



MISSOURI WORKS – NEW JOBS ANNUAL VERIFICATION

QUALIFIED COMPANY		Tax Period		Beg	End
Name of Company (Parent or Primary Project Facility)				Federal Tax ID No. (FEIN)	
Primary Project Facility Address				NAICS	
City	County	MISSOURI		Zip Code	
Additional PROJECT FACILITY(ies) Information			<input type="checkbox"/> N / A	(Attach additional sheet(s) if needed)	
Facility Address 1	City	Zip Code	FEIN	Current # of FT Employees	
Facility Address 2	City	Zip Code	FEIN	Current # of FT Employees	
Facility Address 3	City	Zip Code	FEIN	Current # of FT Employees	
CONTACT INFORMATION (Please provide two (2) contact persons that DED may contact directly regarding this program)					
Contact Person			Title		
Mailing Address		City	State	Zip Code	
Telephone Number	Fax Number	Email			
Contact Person			Title		
Mailing Address		City	State	Zip Code	
Telephone Number	Fax Number	Email			
PROJECT FACILITY, RELATED FACILITY, QUALIFIED COMPANY INFORMATION					
Has any information (below) regarding the project facility, related facilities, or the qualified company changed since the Notice of Intent (NOI) was submitted and approved?				<input type="checkbox"/> YES	<input type="checkbox"/> NO
If YES to question above – Complete <u>entire</u> Section below; If NO to first question – SKIP to “Other Programs Utilized” section					
• Is the Project Facility address the permanent facility?				<input type="checkbox"/> YES	<input type="checkbox"/> NO
• Is the Project Facility address(es) the same as outlined in the NOI? If no, please explain. _____				<input type="checkbox"/> YES	<input type="checkbox"/> NO
• Is there more than one company considered the Qualified Company, which is not listed on the NOI? If yes, please explain. _____				<input type="checkbox"/> YES	<input type="checkbox"/> NO
• Is the Health Insurance offered to employees the same as listed on the NOI?				<input type="checkbox"/> YES	<input type="checkbox"/> NO
If NO →		Name of Health Insurance			
What percentage of the health insurance premium is paid by the company for full-time employees at the project facility?					%
Does Health Insurance begin immediately upon hire?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	If NO, when are they eligible? _____ days	
• Does the company continue to offer health insurance to all full-time employees at ALL facilities in MO?				<input type="checkbox"/> YES	<input type="checkbox"/> NO
• Are full-time employees scheduled to work at least 35 hours a week working in the new jobs?				<input type="checkbox"/> YES	<input type="checkbox"/> NO
• Does the company participate in an employee stock ownership plan?				<input type="checkbox"/> YES	<input type="checkbox"/> NO
• Was there a decrease in the number of full-time employees at any related facility(ies) or company(ies) in MO?				<input type="checkbox"/> YES	<input type="checkbox"/> NO
• Has the type of business changed since the NOI was submitted? If yes, please check the appropriate box.				<input type="checkbox"/> YES	<input type="checkbox"/> NO

Type of Business	<input type="checkbox"/> C Corp	<input type="checkbox"/> S Corp	<input type="checkbox"/> NFP	<input type="checkbox"/> LLC	<input type="checkbox"/> LLP	<input type="checkbox"/> Fiduciary	<input type="checkbox"/> Partnership	<input type="checkbox"/> Other					
<ul style="list-style-type: none"> Has the ownership of the company changed? If yes, provide information below or on an additional sheet. If LLC, Partnership, S-Corp, provide SSNs for the individuals. 								<input type="checkbox"/> YES	<input type="checkbox"/> NO				
Aggregate proportionate shares or percent of total ownership for ALL TYPES OF BUSINESSES must total 100%													
Name (First, MI, Last)/Company/Trust			SSN / FEIN		Ownership %		Name (First, MI, Last)/Company/Trust			SSN / FEIN		Ownership %	
<ul style="list-style-type: none"> Is the company now owned 51% or more by women? 									<input type="checkbox"/> YES	<input type="checkbox"/> NO			
OTHER PROGRAMS UTILIZED		<input type="checkbox"/> N / A											
<p>NOTE: Benefits for which the qualified company is eligible and utilize withholding tax from the jobs at the facility shall first be credited to the other state program before the applicable withholding period for benefits provided under this program begin. If the qualified company participates in the MO Works Training Program, it cannot retain any withholding tax that has already been allocated for use in the MO Works Training Program.</p>													
Has the company utilized another MO Works program for the new jobs? If yes, those jobs will be claimed on the Missouri Works Annual Verification.									<input type="checkbox"/> YES	<input type="checkbox"/> NO			
Is the company utilizing any other state program(s) authorizing the retention of withholding tax (e.g. MO Works Training, Tax Increment Financing (TIF), MO Downtown Economic Stimulus Act (MODESA) & MO Rural Economic Stimulus Act (MORESA))?									<input type="checkbox"/> YES	<input type="checkbox"/> NO			
If YES, name program(s) ►													
EMPLOYEES / CAPITAL INVESTMENT													
ATTACH		ZONE & RURAL WORKS PROJECTS ONLY			Include invoice & proof of payment proving at least \$100,000 in capital investment.								
What is the cumulative capital investment made to date?				\$									
ATTACH		<p>This listing should include all full-time employees located at the project facility during the tax year reported with this application. Full-time employees that terminated during the twelve-month period should be included. If more than one entity is participating in this project, add a column to list the entity name. Include owners but note that they are not eligible for benefits. Please send this listing in an Excel worksheet. Send electronically to dedfin@ded.mo.gov, noting that the list is intended for use with Missouri Works Program.</p>											
Name	Employee ID	Date of Hire	Termination Date	Job Title	Status (F/P)	Company Name	Facility Address	Actual Gross Taxable Wages Paid	Actual OT, Commission, bonuses, etc.	Annual Hours Scheduled			
PROVIDE Employment Information for the Project Facility(ies) for each month during the tax period													
Month	Year	Total number of employees at the facility(ies)			# of Employees Claimed for Program			Number of Part-Time Jobs					
	20__												
	20__												
	20__												
	20__												
	20__												
	20__												
	20__												
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	20__												
	20__												

CERTIFICATION

I, the undersigned, acting on behalf of the Company named below, hereby certify and agree to the following:

- The information submitted by the Company to DED in connection with the Project is true and correct and such information is consistent with documents provided to lenders, other government programs, or investors. The Company hereby authorizes DED to verify such information from any source;
- Neither the Company nor any person identified in the application:
 - a) Has committed a felony, is currently under indictment for a felony, or is currently on parole or probation;
 - b) Is delinquent with respect to any non-protested federal, state or local taxes or fees;
 - c) Has filed (or is about to file) for bankruptcy, unless otherwise disclosed to DED; or
 - d) Has failed to fulfill any material obligation under any other state or federal program;
- There are no pending or threatened liens, judgments, or material litigation against the Company or any person identified on the application which is likely to have a material impact on the Company's viability;
- Neither the operations of the Project itself nor the receipt of incentives for the Project would violate any existing agreement;
- The Company has obtained or is capable of obtaining all necessary federal, state and local permits and licenses for the Project;
- I certify that the applicant does NOT knowingly employ any person who is an unauthorized alien and that the applicant has complied with federal law (8 U.S.C. § 1324a) requiring the examination of an appropriate document or documents to verify that each individual is not an unauthorized alien.
- I certify that the applicant is enrolled and will participate in a federal work authorization program as defined in Section 285.525(6), RSMo., with respect to employees working in connection with the activities that qualify applicant for this program. I certify that the applicant will maintain and, upon request, provide the Department of Economic Development documentation demonstrating applicant's participation in a federal work authorization program with respect to employees working in connection with the activities that qualify applicant for this program.
- I certify that the Applicant shall include in any contract it enters with a subcontractor in connection with the activities that qualify applicant for this program, an affirmative statement from the subcontractor that such subcontractor is not knowingly in violation of Section 285.530.1, RSMo, and shall not be in violation during the length of the contract. In addition the Applicant will receive a sworn affidavit from the subcontractor under the penalty of perjury, attesting that the subcontractor's employees are lawfully present in the United States. I certify that the Applicant will maintain and provide the Department of Economic Development and Department of Revenue access to documentation demonstrating compliance with this requirement.
- I understand that, pursuant to section 285.530.5, RSMo, a general contractor or subcontractor of any tier shall not be liable under section 285.525 to 285.550 when such general contractor or subcontractor contracts with its direct subcontractor who violates section 285.530.1, if the contract binding the contractor and subcontractor affirmatively states that the direct subcontractor is not knowingly in violation of section 285.530.1 and shall not henceforth be in such violation and the contractor or subcontractor receives a sworn affidavit under the penalty of perjury attesting to the fact that the direct subcontractor's employees are lawfully present in the United States.
- I understand that if the applicant is found to have employed an unauthorized alien, applicant maybe subject to penalties pursuant to Sections 135.815, 285.025, and 285.535, RSMo.
- I understand that if the applicant is found to have employed an unauthorized alien in Missouri and did not, for that employee, examine the document(s) required by federal law, the applicant shall be ineligible for any state-administered or subsidized tax credit, tax abatement or loan for a period of five years following any such finding.
- I attest that I have read and understand the Missouri Works Program guidelines.
- I hereby agree to allow representatives of the Department of Economic Development (DED), Department of Revenue, or either of their designated representatives, access to the property and applicable records as may be necessary for the administration of this program.
- The Company agrees that if, at any point during the benefit period, threshold levels for the number of new jobs fall below the program minimum on average for the tax year, or any other program requirement is not met or maintained, the Company will notify DED immediately. In addition, the Company will stop retaining the state withholding tax in conjunction with the benefits of this program and will remit the state withholding tax to the Missouri Department of Revenue.
- I certify under penalties of perjury that the above statements and information contained in the application and attachments are complete, true, and correct to the best of my knowledge and belief.

I certify that I am an executive level representative of the Company and have the proper authority to execute this document on behalf of the Company and that I am authorized to make the statement of affirmation contained herein. I also realize that failure to disclose material information regarding the Company, any owners or individuals engaged in the management of the Company, or other facts may result in criminal prosecution.

Applicant Signature	Print Name	Title	Date
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STATE OF _____ SS. _____ COUNTY OF _____

On this _____ day of _____ in the year 20 ____ before me, _____, a Notary Public in and for said state, personally appeared _____ [name of Corporate Officer / Member], _____ [Name of Corporation / Limited Liability Corporation], known to me to be the person who executed the within Agreement in behalf of said company and acknowledged to me that he or she executed the same for the purposes therein stated.

_____ Notary Public My commission expires _____

ATTACH A CORPORATE RESOLUTION AUTHORIZING APPROVAL OF THIS AGREEMENT & AUTHORIZING THE ABOVE NAMED PERSON TO SIGN ON BEHALF OF COMPANY. If more than one representative signs, use a copy of this page for each signatory.

NEW JOBS – ANNUAL APPLICATION

ATTACHMENTS

- **Fixed Asset Detail** – Provide a detailed listed of the new investment to include: Date purchased – Date put in Service – Description – Cost. Provide documentation of invoices, lease, and proof of payment for the new investment list for the fiscal year reported.
- **Employee List** – Provide a list of ALL Full-Time employees (scheduled to work at least 35 hours / week) that worked at the Project facility(ies) during the fiscal year reported with requested headings.
- **List of Additional Facility Addresses in MO NOT part of the Project Facility** – On a separate sheet of paper, please list all facilities (Company Name, address, Average Number of employees) in Missouri that are NOT part of the Project Facility.
- **Power of Attorney** – If the Certification is signed by a third party (an individual that is not an employee with the company); a copy of the Power of Attorney or document giving permission for such person to make the representation on behalf of the company must be attached.
- **Memorandum of Understanding (MOU)** - A copy of the executed MOU (electronically signed by company & DHS-USCIS) between the company / organization and the Department of Homeland Security, United States Citizenship and Immigration Services (DHS-USCIS) and the Social Security Administration must be on file for the company(ies) participating in the project (if not previously submitted).
- **Company Health Plan** – If the company’s health plan has changed during the tax year reported, attach a copy of the company’s health benefit plan including documentation that the company pays at least 50% of the premiums. Documentation should include the name of the health plan offered to employees, the percentage the employer pays compared to the employee and when the employee becomes eligible for the company’s health plan.
- **Organization Chart** – Attach a copy of the complete organization chart if it has changed since the Verification of Eligibility Threshold (VET) or last year’s Annual Report/Application for Tax Benefits was submitted. The organization chart should illustrate the qualified company’s ownership as well as other subsidiaries owned by the same parent company or by the qualified company.

Contact information:

Missouri Department of Economic Development, BCS, Business & Community Finance
301 W. High Street, Room 770, P.O. Box 118, Jefferson City, MO 65102-0118
Phone: 573-751-4539 • Fax: 573-522-4322
www.ded.mo.gov
E-mail: dedfin@ded.mo.gov

If this application package contains any materials that the Company considers to be closed records pursuant to Section 620.014, RSMo, each page must be clearly marked as “confidential” and the Company must provide written support that releasing the information would endanger the competitiveness of the business.

Notice: Tax credits may be claimed against taxes imposed by Chapters 143 (state income tax, excluding withholding tax) and 148 RSMo (financial institution tax) and may not be carried forward; but shall be claimed within one year of the close of the taxable year for which they were issued.

The tax credits may be transferred, sold or assigned; or the company can receive a refund in the amount exceeding the company’s income tax liability.

