

# SEIU USWW Workshare Program

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## How to Complete the Initial Claim & Payment Certification Form



Building Skills Partnership  
& SEIU USWW



If **you are** planning on filing a claim for  
Workshare Unemployment Benefits,  
**you must:**



**Verify with your employer or union rep that  
your site is participating in the workshare  
program**



**Wait for your employer to hand you two  
forms to complete:**

**1** Initial Claim & Payment Certification Form  
(completed one time for 1st Work Share week)

**2** Work Sharing Certification Form  
(completed every 2 weeks starting 2nd Work Share week)



**EDD will notify claimant by mail if eligible to  
receive benefits, if so, will be mailed an  
EDD BofA card**



**Continue completing and mailing the  
Work sharing Certification Form for all Work  
Share weeks**

# Information you will need:

- Name and Social Security Number
- Mailing and residential address, and phone number
- Citizenship Status: provide proof if you are a legal resident or have work authorization
- State-issued driver license number or identification card number
- Work history and earning estimates for the past 18 months
- Additional employer's information including company name, address and employee' earnings
- The date you last filed for unemployment insurance, **if** you ever have
- Pension information, **if** receiving or will receive within a year

# Initial Claim & Payment Certification (DE 8648)

- Complete this form to file a claim for Workshare Unemployment benefits
- Only needs to be completed once
- Blank forms will be mailed to and distributed by employer, NOT the union or BSP



EDD Employment Development Department State of California		INITIAL CLAIM AND PAYMENT CERTIFICATION																															
<p><b>WORK SHARING (WS) EMPLOYER</b></p> <ul style="list-style-type: none"> <li>Please complete Section A - Employer's Information and Certification for the employee participating in the Work Sharing Plan. An original signature is required.</li> <li>Instructions for completion of this form are contained in the Guide for Work Sharing Employers, DE 8684.</li> <li>This form must be issued to the employee for the FIRST work sharing week within 14 calendar days after the Week Ending date shown below.</li> </ul> <p><b>WORK SHARING (WS) CLAIMANT</b></p> <ul style="list-style-type: none"> <li>Please complete Section B - Claimant Certification and Section C - Claimant Information of this form. If you have questions regarding the completion of this form, call the Special Claims Office at 916-464-3300.</li> <li>Print your responses to Section C. Review your form before mailing it to avoid delays.</li> <li>This form must be mailed to the Special Claims Office, P.O. Box 419076, Rancho Cordova, CA 95741-9076 within 14 calendar days from the date your employer issued it.</li> </ul>																																	
<b>SECTION A - EMPLOYER'S INFORMATION AND CERTIFICATION</b>																																	
LAST NAME:		FIRST NAME:	SOCIAL SECURITY NUMBER:																														
<p><b>EMPLOYER'S CERTIFICATION FOR THE WEEK ENDING:</b> ___/___/___</p> <p><b>Note:</b> If your payroll period is other than weekly, you must report the percentage of reduced hours and wages on a CALENDAR WEEK beginning Sunday and ending Saturday.</p> <table border="0"> <tr> <td>Normal Weekly Wages</td> <td><input type="text"/></td> <td>TOTAL Wages Paid</td> <td><input type="text"/></td> <td>% of Wages Reduced for WS</td> <td><input type="text"/></td> </tr> <tr> <td>Normal Hours of Work Per Week</td> <td><input type="text"/></td> <td>TOTAL Hours Worked</td> <td><input type="text"/></td> <td>% of Hours Reduced for WS</td> <td><input type="text"/></td> </tr> </table> <p>1. Was the employee absent from work for reasons other than Work Sharing, including a holiday, jury duty, illness, personal leave, or vacation during this week? <input type="checkbox"/> Yes <input type="checkbox"/> No            a. If yes, was the absence approved? <input type="checkbox"/> Yes <input type="checkbox"/> No            b. Enter the date(s) and reason: ___/___/___ / ___/___/___ / ___/___/___ / ___/___/___</p> <p>2. Did the employee refuse any work you made available during hours scheduled off due to your Work Sharing Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Enter the date(s) and hour(s) used for Work Sharing reductions during this week:</p> <table border="0"> <tr> <td>Date</td> <td>Hours</td> <td>Date</td> <td>Hours</td> <td>Date</td> <td>Hours</td> </tr> <tr> <td>___/___/___</td> <td><input type="text"/></td> <td>___/___/___</td> <td><input type="text"/></td> <td>___/___/___</td> <td><input type="text"/></td> </tr> <tr> <td>___/___/___</td> <td><input type="text"/></td> <td>___/___/___</td> <td><input type="text"/></td> <td>___/___/___</td> <td><input type="text"/></td> </tr> </table>				Normal Weekly Wages	<input type="text"/>	TOTAL Wages Paid	<input type="text"/>	% of Wages Reduced for WS	<input type="text"/>	Normal Hours of Work Per Week	<input type="text"/>	TOTAL Hours Worked	<input type="text"/>	% of Hours Reduced for WS	<input type="text"/>	Date	Hours	Date	Hours	Date	Hours	___/___/___	<input type="text"/>	___/___/___	<input type="text"/>	___/___/___	<input type="text"/>	___/___/___	<input type="text"/>	___/___/___	<input type="text"/>	___/___/___	<input type="text"/>
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___/___/___	<input type="text"/>	___/___/___	<input type="text"/>	___/___/___	<input type="text"/>																												
<p>I certify that the above information concerning the status of this company and the status/earnings of this employee for the purpose of participating in the Work Sharing program is true and correct. At least two employees, and not less than 10 percent, of the regular permanent work force (involved in the affected work units), participated in the Work Sharing program, or in at least one week of a two consecutive week period. This company will maintain employees' health and retirement benefits under the same terms and conditions as prior to the reduction in hours and wages or to the same extent as other employees not participating in the Work Sharing plan pursuant to the California Unemployment Insurance Code Section 1279.5(c)(4)(A).</p>																																	
BUSINESS NAME AND ADDRESS:		TITLE:	DATE ISSUED TO EMPLOYEE:																														
		PRINTED NAME OF SIGNER:	EMPLOYER TELEPHONE NUMBER:																														
		EMPLOYER ORIGINAL SIGNATURE:	EMPLOYER ACCOUNT NUMBER:																														

DE 4511WS Rev. 8 (6-14) Page 1 of 4 CU

# Initial Claim & Payment Certification (DE 8648)

Your company  
will complete  
**Section A**  
before handing  
form to you



## INITIAL CLAIM AND PAYMENT CERTIFICATION

### WORK SHARING (WS) EMPLOYER

- Please complete Section A - Employer's Information and Certification for the employee participating in the Work Sharing Plan. An original signature is required.
- Instructions for completion of this form are contained in the *Guide for Work Sharing Employers, DE 8684*.
- This form must be issued to the employee for the **FIRST** work sharing week within **14** calendar days after the **Week Ending** date shown below.

### WORK SHARING (WS) CLAIMANT

- Please complete Section B - Claimant Certification and Section C - Claimant Information of this form. If you have questions regarding the completion of this form, call the Special Claims Office at 916-464-3300.
- Print your responses to Section C. Review your form before mailing it to avoid delays.
- This form must be mailed to the Special Claims Office, P.O. Box 419076, Rancho Cordova, CA 95741-9076 within **14** calendar days from the date your employer issued it.

You must complete **Section B & C** and **mail** the form within **14 days** from the date it was issued to you. Mail to:

EDD Special Claims Office  
P.O. Box 41906  
Rancho Cordova, CA 95741-9076

# Section A - Employer's Information & Certification

Your employer will complete Section A with information for the "Week Ending", including your:

- Name and Social Security Number
- Normal and reduced wages
- Absences
- Work Schedule

Week Ending

SECTION A - EMPLOYER'S INFORMATION AND CERTIFICATION					
LAST NAME:		FIRST NAME:		SOCIAL SECURITY NUMBER:	
<b>EMPLOYER'S CERTIFICATION FOR THE WEEK ENDING:</b> ____ / ____ / ____					
<i>Note:</i> If your payroll period is other than weekly, you must report the percentage of reduced hours and wages on a CALENDAR WEEK beginning Sunday and ending Saturday.					
Normal Weekly Wages	<input type="text"/>	TOTAL Wages Paid	<input type="text"/>	% of Wages Reduced for WS	<input type="text"/>
Normal Hours of Work Per Week	<input type="text"/>	TOTAL Hours Worked	<input type="text"/>	% of Hours Reduced for WS	<input type="text"/>
1. Was the employee absent from work for reasons other than Work Sharing, including a holiday, jury duty, illness, personal leave, or vacation during this week? <input type="checkbox"/> Yes <input type="checkbox"/> No					
a. If yes, was the absence approved? <input type="checkbox"/> Yes <input type="checkbox"/> No					
b. Enter the date(s) and reason: ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____ / ____					
2. Did the employee refuse any work you made available during hours scheduled off due to your Work Sharing Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No					
3. Enter the date(s) and hour(s) used for Work Sharing reductions during this week:					
Date	Hours	Date	Hours	Date	Hours
____ / ____ / ____	<input type="text"/>	____ / ____ / ____	<input type="text"/>	____ / ____ / ____	<input type="text"/>
____ / ____ / ____	<input type="text"/>	____ / ____ / ____	<input type="text"/>	____ / ____ / ____	<input type="text"/>
I certify that the above information concerning the status of this company and the status/earnings of this employee for the purpose of participating in the Work Sharing program is true and correct. At least two employees, and not less than 10 percent, of the regular permanent work force, involved in the affected work unit(s), participated in the Work Sharing program, or in at least one week of two consecutive week period. This company will maintain employees' health and retirement benefits under the same terms and conditions as prior to the reduction in hours and wages or to the same extent as other employees not participating in the Work Sharing plan pursuant to the California Unemployment Insurance Code Section, 1279.5(c)(4)(A).					
BUSINESS NAME AND ADDRESS:		TITLE:	DATE ISSUED TO EMPLOYEE:		
			____ / ____ / ____		
		PRINTED NAME OF SIGNEE:	EMPLOYEE SOCIAL SECURITY NUMBER:		
		( )	( )		
		EMPLOYER ORIGINAL SIGNATURE:	EMPLOYER ACCOUNT NUMBER:		

Date Issued to Employee

**Note:** You have 14 days from the "Date Issued to Employee" to mail the completed form to EDD



# Section B - Question #1

## Additional Employment

**Q1: check “No” :**

If you **did not** work for anyone else or **were not** self-employed during Section A’s “Week Ending”, **skip part a, b, c and move on to Q2**

**Q1: check “Yes”:**

If you **did work** for another employer or **were** self-employed during the “Week Ending” written in section A, and include:

- Employer’s name and address, and last day worked during “Week Ending”
- Total earnings, before taxes for “Week Ending”
- Whether or not you are still employed by them

**SECTION B - CLAIMANT'S CERTIFICATION:** Please answer the questions below regarding the Week Ending that was provided by your employer in Section A to determine payment for the week.

1. Did you work for anyone other than your Work Sharing employer? (This includes self-employment.)

Yes    No

a. If yes, enter the employer's name, address, and last date worked during this week:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Last Date Worked: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

b. Enter your earnings, before deductions, from self-employment or other employment, whether you were paid or not: \$ \_\_\_\_\_

c. Are you continuing to work for this employer?    Yes    No

If no, state the reason: \_\_\_\_\_

# Section B - Question #2: Federal Taxes & Signature

**Q2:** If you want your benefits for Section A's "Week Ending" federally taxed, **check the box**. If not, your benefits will be taxed when you file your taxes

- The \$600 from the CARES Act is not taxed benefits

2. If you want federal income tax withheld for the week shown in Section A mark this box:

The information provided above is true and correct to the best of my knowledge and belief. I understand the law provides for a fine and/or imprisonment for making false statements or withholding facts to fraudulently receive Unemployment Insurance benefits.

Claimant Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Once you have completed **Section B**, sign and **date** the section



# Section C - Question #1

## Personal Information

### Step 1: Fill in your basic information:

Last Name, First Name, Middle Initial (if any)  
Date of Birth  
Indicate your Gender (M or F)

### Q1: check “Yes”:

If the **Name** written in the boxes matches the name on your social security card, & skip to the next question

### Q1: check “No”:

If the Name written is **different** from the name on your Social Security card:

- enter the name that appears on your Social Security card.
- *1a: If you have used any other additional names include them in this section.*

SECTION C - CLAIMANT INFORMATION: Provide this information to file this claim.				
LAST NAME:	FIRST NAME:	M.I.	BIRTH DATE: ____ / ____ / ____	GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female
1. Is the name used on this form the same as the one that appears on your Social Security card? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If no, enter the name that appears on your Social Security card. Last: _____ First: _____ M.I.: _____				
a. List other names and/or Social Security numbers you have used: _____				

# Section C - Question #2:

## Address

Write in your mailing address and residence address if different; if they are the same, check "Yes" for "2a" and move on to the next question

2. MAILING ADDRESS: \_\_\_\_\_ UNIT/APT: \_\_\_\_\_  
CITY: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_ TELEPHONE NO.: (\_\_\_\_) \_\_\_\_\_

a. Is your residence address the same as your mailing address?  Yes  No  
If No, enter your residence address. (Include your city, state, ZIP Code, and apartment number.)  
**NOTE:** A Post Office Box is not a residence address.

STREET ADDRESS: \_\_\_\_\_ UNIT/APT: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

Write in your telephone number

# Section C - Questions #3-4

**Q3:** If you **filed** an Unemployment Insurance or Disability Insurance claim in CA in the past 2 years, check “**Yes**” and write the **type of claim** and **date** when it was filed; if you **did not**, check “**No**”

3. Have you ever filed a claim in the past two years for Unemployment Insurance or Disability Insurance in the State of California?  
 Yes     No

If Yes, please list the type of claim and date(s) when the claim(s) were filed.

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_    \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

4. In the last 18 months, did you work for an agency of the federal government or serve in the military?  
 Yes     No

**Q4:** If you worked for a federal agency or served in the military in the past 18 months, check “**Yes**”; if you **did not**, check “**No**”

# Section C - Question #5-6

**Q5:** If you **worked** outside of CA in the last 18 months, check “**Yes**” and **write the state** where you worked; if you **did not**, check “**No**” and move on to the next question

## SECTION C - CLAIMANT INFORMATION (Continued)

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 5. Did you work in a state other than California during the last 18 months?<br>If yes, in which state(s) _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Have you applied for Unemployment Insurance benefits in another state during the last 12 months?            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**Q6:** If you **applied** for Unemployment Insurance in **another state** in the last year, check “**Yes**”; if you **did not**, check “**No**” and move on to the next question

# Section C - Questions #7: Identification

**Q7:** If you have a Driver's License or ID card from **any state**, check "Yes" and enter the **state it was issued** and **DL or ID Number**; if you do not have one, check "No"

7. Do you have a driver license or ID card?

Yes  No

If yes, provide the name of the issuing state and your driver license or ID card number.

Name of issuing state: \_\_\_\_\_ Driver License/ID Number: \_\_\_\_\_

**Note:** A driver's license or ID card is not required to file a claim

# Section C - Question #8: Work Authorization

Q8: If you are a U.S. Citizen or national, select "Yes" and move on to the next question

8. Are you a U. S. citizen or national?  Yes  No

**If no, answer the following questions:**

a. Are you registered with the United States Citizenship and Immigration Services (USCIS, formerly INS) and authorized to work in the United States?  Yes  No

b. What is the title of your USCIS document? Check one of the following:

<input type="checkbox"/> Alien Registration Receipt Card (I-151)	<input type="checkbox"/> Temporary Resident Card (I-688)
<input type="checkbox"/> Permanent Resident Card (I-551)	<input type="checkbox"/> Arrival/Departure Record (I-94)
<input type="checkbox"/> Employment Authorization Card (I-688A)	<input type="checkbox"/> Re-entry Permit (I-327)
<input type="checkbox"/> Employment Authorization Document (I-688B)	<input type="checkbox"/> Refugee Travel Document (I-571)
<input type="checkbox"/> Stamp on VISA	<input type="checkbox"/> Unexpired Foreign Passport
<input type="checkbox"/> Employment Authorization Card (I-766)	<input type="checkbox"/> Other Document _____

**NOTE:** (VISA Stamp states: "Processed for I-551 Temporary Evidence of Lawful Admission of Permanent Residence valid until MM/DD/YYYY, Employment Authorized.")

c. What is your Alien Registration **OR** authorization number on your document? \_\_\_\_\_

d. What is the expiration date of your work authorization? \_\_\_\_\_

e. Were you legally entitled to work in the United States for the last 19 months?  Yes  No

If you are **not** a U.S. Citizen or national, **answer questions 8a-8e**. You will need to provide information from your work authorization document, including:

- 8.b. Type of document
- 8.c. Alien Registration OR authorization number on document
- 8.d. Expiration date for work authorization
- 8.e. Whether you were legally entitled to work in the U.S. for the last 19 months



# Section C - Questions #9: Pension Information

9. Are you receiving, or will you receive within the next year, a pension other than Social Security or Railroad Retirement, which is based on your own work or wages?  Yes  No

If yes:

a. Who pays the pension check to you? \_\_\_\_\_

b. How are you receiving your pension payments?  Monthly  Annually  Lump Sum

c. Did you pay into your pension or retirement?  Yes  No

d. Did any of the employers you worked for in the last 18 months pay into the pension fund?  Yes  No  Unsure

If yes, what is the name of the company paying into the pension? \_\_\_\_\_

**Q9:** If you **are** or **will receive** within the next year, a pension based on your work or wages, check “Yes” and provide:

- 9.a. Who is paying your pension?
- 9.b. How you are/will receive your pension payments?
- 9.c. Did you pay into your pension?
- 9.d. Did any of your employers in the last 18 months pay into the fund?

If you are **not/will not be receiving** pension payments in the next year, check “No”

# Section C - Question #10: Employment History

10. List the employers you've worked for in the last 18 months, starting with your most recent to your earliest:  
List any additional employers on a separate sheet of paper. Be sure to include all the same information requested in this question.  
(Note: How Paid; please specify, hourly, daily, weekly, monthly, commission, or at a piece rate.)

EMPLOYER NAME	DATES WORKED	EARNINGS	HOW PAID
_____	From: ____ / ____ / ____ To: ____ / ____ / ____	\$ _____	_____
_____	From: ____ / ____ / ____ To: ____ / ____ / ____	\$ _____	_____
_____	From: ____ / ____ / ____ To: ____ / ____ / ____	\$ _____	_____
_____	From: ____ / ____ / ____ To: ____ / ____ / ____	\$ _____	_____
_____	From: ____ / ____ / ____ To: ____ / ____ / ____	\$ _____	_____

If you need additional space, you can attach a separate piece of paper

**Q10:** You will need to provide your employment history for the past 18 months, including:

- **Employer Name**
- **Dates Worked:** Dates you worked for them
- **Earnings:** Total earnings, before taxes, while employed
- **How Paid:** Specify if you were paid weekly, biweekly, monthly, etc.



# Section C - Questions #11: Longest Employer

## SECTION C - Claimant Information (Continued)

11. Which employer did you work for the longest? \_\_\_\_\_

a. What type of business was operated by this employer?  
(Please be specific. For example, restaurant, dry-cleaning,  
construction, bookstore, etc.) \_\_\_\_\_

b. What type of work did you do for this employer?  
(Please be specific: cashier, laborer, plumber, etc.) \_\_\_\_\_

c. How long did you work for this employer? Years: \_\_\_\_\_ Months: \_\_\_\_\_

**Q11:** Answer the following questions for the employer you worked the longest for from Q10, include the employer name and:

- a. The type of business. **Example: janitorial company**
- b. The type of work you performed. **Example: janitorial services**
- c. How long you worked for the employer in years & months

# Section C - Question #12-13

**Q12:** Check “No”, if you have not been an officer or stockholder of a corporation

12. Are you now, or have you been in the last 18 months an officer of a corporation or the sole or major stockholder of a corporation?

Yes

No

13. Are you receiving or expect to receive Workers' Compensation?  
If yes, provide the insurance carrier and if possible the case number.

Yes

No

Name of Insurance Carrier: \_\_\_\_\_

Case Number: \_\_\_\_\_

**Q13:** If you are receiving or will be receiving Workers Compensation check “Yes” and write the Insurance Carrier and your case Number; if not, check “No”

# Section C - Questions #14-15:

## Preferred Language

**Q14:** Select your preferred language for **written communication** (Ex. Mailed documents)

14. Would you prefer your written material in English or Spanish?  English  Spanish
15. What is your preferred spoken language?  English  Spanish  Other: \_\_\_\_\_

**Q15:** Select your preferred **spoken language** (Ex. If EDD needs to call you to ask a question about your claim)

# Section C - Question #16-17: Demographics

**These questions are optional**

The following two questions are optional.

16. What race or ethnic group do you identify with? Check one of the following:

- |                                       |                                    |   |                                    |  |
|---------------------------------------|------------------------------------|---|------------------------------------|--|
| <input type="checkbox"/> White        | <input type="checkbox"/> Black     | <input type="checkbox"/> Hispanic                       | <input type="checkbox"/> Asian     | <input type="checkbox"/> American Indian or Alaskan Native |
| <input type="checkbox"/> Chinese      | <input type="checkbox"/> Cambodian | <input type="checkbox"/> Filipino                       | <input type="checkbox"/> Guamanian | <input type="checkbox"/> Other Pacific Islander            |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Japanese  | <input type="checkbox"/> Korean                         | <input type="checkbox"/> Laotian   | <input type="checkbox"/> Samoan                            |
| <input type="checkbox"/> Vietnamese   | <input type="checkbox"/> Hawaiian  | <input type="checkbox"/> Other ( <i>Specify</i> ) _____ |                                    | <input type="checkbox"/> I choose not to answer            |

17. Do you have a disability?  Yes  No  I choose not to answer

(A disability is a physical or mental impairment that substantially limits one or more life activities, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, or working.)

**Q16:** What race or ethnicity to you identify with? Select one.

**Q17:** Do you have a disability? Answer “Yes”, “No” or “Choose not to answer”

**Note:** A disability is a physical or mental impairment that significantly limits one or many life activities

# Section C - Signature

Once you have verified the information you provided, **sign**, write your **Social Security Number**, and **date** the form

I do hereby claim benefits. I am a Work Sharing claimant and working reduced hours. I have answered these questions knowing that the law provides penalties for making false statements.

Pertaining to Question 8, citizenship status, I declare under PENALTY OF PERJURY, under the laws of the State of California, that my answer is true and correct. I understand that the information I provide on this form may be released to other government agencies to the extent allowed by law.

Claimant Original Signature \_\_\_\_\_ Social Security number \_\_\_\_\_ Date Signed \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**EDD USE ONLY**

BYB	TRANS	1254	UCX	UCFE	CIT	DOT	SIC	OC	ETH	HS	PER 99	CORR
-----	-------	------	-----	------	-----	-----	-----	----	-----	----	--------	------

Interviewer's Initials: \_\_\_\_\_

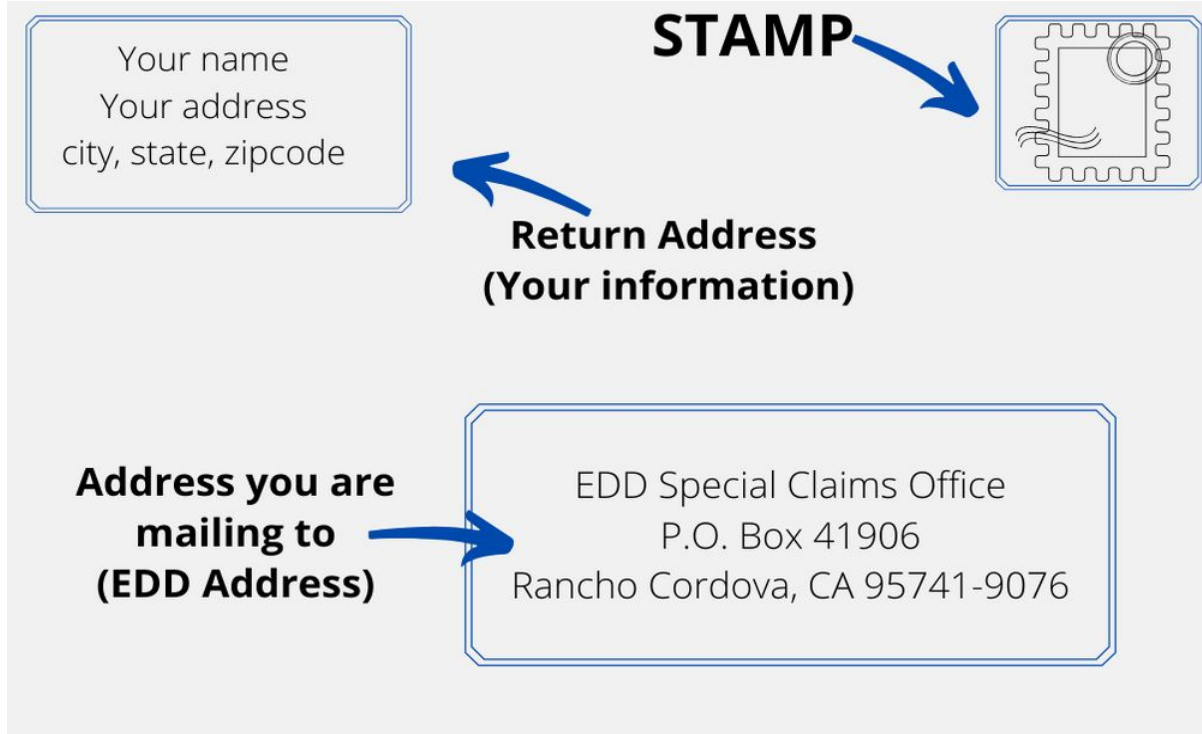
**In signing, you are certifying that you have legal work authorization and are eligible to claim Workshare Unemployment benefits**

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**Review your  
information  
before mailing!**

To avoid delays in  
benefits, **review your  
information** more than  
once to make sure it is  
correct and accurate!

# Mail your application within 14 days of receiving the form



**EDD will review your claim and verify your work authorization**



**EDD will notify you by MAIL with an**

Award Letter in  
2-3 weeks with  
benefit information



**You will also be mailed a Bank of America Debit Card  
where benefits will be deposited.**

If you already have one from a  
previous unemployment claim,  
the same card will be used.



# I applied, what now?

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# Workshare Certification Form

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In order to continue receiving benefits, you must complete the Work Sharing Certification form **every 2 weeks**

The form is 2 pages:

**Page 1 is filled by the employer**

**Page 2 is filled by you, the claimant**



Check out our  
**youtube page** for a  
step-by-step tutorial!



**You are responsible for mailing your form to EDD within 14 days** from the date it was issued to you



# Things to keep in mind

**#1**

If you are unsure if you meet the requirements to file a claim, ask BSP

**#2**

It is up to you if you wish to file a claim for Workshare benefits, as long as you meet the requirements

**#3**

Duration in the Workshare program will vary by site, depending on the local Stay at Home Order and site needs

**#4**

If you have another job, you will need to report that income and this may affect how much you receive in WS benefits

**#5**

Sick days or vacation days will be reported on the Worksharing Certification Form and can affect your WS benefits

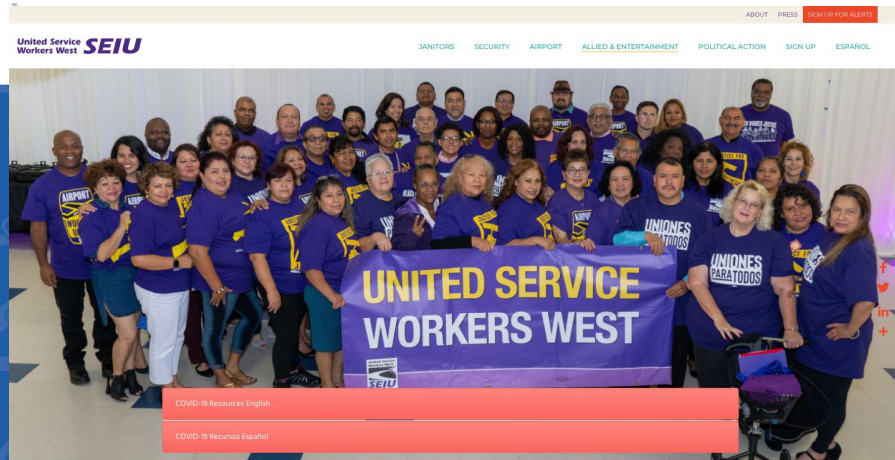
# Resources

Visit the [Building Skills Partnership](https://buildingskills.org/workshare) website or the [SEIU-USWW](https://seiu-usww.org/workshare) website for:

- Step-by-step guide on how to complete the Initial Claim & Payment Certification Form
- Step-by-step guide on how to complete the Worksharing Certification Form
- SEIU-USWW Workshare Program FAQ
- Additional community resources during COVID-19

[buildingskills.org/workshare](https://buildingskills.org/workshare)

[seiu-usww.org/workshare](https://seiu-usww.org/workshare)



# Resources

To ask questions and learn more about participating in the

## **SEIU USWW Workshare Program**

Join a **Zoom call** with your Union:

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**When:** Every Saturday at 12pm

### **How to Join:**

*Call-in: (213) 338 - 8477*

**OR**

*Enter the Meeting ID in the Zoom app: 965-7589-0541*

**OR**

*Use the link: <https://zoom.us/j/96575890541>*

# Additional Resources

## WORKSHARE PROGRAM HOTLINE

Do you have questions about your workshare program benefits or need assistance with the workshare forms?

CONTACT BSP FOR HELP, CALL:

**(402) 235-6677**

**9:00am - 5:00pm**

**Monday - Friday**

If your call is not answered, please leave a voicemail and we will return your call



# THANK YOU

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