this information is authorized by the provisions of the National and Community Service Act of 1990, by the National and Community Service Trust Act of 1993, and the Serve America Act of 2009. The primary purpose of the information is to obtain from AmeriCorps program representatives their data to successfully enroll a member in a term of service and the education award program. The evaluative information will help the Corporation improve its programming and services to members. Information may also be provided to federal, state, and local agencies for law enforcement purposes. Information will not otherwise be disclosed outside the Corporation without written permission. The Internal Revenue Service has determined that the education award is taxable in the year it is used. Your Social Security Number (SSN) is solicited under the authority of the Internal revenue Code (26 U.S.C. 6011© and 6109) for use as a taxpayer identification number. Failure to disclose the SSN or any other information may result in a denial of your receiving an education award or it may delay the processing of your education award. In furtherance of the Corporation's efforts to ensure that the programs are inclusive of persons with disabilities, your Social Security Number may be released to the Social Security Administration to measure aggregate statistical data on the number of AmeriCorps members receiving disability-based benefits. If you do not wish your personal information to be included in this research, mark "prefer not to respond" under question 6.

OMB Approval No.3045-0006

Filling out I-9 Documentation

FIRST: Please fill out Section #1 of the I-9 form in its entirety. When filling out the requested information, please write in print. Make certain to check the correct box when attesting your U.S. citizenship classification. Lastly, sign and date the form.

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification (To be completed and signed by employee at the time employment begins.)

Print Name: Last | First | Middle Initial | Maiden Name

Address (Street Name and Number) | Apt. # | Date of Birth (month/day/year)

City | State | Zip Code | Social Security #

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- ☐ A citizen of the United States
- ☐ A noncitizen national of the United States (see instructions)
- ☐ A lawful permanent resident (Alien #) ____________
- ☐ An alien authorized to work (Alien # or Admission #) ____________ until (expiration date, if applicable - month/day/year)

Employee's Signature | Date (month/day/year)

Preparer and/or Translator Certification (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature | Print Name

Address (Street Name and Number, City, State, Zip Code) | Date (month/day/year)

SECOND: Please provide the local LISC office administrator the following documentation as proof of citizenship:

- US Passport and/or Certificate of Naturalization.

If you **DO NOT** have either US Passport or Certificate of Naturalization please provide:

- your Birth Certificate AND State Drivers License;
- Birth Certificate & State Identification Card;
- Resident Alien card with Work Authorization; or
- Foreign VISA with a valid form I-94 & Form I-551

Section 2. Employer Review and Verification (To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)

	List A	OR	List B	AND	List C
Document title:					
Issuing authority:					
Document #:					
Expiration Date (if any):					
Document #:					
Expiration Date (if any):					

Department of Homeland Security
U.S. Citizenship and Immigration Services

OMB No. 1615-0047; Expires 08/31/12

Form I-9, Employment Eligibility Verification

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification *(To be completed and signed by employee at the time employment begins.)*

Print Name: Last | First | Middle Initial | Maiden Name

Address *(Street Name and Number)* | Apt. # | Date of Birth *(month/day/year)*

City | State | Zip Code | Social Security #

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- ☐ A citizen of the United States
- ☐ A noncitizen national of the United States (see instructions)
- ☐ A lawful permanent resident (Alien #) ______
- ☐ An alien authorized to work (Alien # or Admission #) ______ until (expiration date, if applicable - *month/day/year*) ______

Employee's Signature | Date *(month/day/year)*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature | Print Name

Address *(Street Name and Number, City, State, Zip Code)* | Date *(month/day/year)*

Section 2. Employer Review and Verification *(To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)*

	List A	OR	List B	AND	List C
Document title:					
Issuing authority:					
Document #:					
Expiration Date *(if any)*:					
Document #:					
Expiration Date *(if any)*:					

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* ______ and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative | Print Name | Title

Business or Organization Name and Address *(Street Name and Number, City, State, Zip Code)* | Date *(month/day/year)*

Section 3. Updating and Reverification *(To be completed and signed by employer.)*

A. New Name *(if applicable)* | B. Date of Rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: | Document #: | Expiration Date *(if any)*:

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative | Date *(month/day/year)*

Name of City Where Member is Serving
Mandatory for Michigan Programs

LOCAL INITIATIVES SUPPORT CORPORATION
501 SEVENTH AVENUE, 7TH FLOOR
NEW YORK, NY 10018

REQUEST FOR EMPLOYEE

Date:	Department: AmeriCorps	Job Title: AmeriCorps Member

Annual Stipend: $18,000

Hourly Salary: $

Effective Date: / /	Temporary:	Part time:	Full time: X

Grade:	Exempt: -	Non-exempt: -

Explanation: LISC AmeriCorps member placed at ____________________

Requested by (Local LISC Administrator Signature):

PERSONAL DATA – To Be Completed by the AmeriCorps Member

Name: Social Security #: _ _

Address:

City: State: Zip:

Date of Birth: / / Age: Sex: Marital Status:

Ethnicity: ___White ___Black ___Hispanic ___Asian/Pacific Islander ___Native American

Number of Dependents:_____ Home phone: ( )
Emergency contact:
Relationship: Home phone: ( ) Business phone: ( )

CFO Budget Check	Human Resources Check	VP Approved Check

CENTER TO CHARGE		Account Code	Payroll	Health/ Wk Comp
	CNCS	13-17-311378		
	LISC	13-17-110000		
	Site	13-17-113000		

Form W-4 (2011)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2011 expires February 16, 2012. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $950 and includes more than $300 of unearned income (for example, interest and dividends).

Basic instructions. If you are not exempt, complete the Personal Allowances Worksheet below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the Personal Allowances Worksheet below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2011. See Pub. 919, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for yourself if no one else can claim you as a dependent . . . . . . A ____

B Enter "1" if:
- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.

. . . . B ____

C Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . C ____

D Enter number of dependents (other than your spouse or yourself) you will claim on your tax return . . . . D ____

E Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above) . . E ____

F Enter "1" if you have at least $1,900 of child or dependent care expenses for which you plan to claim a credit . . . F ____
(Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.
- If your total income will be less than $61,000 ($90,000 if married), enter "2" for each eligible child; then less "1" if you have three or more eligible children.
- If your total income will be between $61,000 and $84,000 ($90,000 and $119,000 if married), enter "1" for each eligible child plus "1" additional if you have six or more eligible children . . . . G ____

H Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) ▶ H ____

For accuracy, complete all worksheets that apply.
- If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2.
- If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed $40,000 ($10,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld.
- If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.

Cut here and give Form W-4 to your employer. Keep the top part for your records.

Form **W-4** — Department of the Treasury, Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.

OMB No. 1545-0074 — **2011**

1 Type or print your first name and middle initial. | Last name | 2 Your social security number

Home address (number and street or rural route) | 3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate.
Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.

City or town, state, and ZIP code | 4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ ☐

5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2) 5 ____

6 Additional amount, if any, you want withheld from each paycheck . . . . 6 $ ____

7 I claim exemption from withholding for 2011, and I certify that I meet both of the following conditions for exemption.
- Last year I had a right to a refund of all federal income tax withheld because I had no tax liability and
- This year I expect a refund of all federal income tax withheld because I expect to have no tax liability.

If you meet both conditions, write "Exempt" here . . . . ▶ 7 ____

Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ▶ Date ▶

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.) | 9 Office code (optional) | 10 Employer identification number (EIN)

For Privacy Act and Paperwork Reduction Act Notice, see page 2. Cat. No. 10220Q Form **W-4** (2011)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1 Enter an estimate of your 2011 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions . . . . **1** $______

2 Enter: { $11,600 if married filing jointly or qualifying widow(er) / $8,500 if head of household / $5,800 if single or married filing separately } . . . . **2** $______

3 Subtract line 2 from line 1. If zero or less, enter "-0-" . . . . **3** $______

4 Enter an estimate of your 2011 adjustments to income and any additional standard deduction (see Pub. 919) **4** $______

5 Add lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2011 Form W-4 Worksheet* in Pub. 919.) . . . . **5** $______

6 Enter an estimate of your 2011 nonwage income (such as dividends or interest) . . . . **6** $______

7 Subtract line 6 from line 5. If zero or less, enter "-0-" . . . . **7** $______

8 Divide the amount on line 7 by $3,700 and enter the result here. Drop any fraction . . . . **8** ______

9 Enter the number from the **Personal Allowances Worksheet**, line H, page 1 . . . . **9** ______

10 Add lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet**, also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 **10** ______

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1 Enter the number from line H, page 1 (or from line 10 above if you used the Deductions and Adjustments Worksheet) **1** ______

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3" . . . . **2** ______

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet . . . . **3** ______

Note. If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet . . . . **4** ______

5 Enter the number from line 1 of this worksheet . . . . **5** ______

6 Subtract line 5 from line 4 . . . . **6** ______

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . **7** $______

8 Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . **8** $______

9 Divide line 8 by the number of pay periods remaining in 2011. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2010. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . . **9** $______

Table 1

Married Filing Jointly		All Others	
If wages from LOWEST paying job are—	**Enter on line 2 above**	**If wages from LOWEST paying job are—**	**Enter on line 2 above**
$0 - $5,000 -	0	$0 - $8,000 -	0
5,001 - 12,000 -	1	8,001 - 15,000 -	1
12,001 - 22,000 -	2	15,001 - 25,000 -	2
22,001 - 25,000 -	3	25,001 - 30,000 -	3
25,001 - 30,000 -	4	30,001 - 40,000 -	4
30,001 - 40,000 -	5	40,001 - 50,000 -	5
40,001 - 48,000 -	6	50,001 - 65,000 -	6
48,001 - 55,000 -	7	65,001 - 80,000 -	7
55,001 - 65,000 -	8	80,001 - 95,000 -	8
65,001 - 72,000 -	9	95,001 -120,000 -	9
72,001 - 85,000 -	10	120,001 and over	10
85,001 - 97,000 -	11		
97,001 -110,000 -	12		
110,001 -120,000 -	13		
120,001 -135,000 -	14		
135,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from HIGHEST paying job are—	**Enter on line 7 above**	**If wages from HIGHEST paying job are—**	**Enter on line 7 above**
$0 - $65,000	$560	$0 - $35,000	$560
65,001 - 125,000	930	35,001 - 90,000	930
125,001 - 185,000	1,040	90,001 - 165,000	1,040
185,001 - 335,000	1,220	165,001 - 370,000	1,220
335,001 and over	1,300	370,001 and over	1,300

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

LISC
Helping neighbors build communities

REQUEST FOR DIRECT DEPOSIT OF LIVING STIPEND

This request will serve as authorization for LISC to directly deposit my living stipend check into the following account(s). I understand that the request takes a minimum of two pay periods to become final and that I will receive a regular stipend check until the process has been completed. **Attached is a voided blank check from my checking account and/or a letter from my from my financial institution that indicates their routing and transit number for automatic deposits.**

BANK NAME: ____________________

BANK ADDRESS: ____________________

ACCOUNT TYPE (PLEASE INDICATE)

☐ CHECKING ☐ SAVINGS ☐ MONEY MARKET

ACCOUNT NUMBER: ____________________

ACCOUNT NAME: ____________________

ATTACHMENT (PLEASE CHECK ONE)

☐ A VOIDED BLANK CHECK IS ATTACHED

☐ A LETTER FROM MY FINANCIAL INSTITUTION IS ATTACHED

MEMBER SIGNATURE ____________________

MEMBER E-MAIL ADDRESS ____________________

Please Note:

- ***Stipend payments are sent via regular US Mail to the address on the Request for Employee form***
- ***Stipend payments are mailed on the actual pay date***
- ***Your direct deposit will be in effect until 08/15/2012***

Permission to Use Photographs and Video Images

I do hereby grant to Local Initiatives Support Corporation and its affiliates and subsidiaries (collectively, "LISC"), its representatives and assigns, including any photographer, videographer, or other agent acting on behalf of LISC, the full right and permission to use, publish and produce photographic pictures, video, or other images of me or in which I may be included, in whole or in part, without restriction, in connection with publications or other printed matter, video, or slide presentations or in any other form or media, prepared by or for LISC for illustration, public relations, or any other purpose that is connected to and furthers LISC's charitable mission.

I also release and discharge LISC, its representatives and assigns, including any photographer, videographer, or agent acting on behalf of LISC, from any claim by virtue of any lack of clarity or imperfection that may occur or be produced in the taking or use of the photographs, video, or other images, or in any subsequent processing thereof, as well as in any publication thereof.

Name: ______________________________

Date: ______________________________

Signature: ______________________________

LISC has regulatory requirements under some of our government contracts. One of the requirements is that LISC establish a formal drug free workplace policy, noted below. In addition, we must document that every member is aware of the policy. Please read and acknowledge receipt of the policy by signing and returning for inclusion in your personnel file.

LISC AMERICORPS MEMBER DRUG FREE WORKPLACE POLICY

It is the policy of LISC AmeriCorps to maintain a workplace that is free from the effects of drug and alcohol abuse. All members are prohibited from the use, sale, dispensing, distribution, possession or manufacture of controlled substances, and abusing alcohol. Drug use and alcohol abuse, in the workplace reduces effective job performance, increases absenteeism and endangers safety.

Any member who violates this policy will be subject to disciplinary action, which may include suspension, dismissal or other appropriate personnel action, and may also be required to participate satisfactorily in an approved drug abuse assistance or rehabilitation program.

Members will be assisted in seeking treatment. Members who seek referrals to local rehabilitation and counseling programs should contact the LISC AmeriCorps Director at 212-455-9800.

As a condition of service, and continued service, all members must abide by this Drug-Free Workplace Policy, and must notify LISC AmeriCorps® of any criminal drug statute charge, arrest or conviction for a violation occurring in the workplace no later than five days after such charge, arrest or conviction. Notices should be sent to: Program Director, LISC AmeriCorps Program, 501 7th Avenue, 7th Floor, New York, 10018.

____

Signature Date

LISC
Helping neighbors build communities

Health Care Plan & Childcare Assistance Enrollment Form
LISC AmeriCorps Participants

Participant Name ____________ Social Security Number ____________ Date of Birth ____________

Number and Street ____________________________

City ____________ State ____________ Zip Code ____________

Please check if you are enrolling or waiving Healthcare coverage.

☐ I am enrolling in the **HEALTH CARE PLAN** for AmeriCorps Members and I hereby certify that I am not otherwise covered by a health care policy. My signature also acts as acknowledgement that have received and read Continuation of Coverage Notice (included in enrollment package)

Please note: A photocopy of your ID card from your other insurance carrier must accompany this form

I have been offered **Health Care** coverage under the NASCC Insurance plan, but I am declining **Health Care** coverage because:

☐ I am already covered by another plan as a subscriber or a dependant.
Insurance Company Policy #

☐ Other: Please Explain: ____________________________

Please check if you are enrolling or waiving Childcare Assistance.

☐ I am enrolling in the **CHILDCARE ASSISTANCE PLAN** for AmeriCorps Members. My signature certifies that I am not otherwise covered by a childcare policy.

I understand that the only reason I will be able to obtain coverage under this plan in the future is if, through no fault of my own, I lose my other coverage and I apply for the plan within 31 days of the loss.

☐ I am not enrolling in the **Childcare Assistance Plan** for AmeriCorps Members as either I am otherwise covered; or, I am neither a parent nor a legal guardian. My signature acknowledges that I waive coverage under this plan.

____
Participant Signature

NOTICE OF COBRA RIGHTS

LISC
501 7th Avenue
7th Floor
New York, NY 10018

Via Member Enrollment Package

Dear AmeriCorps member:

NOTICE OF AMERICORPS MEMBER GROUP HEALTH PLAN CONTINUATION COVERAGE

VERY IMPORTANT NOTICE

A Federal law, commonly known as "COBRA," requires that **Local Initiatives Support Corporation – AmeriCorps Program** ("Sponsoring Organization") offers participating LISC AmeriCorps members the opportunity to extend Sponsoring Organization group health plan ("Plan") coverage (called "continuation coverage") at group rates in certain instances when coverage otherwise would end. This notice explains, in summary fashion, your rights and obligations under the continuation coverage provisions of COBRA. You should read this notice carefully.

When Am I Entitled to Continuation Coverage?

If you meet the eligibility requirements and are covered by the Plan as a participating LISC AmeriCorps member, you have the right to choose continuation coverage if you lose coverage for either of the following reasons:

(1) Your hours of service with the Sponsoring Organization are reduced.

(2) Your service with the Sponsoring Organization has ended (for reasons other than gross misconduct on your part).

What Health Information Must I Provide?

If you are currently covered by the plan and lose coverage, you do not have to show that you are insurable to choose continuation coverage.

Who Has the Responsibility of Providing Notice of Various COBRA Events?

Under COBRA, each covered AmeriCorps member must notify the Plan Administrator of the determination that he or she was disabled (as defined in the Social Security Act) at the time of the member's end of service or reduction in hours. You must give this notice within 60 days after the date of such determination. You also must notify the Plan Administrator within 30 days after the date that it is determined that you are no longer disabled.

When the Sponsoring Organization determines that a participating LISC AmeriCorps member has ended service, the Sponsoring Organization will in turn notify you whether you have the right to choose continuation coverage, and if so, will provide an election form.

You must notify the Sponsoring Organization in writing if you want continuation coverage within 60 days of the date you lose coverage or the date of the Sponsoring Organization's notice, whichever is later.

How Long Does My Continuation Coverage Last?

If you do not choose continuation coverage, your group health coverage under the Plan will end.

If you choose continuation coverage, your coverage will be identical to the coverage provided under the Plan to similarly situated participating LISC AmeriCorps members, as of the time coverage is being provided. This means that if the coverage for similarly situated participating LISC AmeriCorps members is modified, your coverage will be modified in the same manner. Your continuation coverage period generally will be 18 months if you lost coverage because of ending service, or if a reduction in hours of service occurs. Nonetheless, the 18-month coverage period will be extended in the following situation. The period of continuation coverage may be extended to 29 months if you are determined to be disabled by the Social Security Administration at the time your service ended or reduction in hours of service, provided you notify the Plan Administrator within 60 days of the date of such determination and within the 18-month period.

Are There Any Circumstances In Which My Continuation Coverage May Be Cut Short?

Your continuation coverage may be cut short for *any* of the following reasons:

(1) You become covered under any other group health plan (as an employee or otherwise) that does not contain any exclusion or limitation for any preexisting conditions clause that applies to you.

(2) The premium for your continuation coverage is not paid within 15 days of the due date.

(3) The Sponsoring Organization no longer provides any group health coverage to LISC AmeriCorps members.

(4) You are determined to be no longer disabled by the Social Security Administration.

How Much Do I Have to Pay for Continuation Coverage?

You must pay the entire Plan premium in order to obtain continuation coverage. The rate includes a 2% administrative fee. If the maximum coverage is extended from 18 months to 29 months due to a disability, the required payment is 150% of the premium for the 19th and all succeeding months. As of July 1, 2011 the current cost for coverage is $143.84 per month.

When Do I Pay for Continuation Coverage?

Payments for coverage are due on a quarterly basis and are calculated on a member's start date with the program. Payments are pro-rated for start dates only by month. AmeriCorps members with mid-month start dates are covered through the last day of the month as per insurance carrier billing practices. The chart below indicates the estimated premium, payment due date, and effective cancellation date (date coverage is cancelled if the premium is not received). Payments not received within 15 days of the due date will result in coverage cancellation back to the last day of the previous month.

Quarterly Payment	Start Date	Premium Total	Payment Due Date	Coverage Period	Cancellation Date
First Quarter	September 1	$ 431.52	September 1	September – November	September 15
First Quarter	September 16 or October 1	$ 287.68	October 1	October – November	October 15
First Quarter	October 16 or November 1	$ 143.84	November 1	October – November	November 15
Second Quarter	All	$ 431.52	December 1	December – February	December 15
Third Quarter	All	$ 431.52	March 1	March – May	March 15
Fourth Quarter	All	$ 431.52	June 1	June – August	June 15

**If the premium is raised by the insurance carrier, the premium totals will change to reflect the increase.*

Updated on 12/20/11

What Happens if I Obtain Other Coverage and Have Already Paid the Quarterly Premium?

Inform the program, in writing, at least 10 days prior to the first day of the month. After the first day of any month, coverage can be cancelled but premiums can not be refunded as per our carrier. Any remaining premium balance will be refunded.

Who Can I Contact with Questions About Continuation Coverage?

If you have any questions about continuation of coverage, please contact Samuel Prater at (212) 455-9324.

If you change addresses, or other changes occur, please notify Samuel Prater at sprater@lisc.org in writing at:

LISC
501 7th Avenue
7th Floor
New York, NY 10018

Please acknowledge that you have received and read this letter by signing the enclosed copy and returning it with your enrollment package.

I acknowledge that I received this letter, and I have read it.

____
LISC AmeriCorps Member Name

____
LISC AmeriCorps Member Signature

____
Date

LISC
Helping neighbors build communities

Income Verification Form Letter

LISC AmeriCorps is able to assist our full-time (1700 hr) and part-time (900 hr) members with supporting documentation for those that are receiving or applying for Public Assistance Benefits as it pertains to your living stipend.

Please provide the following information:	
Agency Name:	
Agency Contact Person/Case Worker:	
Your Case Number (if applicable):	
Agency Mailing Address:	
City:	
State:	
Zip Code:	
Agency Fax Number:	
Purpose for Letter (ex: Food Stamps, Housing, etc)	

Please email this completed form to Stacey Rapp (srapp@lisc.org), Sam Prater (sprater@lisc.org), or Robert Beach (rbeach@lisc.org) and allow 5 business days for processing.

Our office address mailing address is:
LISC AmeriCorps
501 7th Avenue
7th Floor
New York, NY
10018

Fax number : 212-983-4718

AmeriCorps
Parental Consent Form

FOR PARENT OF GUARDIAN OF MEMBERS UNDER 18 YEARS OF AGE:

I, the undersigned parent/guardian of ______________________________ understand the responsibilities and benefits associated with AmeriCorps. I authorize my son/daughter/legal ward to participate in AmeriCorps including educational, training and service related activities provided by the AmeriCorps program.

I authorize the exchange of information between the AmeriCorps sponsor, the LISC AmeriCorps Program, and the Corporation for National and Community Service which is relevant to successful participation in the AmeriCorps program.

I grant permission for the AmeriCorps sponsor to provide or arrange the necessary medical assistance for my son/daughter/legal ward if I cannot be immediately reached in the event of an accident or illness. I have listed any illnesses, allergies, medical conditions or disabilities that might affect participation in the AmeriCorps program or require medical attention.

____

Signature of Parent or Guardian Date

Please Print:

Name: ______________________________

Address: ______________________________

____

City State Zip Code

Daytime Telephone Number: ____________

Evening Telephone Number: ____________

Member Request
Income Verification/ Public Assistance Benefits Determination

Stipend payments to participants in AmeriCorps programs are not considered income for the purposes of determining eligibility for many public assistance programs. As a LISC AmeriCorps member you may request a letter be sent directly to an agency/ organization regarding how your living stipend is determined and explaining your relationship to LISC and placement partner is as a participant. AmeriCorps members should apply for the benefit ***PRIOR TO*** requesting a supporting letter. Please note that all requests are processed by the national office and not the local office. If an AmeriCorps member requests this information from his/ her local contact, the local administrator will forward this form to the national office.

- All requests must be in writing using this from and from the AmeriCorps member.
- The letter generated by national is sent directly to the agency and a pdf copy is sent to the member's attention via e-mail.
- National will not send a "blank letter;" it must be addressed to an agency or organization.
- Letters are provided by the national LISC staff and take five (5) business days to process. While every attempt will be made to process them sooner, members should plan on this timeframe. Same day/ next day requests are not possible.
- A member can provide the information at the time of enrolling in the program or at any time by e-mailing this form to Stacey Rapp (srapp@lisc.org) or Robert Beach (rbeach@lisc.org)

Member Name:

Purpose for Letter
(ex: Food Stamps, Housing, etc)

Agency Name:

Agency Contact/Case Worker:

Case Number (if applicable):

Agency Mailing Address:

City, State Zip:

Agency Fax Number: