

Federal WOTC Case/Application Number: \_\_\_\_\_

**For Agency Use Only**

Date Received: \_\_\_\_\_



## Maryland Disability Employment Tax Credit

### Applicant/Employee Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Employment Start Date: \_\_\_\_\_ Starting Wage: \$ \_\_\_\_\_  hourly  weekly  
Position/Title: \_\_\_\_\_  
Have you worked for this employer before?  Yes  No

If you are a **Division of Rehabilitation Services (DORS) consumer**, your DORS counselor must sign this form below as "Agency Representative." If you are **not** a DORS consumer, please indicate which of these apply to you:

- Behavioral Health Administration (BHA) consumer** – your BHA case manager should fill out the "Agency Representative" section of this form.
- Developmental Disabilities Administration (DDA) consumer** – your DDA case manager should fill out the "Agency Representative" section of this form.
- Receive Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) benefits** – attach a copy of your benefits award letter or a copy of a benefits check. Leave the "Agency Representative" section of this form blank.
- Receive disability benefits from the Veterans' Administration (VA)** – attach a copy of your disability benefits award letter or a copy of a VA disability check **OR** have your VA case manager fill out the "Agency Representative" section of this form.

**I certify that this information is true and correct to the best of my knowledge. I understand that the information above may be subject to verification.**

\_\_\_\_\_  
Signature of Applicant/Employee

\_\_\_\_\_  
Date

### Agency Representative Information

Name: \_\_\_\_\_ Agency:  DORS  BHA  DDA  VA  
Office Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
**I certify that this individual meets the established criteria for the Maryland Disability Employment Tax Credit.**

\_\_\_\_\_  
Signature of Agency Representative

\_\_\_\_\_  
Date

### Employer Information

Company Name: \_\_\_\_\_ Federal I.D. Number: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Employer Representative Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
**I certify this employee has been hired by the above referenced company.**

\_\_\_\_\_  
Signature of Employer Representative

\_\_\_\_\_  
Date

When all sections have been filled out and signed, mail or fax the completed form to:

**Tax Credit Program Administrator**  
Maryland Department of Labor, Licensing & Regulation  
1100 N. Eutaw Street, Room 203, Baltimore, MD 21201  
410-767-2063 • 410-767-2060 Fax