Chautauqua Works

Use for Program Dates
9/1/26 – 12/31/26

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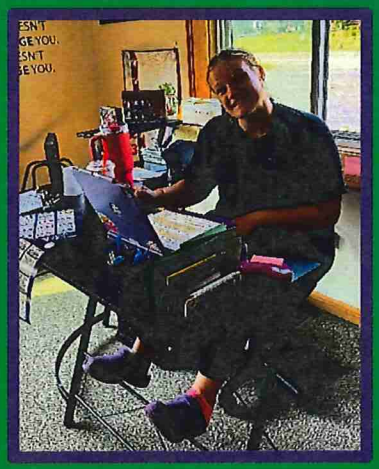
PLEASE KEEP THIS PAGE FOR YOUR REFERENCE

Build a Resumé

$
Earn Money
$



Explore Career Interests

ARE YOU ELIGIBLE for

YEP

Youth Employment Program?

Income: Does your family receive Medicaid, SNAP Benefits, Family Assistance, SSI or HEAP?
If not, is your annual household income at or below:

HOUSEHOLD SIZE	YEARLY INCOME:
1	**$31,920**
2	**43,280**
3	**54,640**
4	**66,000**
5	**77,360**
6	**88,720**
7	**100,080**
8	**111.440**

For family units with more than eight members add **$11,360** annually for each additional family member.

Age: Are you between the ages of 14 and 20?

Residence: Chautauqua County

If you answered "yes" to the above questions, you may qualify for the **Youth Employment Program (YEP).**

Let us know if you are interested in participating in this program by filling out the enclosed Eligibility Packet. All areas highlighted in yellow must be filled out. All areas in green must be filled out if applicable. Fill out and return this Eligibility Packet to:

Chautauqua Works
4 E. 3rd Street
Jamestown, NY 14701

OR

Chautauqua Works
407 Central Avenue
Dunkirk, NY 14048

ChautauquaWorks

americanjobcenter®

IMPORTANT INFORMATION
PLEASE READ

Please bring in additional information that may make you eligible to participate in the program. By bringing in this additional information with your application, it will eliminate the need to set up an appointment.

The additional information you will need to bring into our office with your application is:

- A Passport **OR**
- One of the following:
  - Driver's License,
  - ID Card issued by federal, state, or local government with photo
  - School record/report card
  - Doctor, or hospital record

AND

- Social Security Card

AND

- Working Papers if you are under 18 years or age.

There are additional forms of ID that we can accept, however, the above are the basic acceptable forms of ID.

Completion of the Eligibility Packet does not guarantee placement into the program. Opportunities are limited and based on established priorities. Once we determine if you would be an eligible candidate, we will contact you, either by phone or email, at the telephone number/email address you provided in your Participant Information Packet **(please make sure you indicate a valid telephone number/email address)**. At that time, you will be given additional information.

If you have any questions, please call (716) 487-5193 or Email:

Megan at mhall@chautauquaworks.com

Chautauqua Works

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Office Use ONLY
Received Date:
Received Time:

PARTICIPANT INFORMATION

Completed applications will be considered on a first come, first served basis for a Work Experience Program with Chautauqua Works. The application will not be considered complete unless all Items highlighted in Yellow are answered.

Items highlighted in yellow are required. Items highlighted in Green are required, if applicable.

SUBMISSION OF AN APPLICATION DOES NOT GUARANTEE ELIGIBILITY OR ENROLLMENT INTO THE PROGRAM. Nothing in this application should be viewed as expressing directly or indirectly, any limitation, specification or discrimination as to Age, Race, Creed, Color, National Origin, Sexual Orientation, Gender, Disability, or Marital Status. The questions are for government reporting purposes and to determine an appropriate worksite for placement purposes. They have no bearing on whether you are accepted into the work experience program, receive employment or receive services.

Last Name _____ **First Name** _____ **MI** _____

Street Address (Number And Street) _____ **Apt #** _____

City _____ **State** _____ **Zip Code** _____

Applicant's Home Phone # ____ - ____ - _____ **Applicant's Cell Phone #** ____ - ____ - _____

Gender : ☐ **Male** ☐ **Female**

Social Security Number _____ - _____ - _____ **Birth Date** ____ / ____ / _____ **Age** _____

Marital Status ☐ **Single** ☐ **Married** **Applicant's Email** _____

Selective Service Registration # _____ Date _____ Males 18 years of age must be registered with the Selective Service System to participate in the program. (If you have not already registered, visit www.sss.gov)

Ethnicity ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Native American/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ Unknown

IN/OUT of School ☐ In School (Enrolled in High School or College) ☐ Out of School (Not enrolled in High School or College)

If Out of School, what is the reason? ☐ Graduated ☐ Have GED ☐ Drop Out Last grade of school completed? _____ (e.g. 9th, 10th, 11th, 12th grade)

Do any of the following apply to you? ☐ On Probation/Juvenile Justice/Criminal Justice ☐ Homeless/Runaway ☐ Foster Care ☐ Disability Type of Accommodation needed?_____ ☐ Not Applicable

Emergency Contact Information – Please list the names and contact information of the person that we may contact in case of emergency.

Last Name _____ **First Name** _____

Street Address (Number And Street) _____ **Apt #** _____

City _____ **State** _____ **Zip Code** _____

Phone # ____ - ____ - _____ **Alt.Phone #** ____ - ____ - _____ **Relationship:** _____

Additional Contact Information – Please list the names and contact information of a family member and/or close friend through whom we can contact you in the event that we cannot contact you directly.

Last Name _____ **First Name** _____

Phone # ____ - ____ - _____ **Alt.Phone #** ____ - ____ - _____ **Relationship:** _____

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Have you participated in a Work Experience Program previously? ☐ Yes ☐ No

Which program? ☐ SYEP ☐ YEP ☐ GVP ☐ WIOA ☐ OTHER _____

If Yes, Where did you work? _____

Would you like to be placed with the same Employer? ☐ Yes ☐ No

If No, do you know where you want to work or what do you want to do? _____

What language(s) do you speak**? ☐ English ☐ Spanish ☐ Other _____

Do you have difficulty speaking, reading, writing, or understanding English**? ☐ Yes ☐ No

Phone use, including texting and internet, is NOT allowed during work. Can you accept a position knowing this? ☐ Yes ☐ No

Do you have any days that you will not be able to work during the program due to scheduled vacation, summer school, drivers education, etc.? ☐ Yes ☐ No

If yes, please list reason and dates. _____

_____

_____

How do you plan to get to and from work? ☐ Walk (within 1.5 miles) ☐ Ride Bicycle (within 3 miles) ☐ Drive Myself ☐ Ride with Parent/Family/Friend ☐ UBER/Taxi ☐ CARTS ☐ Other _____

** This will NOT affect your chances of placement. This is for placement purposes only.

Typical Work Experience Jobs are listed below.

Write 1 by your FAVORITE choice; Write 2 by your 2nd FAVORITE choice; and Write 3 by your 3rd FAVORITE choice.
ONLY use numbers 1—3, **Do not use a number more than once.**

Rating	General Job Title/Job Descriptions/Duties
	Clerical -Answering phones & taking messages; Greeting customers; Photocopying; Filing, Shredding; Working with computers.
	General Maintenance - Lawn Care/Grounds Maintenance (mowing, trimming, weeding, clean-up); Rearranging office furniture (lifting, moving); Loading/Unloading trucks; Painting; Marina Work; Factory Laborer; Cleaning Stalls/Pens/ cages. Feeding, watering, grooming and walking animals.
	Janitorial - Cleaning, washing windows, collecting trash cans, vacuuming, sweeping, dusting, mopping, etc.
	Working with Young Kids / Teens- Assist/Supervise youth activities in a daycare or recreational setting/day camp.
	Working with Elderly - Assist with activities in adult daycare/elderly housing/senior living facility.
	Sales/Marketing/Customer Service/Retail - Hanging and folding merchandise; Ticketing Merchandise; Handle, record, and account for all cash transactions.
	Restaurant/Food Service - Food Preparation (cooking, peeling, cutting, packaging); Janitorial (dishwashing & cleaning); Customer Service; Sales transactions.

TANF YOUTH SERVICES APPLICATION

The information requested on this form is necessary to determine whether or not federal Temporary Assistance for Needy Families (TANF) funds may be used to provide services to you. This application form may be used by an applicant for services who is under 21 years of age.

SECTION ONE

A. Information About the Youth Applicant

1. Applicant's Name: _____

Home Address: _____
(Street) (Apartment Number)

_____
(City) (State) (Zip Code)

Social Security Number: _____ Date of Birth: _____
(Month, Day, Year)

Telephone Number: _____

SECTION TWO Citizen / Non-Citizen Status

A. Are you a United States citizen?

- ☐ **Yes.** If yes, **go to** Section Three.
- ☐ **No.** If no, complete Item B.

B. If you (the youth applicant) are not a United States citizen, look at the *"Immigration Status List"* on pages 5 and 6 and tell us which status applies to you. Enter the status number from the list and complete the information below.

Immigration status (# 1 through 15) that applies: _____
INS Form Number: _____
Alien Number: _____
Date of Entry into United States: _____

SECTION THREE Income of Family Members

A. Do you (the youth applicant) currently receive benefits under one or more of these programs?

- ☐ **Yes,** check which program(s) and then **go to** Section Four.

*Indicate which benefit(s) you receive by putting an "X" in one or more of the box(es) below

FAMILY ASSISTANCE/ SAFETY NET	MEDICAID	SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)	HEAP	SSI

- ☐ **No**, complete Item B, on page 2.

B. If you do not currently receive one of the programs listed above, please tell us about any income of your family members.

Include the gross income (income before taxes and deductions) of each family member who lives with you. Family members include your mother, father, stepmother, stepfather, any brothers or sisters (including half-siblings) who are under 18 years of age (or 18 and in secondary school) and these siblings' parents. If you have a child of your own, you should include that child, any brothers or sisters of the child, and the child's parent. You should not include any of these people if they do not live with you. You should not include other family members such as grandparents, uncles or aunts. If you are married, you should include your spouse, but do not need to include your parents or siblings.

List all sources of gross income, including wages, social security benefits, public assistance benefits, child support, alimony, etc. received and any other recurring income of a family member. You do not need to include any earned income (wages) received by you or any other family member who is under 18 years of age (or 18 and in secondary school) but must include any unearned income.

	NAME	INCOME SOURCE: WAGES, SOCIAL SECURITY, etc.	AMOUNT	RECEIVED (Check One)		
				Yearly	Monthly	Weekly
1.						
2.						
3.						
4.						
5.						
6.						

SECTION FOUR Applicant Notification and Signature

The individual signing this application may be asked to prove any or all of your statements. If we ask you to do this, we will tell you how to prove your statements.

We are asking for Social Security number(s) because any person applying for or receiving federal TANF services must give us his or her Social Security number; Social Security numbers are required under federal law (Section 409(a)(4) of the Social Security Act) and federal regulations (45 CFR 264.10). We may use Social Security number(s) to do computer matches with other programs to prove you are receiving these programs (for example, SNAP), to do a computer match to verify other information on the application, or to verify your alien status.

If you disagree with any decisions we make regarding your eligibility to receive TANF services, you may have your certification reviewed by a person at a level above the person who made the first decision.

Parent/Guardian Signature

By signing this, I am swearing, under penalty of perjury, that all of the above statements are true to the best of my knowledge and that I am willing to cooperate with any efforts to verify the information provided.

Signed: _____ **Date:** _____

Relationship to Applicant: _____

If the applicant lives with his or her parents, a parent or other adult relative caretaker must sign this form for the application to be complete. The Commissioner of the Department of Social Services or his or her designee must sign for children in foster care.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2026

Step 1: Enter Personal Information

(a) First name and middle initial | Last name | (b) Social security number

Address

City or town, state, and ZIP code

Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if you: are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(b) is more accurate . . . . . ☐

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

(a) Multiply the number of qualifying children under age 17 by $2,200 . . . . . **3(a)** $

(b) Multiply the number of other dependents by $500 . . . **3(b)** $

Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here . . . . . **3** $

Step 4: Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Exempt from withholding

I claim exemption from withholding for 2026, and I certify that I meet **both** of the conditions for exemption for 2026. See *Exemption from withholding* on page 2. I understand I will need to submit a new Form W-4 for 2027 . ☐

Step 5: Sign Here

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

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

Employers Only

Employer's name and address
WIB INC DBA CHAUTAUQUA WORKS
4 E. 3RD ST. STE 102,
JAMESTOWN, NEW YORK 14701

First date of employment

Employer identification number (EIN)
16-1589572

NEW YORK STATE 2026

Department of Taxation and Finance

Employee's Withholding Allowance Certificate

New York State • New York City • Yonkers

IT-2104

First name and middle initial	Last name	Your Social Security number
Permanent home address *(number and street or rural route)*	Apartment number	Single or Head of household ☐ Married ☐
		Married, but withhold at higher single rate ☐
City, village, or post office	State / ZIP code	**Note:** If married but legally separated, mark an ***X*** in the *Single or Head of household* box.

Are you a resident of New York City (this includes the Bronx, Brooklyn, Manhattan, Queens, and Staten Island)? ..... Yes ☐ No ☐

Are you a resident of Yonkers? ..... Yes ☐ No ☐

Before making any entries, see *Note*, and if applicable, complete the worksheet in the instructions.

1	Total number of allowances you are claiming for New York State and Yonkers, if applicable *(from line 19, if using worksheet)*	1
2	Total number of allowances for New York City *(from line 31, if using worksheet)*	2

Use lines 3, 4, and 5 to have additional withholding per pay period under special agreement with your employer.

3	New York State amount	3
4	New York City amount	4
5	Yonkers amount	5

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

Penalty – A penalty of $500 may be imposed for any false statement you make that decreases the amount of money you have withheld from your wages. You may also be subject to criminal penalties.

Employee's signature	Date

Employee: Give this form to your employer and keep a copy for your records. Remember to review this form once a year and update it if needed.

Note: Single taxpayers with one job and zero dependents, enter ***0*** on lines 1 and 2 (if applicable). Married taxpayers with or without dependents, heads of household or taxpayers that expect to itemize deductions or claim tax credits, or both, complete the worksheet in the instructions. Visit our website at *www.tax.ny.gov* (search: *it-2104-i)* or scan the QR code.

Employer: Keep this certificate with your records.

If any of the following apply, mark an ***X*** in each corresponding box, complete the additional information requested, and send an additional copy of this form to New York State. See ***Employer*** in the instructions. Visit our website at *www.tax.ny.gov* (search: *it-2104-i)* or scan the QR code.

A Employee claimed more than 14 exemption allowances for New York State ..... A ☐

B Employee is a new hire or a rehire ... B ☐ First date employee performed services for pay *(mmddyyyy) (see Box B instructions)*: ☐

You may report new hire information online instead of mailing the form to New York State. Visit *www.nynewhire.com/#/login.*

Note: Employers **must** report individuals under an **independent contractor arrangement** with contracts in excess of $2,500 using the online reporting website *www.nynewhire.com/#/login*, **not** Form IT-2104.

Are dependent health insurance benefits available for this employee? ..... Yes ☐ No ☐

If *Yes*, enter the date the employee qualifies *(mmddyyyy)*: ☐

Employer's name and address *(Employer: complete this section only if you are sending a copy of this form to the New York State Tax Department.)*	Employer identification number
WIB INC DBA CHAUTAUQUA WORKS 4 E. 3RD ST. STE 102 JAMESTOWN, NEW YORK 14701	161589572

www.tax.ny.gov/r/it2104i-2026

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No.1615-0047
Expires 05/31/2027

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

Section 1. Employee Information and Attestation: Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. An alien authorized to work until (exp. date, if any) _____

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

Signature of Employee	Today's Date (mm/dd/yyyy)

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
Lester, Colleen Accounting & Business Serv. Assoc		

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
W I B Inc dba Chautauqua Works	**4 E. Third St Ste 102 Jamestown, NY 14701**

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

Chautauqua Works

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AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION

I hereby authorize Chautauqua Works to disclose or receive pertinent information to or from various agencies for any of the following purposes:

- To determine eligibility for employment and/or training services
- To coordinate service planning and delivery
- To provide follow up information regarding program termination and/or completion and employment.

This includes the following agencies that **I currently receive services from or may need services from**:

☐ DMHHS Program **(formerly known as DSS or HHS—Medicaid, SNAP, Cash Assistance, etc.)**
*If you indicated on page 3A that you are receiving benefits, please check this box.

☐ School District _____

☐ Probation
Probation Officer Name: _____
Phone #: _____

☐ Foster Care

☐ GA Home

☐ New Directions

☐ TRC - The Resource Center

☐ ACCES-VR

☐ LDA-Learning Disabilities Association of WNY

☐ Department of Mental Health

☐ Gateways/Pathways (TRC MH Programs)

☐ COI Program

☐ BOCES Program

☐ Higher Ed/Training Program _____

☐ Other * _____
*Include full name, address, and telephone number of back of sheet.

List any agency/agencies below that you DO NOT WANT Chautauqua Works to share information with:

_____

_____

This Release and Exchange of Information shall remain in effect for one year after date of signature. I may modify or revoke this release at any time by notifying Chautauqua Works in writing of my desire to do so.

Is Participant 18 years or older? ☐ Yes ☐ No - (If no must have Parent/Guardian signature)

_____ _____
Signature of Participant Signature of Parent/Guardian

_____ _____
Print Name Print Name

_____ _____
Date Date

Chautauqua Works

americanjobcenter®

Consent for Medical Treatment

I , or the parent/legal guardian of the participant, hereby give consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve the life, limb or well-being of my dependent.

Is Participant 18 years or older? ☐ Yes ☐ No - (If no, must have Parent/Guardian signature)

_____	_____
Signature of Participant	Signature of Parent/Guardian
_____	_____
Print Name	Print Name
_____	_____
Date	Date

MEDIA RELEASE

Select ONE of the Options below:

_____ I agree that any photographs/video taken of me during my participation in the Youth Employment Program are the property of Chautauqua Works and, although I may also receive a copy for my portfolio or personal use, I give Chautauqua Works permission to use images, including me for their publicity and records.

_____ I do not want any photograph/video to be taken for my personal portfolio, for publicity, or for records of Chautauqua Works.

Is Participant 18 years or older? ☐ Yes ☐ No - (If no, must have Parent/Guardian signature)

_____	_____
Signature of Participant	Signature of Parent/Guardian
_____	_____
Print Name	Print Name
_____	_____
Date	Date