Lemont-Bromberek Combined School District 113A
Substitute Support (Non-Certified) Checklist

District 113A Administrative Center
16100 W 127th Street
Lemont, Illinois 60439
Telephone: 630/257-2286
Fax: 630/243-5199

NAME: _____ **POSITION:** _____ **DATE:** _____

Submit the documents listed below to the district office (address noted above). If you have any questions, contact Patti McDonald at 630-257-2286, extension 4617 or pmcdonald@sd113a.org.

_____ submit a completed on-line District 113A application (www.sd113a.org)

_____ fingerprint applicant form ***(enclosed: complete form and call 708/687-0900 to schedule an appointment)***
Date you were fingerprinted

You are entitled to obtain a paper copy of your background check that was conducted. Initial either yes or no.
_____ Yes. I would like a copy of my background check.
_____ No. I would not like a copy of my background check.

_____ Educator license or educator license with stipulations registered in South Cook ISC4 Region 07
(If you do not have an educator license or an educator license with stipulations, contact the South Cook ISC4 at 708-754-6600.)

_____ record of physical examination and documentation of freedom from tuberculosis (conducted not more than 90 days preceding date of application)

_____ DCFS 2 forms

_____ emergency information form

_____ I-9 form, Employment Eligibility Verification *See page 3 for acceptable documents to bring to District Office.*

_____ IMRF form

_____ job description

_____ new hire reporting form

_____ race/ethnicity form

_____ sexual harassment policy receipt

_____ W-4 ***(2 forms - State and Federal)*** forms

_____ Check for $40.00 (the cost of fingerprinting) made payable to Lemont-Bromberek CSD 113A

Note: You will only be added to our District's substitute pool after all of the above documents have been submitted, references have been checked, and you have been interviewed.

CALL TO MAKE AN APPOINTMENT:
708/687-0900

Southwest Cook County Cooperative Association for Special Education

Certified School Employee (CSE) Fingerprint Applicant Form

Please Bring A Photo ID

Please Provide the Following Information (Please Print Clearly)

District ORI #: IL016113S

Last Name: _____ **First Name:** _____ **Middle:** ____

U.S. Citizen: Yes ___ **No** ___ **Drivers License Number:** _____ **DL State:** ____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Date of Birth: ____/____/____ **Sex:** _____ **Race:** _____ **Height:** _____ **Weight:** _____

Hair Color: _____ **Eye Color:** _____ **Social Security #:** _____/_____/_____

Place of Birth (Enter the name of State) _____

Applicant's Phone Number: _____-_____-_____.

I authorize the SWCCCASE to submit the above information that I acknowledge being true and accurate, to the best of my knowledge, to the Illinois State Police (ISP). The ISP shall conduct a fingerprint-based criminal history records check and shall furnish to the president of the school board of the receiving school district the applicant's records of convictions, until expunged. The president of the school board shall keep a conviction record confidential and share it only with the Superintendent or any other person necessary to the hiring decision. A copy of the record of convictions shall be provided to the applicant for employment upon request.

_____ _____

Signature of Applicant **Date**

DO NOT WRITE BELOW THIS LINE – FOR OFFICE USE ONLY

_____ _____

Fingerprint Technician **Date of Fingerprint**

_____ _____

Receiving School District/Agency **TCN #**

"Opening the world through education to children and young adults with diverse abilities"

Administrative Offices **6020 West 151st Street** **Oak Forest, Illinois 60452-1899** **Phone: 708 / 687 0900** **Fax: 708 / 687 5695**

Visit us at: www.swcccase.org

Serving these school districts: 113 Lemont • 117 North Palos • 118 Palos • 142 Forest Ridge • 145 Arbor Park • 146 Tinley Park 159 Matteson • 160 Country Club Hills • 210 Lemont High School • 228 Bremen High School • 230 Consolidated High School

Lemont-Bromberek Combined School District 113A

Pre-Employment Health Examination Form

_____ _____

(Name) (Position)

HEALTH EXAMINATION INFORMATION

A school board must require a new employee/substitute to present evidence of physical fitness to perform the duties assigned and freedom from communicable disease, including tuberculosis. Evidence must consist of a physical examination and a tuberculin skin test, and if appropriate, an X-ray made by a physician licensed in Illinois or any other state to practice medicine and surgery in all its branches or an advanced practice nurse who has a written collaborative agreement with a collaborating physician that authorizes the advanced practice nurse to perform health examinations or a physician assistant who has been delegated the authority to perform health examinations by his or her supervising physician. Such examination must occur not more than 90 days preceding the time of presentation of the prospective substitute. The cost of the examination is paid by the substitute.

Directions to Applicant: Please schedule your health examination as soon as possible and return this completed form to the District Office.

This Section to Be Completed by Physician/Advanced Practice Nurse/Physician Assistant:

1. Is there any condition of a chronic nature which will in any way hamper the individual named above from effectively performing the duties of his/her position (job description attached)?

   ☐ yes ☐ no

   If yes, explain: _____

2. He/she has been examined for tuberculosis* _____ _____
   (Date) (Results)

**Mantoux skin test required, with X-ray follow-up (if Mantoux test is positive).*

_____ _____

Name of Health Care Provider I.D.#

_____ _____

Street Address City, State & Zip Code

_____ _____

Phone Number Date of Exam

_____

Signature of Health Care Provider

CFS 689
Rev 7/2012

State of Illinois
Department of Children and Family Services

AUTHORIZATION FOR BACKGROUND CHECK

Child Abuse and Neglect Tracking System (CANTS)

For Programs NOT Licensed by DCFS

NOTE: Do not use this form if you are an applicant for licensure or an employee/volunteer of a licensed child care facility. Please contact your licensing representative.

Name: _____
Last First Middle

Date of Birth: ☐ -- ☐ -- ☐ Gender: ☐ Male ☐ Female Race: _____

Current Address: _____
Street/Apt #

_____
City State Zip Code

If you currently reside in Illinois, please list all previous addresses for the past five years.
OR
If you currently reside out-of-state, please provide ALL Illinois addresses in which you did reside while living in Illinois.

(Street/Apt#/City/County/State/Zip Code)	Dates From/To

List maiden name and/or all other names by which you have been known: (last, first, middle)

I hereby authorize the Illinois Department of Children and Family Services to conduct a search of the Child Abuse and Neglect Tracking system (CANTS) to determine whether I have been a perpetrator of an indicated incident of child abuse and/or neglect or involved in a pending investigation. I further consent to the release of this information to the agency listed below.

_____
Signed Date

Submit by mail OR fax OR email.
Mail to: Department of Children and Family Services
406 E. Monroe – Station # 30
Springfield, IL 62701
FAX to: 217-782-3991
Scan/Email to: CFS689Background@illinois.gov

Please type, use bold letters or label:

630-243-5199 (Submitting Agency Fax Number)
pmcdonald@sd113a.org (Submitting Email Address)

Lemont-Bromberek CSD 113A (Agency Name)
Patti McDonald (Contact Person)
16100 W 127th Street (Address)
Lemont, Illinois 60439 (City/State/Zip)

Print Form

Illinois Department of
DCFS
Children & Family Services

ACKNOWLEDGEMENT OF MANDATED REPORTER STATUS

I, _____, understand that when I am employed as a
(Employee Name)

_____, I will become a mandated reporter under the
(Type of Employment)
Abused and Neglected Child Reporting Act [325 ILCS 5/4]. This means that I am required to report or cause a report to be made to the child abuse Hotline number at 1-800-25-ABUSE (1-800-252-2873) whenever I have reasonable cause to believe that a child known to me in my professional or official capacity may be abused or neglected. I understand that there is no charge when calling the Hotline number and that the Hotline operates 24-hours per day, 7 days per week, 365 days per year.

I further understand that the privileged quality of communication between me and my patient or client is not grounds for failure to report suspected child abuse or neglect, I know that if I willfully fail to report suspected child abuse or neglect, I may be found guilty of a Class A misdemeanor. This does not apply to physicians who will be referred to the Illinois State Medical Disciplinary Board for action.

I also understand that if I am subject to licensing under but not limited to the following acts: the Illinois Nursing Act of 1987, the Medical Practice Act of 1987, the Illinois Dental Practice Act, the School Code, the Acupuncture Practice Act, the Illinois Optometric Practice Act of 1987, the Illinois Physical Therapy Act, the Physician Assistants Practice Act of 1987, the Podiatric Medical Practice Act of 1987, the Clinical Psychologist Licensing Act, the Clinical Social Work and Social Work Practice Act, the Illinois Athletic Trainers Practice Act, the Dietetic and Nutrition Services Practice Act, the Marriage and Family Therapy Act, the Naprapathic Practice Act, the Respiratory Care Practice Act, the Professional Counselor and Clinical Professional Counselor Licensing Act, the Illinois Speech-Language Pathology and Audiology Practice Act, I may be subject to license suspension or revocation if I willfully fail to report suspected child abuse or neglect.

I affirm that I have read this statement and have knowledge and understanding of the reporting requirements, which apply to me under the Abused and Neglected Child Reporting Act.

_____
Signature of Applicant/Employee

_____
Date

CANTS 22
Rev. 8/2013

Office of the Director
406 E. Monroe Street • Springfield, Illinois 62701
www.DCFS.illinois.gov

Lemont-Bromberek Combined School District 113A

STAFF EMERGENCY INFORMATION

PERSONAL INFORMATION – Please print

Name: _____
(First) (Last)

Address: _____
(Street) (City) (Zip Code)

Phone: _____ Birthdate: _____
(Month) (Day) (Year)

Home Email: _____

Significant Other's Name: _____

Your Maiden Name (if applicable) : _____

EMERGENCY INFORMATION – In case of an emergency, contact:

Name: _____

Phone: _____ Relation to you: _____

MEDICAL INFORMATION

Allergies/Medications:

_____

_____

_____

VEHICLE INFORMATION

Make/Model of car you drive to school: _____ License Plate: _____

All of the above information is personal and kept within our school district files in the event of an emergency situation. Please remember: If any of your information changes, please advise the district office and your school office. Thank you.

_____ _____
(Signature) (Date)

Please Initial Below

_____ I consent to give my address to another District 113A staff member per request for the purpose of sending cards or other written communications that may occur during the year.

_____ I do NOT consent to give my address to another District 113A staff member per request for the purpose of sending cards or other written communications that may occur during the year.

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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	Other Last Names Used *(if any)*

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

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

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 boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear 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.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

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	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**10.** School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

NOTICE OF ENROLLMENT IN IMRF

IMRF Form 6.10 (Rev. 10/07)

PLEASE PRINT OR TYPE ALL ANSWERS

How to complete this form

Employment Information

The Authorized Agent completes questions 9 through 15. ***Refer to Section 3 of the Manual for Authorized Agents for information on eligibility requirements for participation in IMRF.***

- **Question 1 – Member name**
  The name entered in Box 1 should be the name used to report the member's earnings to IMRF. Using the same name will better ensure that the member receives proper credit for contributions made and service earned.
- **Questions 2 - 10**
  Enter the requested information.
- **Question 11**
  Enter the requested information for each position the member will hold. If the date employed is different than the participation date (the date the member began working in the position(s) qualified under the annual hourly standard), please explain in the space provided. The Illinois Pension Code does not recognize reasons such as probationary, temporary or trial work period. Enter a detailed explanation why the member was not enrolled immediately. Refer to Section 3 of the Manual for Authorized Agents for more information regarding participation requirements. Full Time/Part Time applies only to SLEP. Circle the appropriate response.
- **Question 12**
  Check "yes" if the member is in a position that requires at least six months of consecutive service but less than 12 in any 12-month period.

  OR

  Check "yes" if the member's earnings will be reported to IMRF other than on a monthly basis, e.g. annually, quarterly, etc.

  If answered "yes" to either question and seasonal employer is not a school district, park district, or recreation association, or if the employee will be paid irregularly (applies only to elected officials) check the months the employee will not be paid.
- **Question 13 A**
  If the member is a police chief eligible for transfer into the Sheriff's Law Enforcement Personnel plan (SLEP), please complete and attach IMRF Form 6.22, "Election of Police Chief to Participate as SLEP Member." *(Refer to Section 3 of the SLEP supplement to the Manual for Authorized Agents for information on SLEP eligibility requirements.)*
- **Question 13 B**
  Check "yes" if the member has been sworn in to perform police duties. *(Refer to Section 3 of the Manual for Authorized Agents for eligibility requirements.)*
- **Question 13 C**
  Check "yes" if the member will perform fire protection duties. *(Refer to Section 3 of the Manual for Authorized Agents for eligibility requirements.)*
- **Question 13 D**
  Check "yes" if the member will provide instructional support in the classroom, tutor, supervise students, or perform clerical tasks required by teachers.
- **Question 13 E and 14**
  If the member is an elected official, appointed to elected office, or is a city hospital worker, please complete and attach IMRF Form 6.21, "Election to Participate."
- **Question 15 - COUNTY EMPLOYERS ONLY**
  If the employer is a county and the member is/was elected or appointed to elected office, complete question 15. If "yes" is checked and the member elected to participate in the Elected County Official plan, complete and attach IMRF Form 6.21B, "Election of Elected County Official to Participate in ECO."

AUTHORIZED AGENT PLEASE NOTE:

Social Security card/number

Tape a copy of the member's Social Security card in the box. IMRF uses Social Security numbers to identify members' accounts and files. Social Security numbers are also used on IRS statements issued by IMRF.

If the name in Box 1 is not the same as shown on the Social Security card, the member should take evidence to substantiate the change of name to a local Social Security office so a new card may be issued. Once issued, please forward a copy to IMRF.

If the member does not have a copy of his/her Social Security card, IMRF will use the Social Security number entered on this form. Any IRS penalties that result from an incorrect Social Security number will be the responsibility of the IMRF employer. If the member obtains a Social Security card after being enrolled, please forward a copy to IMRF.

When calling

When calling IMRF regarding enrollment, ask for the Enrollment Auditor.

NOTICE OF ENROLLMENT IN IMRF

IMRF Form 6.10 (Rev. 10/07)

Please print or type — Use Black Ink.
Please do not use a highlighter anywhere on the form.

MEMBER INFORMATION ***(to be completed by member - please print or type)***

1. Last Name | First | Middle Initial | Jr., Sr., II, etc.

2. Social Security Number
__ __ __ - __ __ - __ __ __ __

3. Mailing Address

City | State | Zip + 4 | County

4. Home Telephone No.
( )

5. Birth Date: month/day/year

TAPE A COPY OF SOCIAL SECURITY CARD IN THIS SPACE

If a copy of the Social Security card is not attached, IMRF will use the Social Security number entered on this form. Any IRS penalties that result from an incorrect Social Security number will be the responsibility of the IMRF employer. **(Do not staple card—use tape and please stay within this border.)**

6. Martial Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

7. Gender ☐ Female ☐ Male

8. Are you currently participating or have you previously participated in IMRF or any other Illinois Public Pension systems?
☐ **No** ☐ **Yes** ***[please check the box(es) to identify the pension system(s)]***

☐ IMRF (If indicating IMRF, are you currently collecting a pension from IMRF?) ☐ Yes ☐ No
☐ Chicago Public School Teachers' ☐ Cook County Annuity & Benefit Fund ☐ General Assembly Retirement System
☐ Judges' Retirement System ☐ Laborers' Annuity & Benefit Fund ☐ Cook County Forest Preserve Annuity & Benefit
☐ Metro Water Reclaim. Retirement System ☐ Municipal Employees Annuity & Benefit Fund ☐ Park Employees' Annuity & Benefit Fund
☐ State Universities Retirement System ☐ State Employees' Retirement System ☐ State Teachers' Retirement System

I certify this information is correct to the best of my knowledge and belief.

Employee signature ***(write; do not print or type)***
X

Date

EMPLOYMENT INFORMATION - ALL FIELDS MUST BE COMPLETED ***(to be completed by employer — please print or type)***

9. Employer Name

10. Employer IMRF I.D. Number

11. Position Information

Date employed mo day yr	Participation date* mo day yr	Employee will participate in:	(SLEP ONLY: CIRCLE ONE)	Position Title(s)
		☐ Regular	☐ ECO ☐ SLEP (FT / PT)	
		☐ Regular	☐ ECO ☐ SLEP (FT / PT)	

***If date employed is earlier than participation date, explain in detail** why the member was not enrolled immediately. The Illinois Pension Code does not recognize "probationary," "temporary," or "trial work period." Refer to Section 3 of the Authorized Agents Manual for details on participation requirements.

12. Will employee work in a seasonal position? ..... ☐ No ☐ Yes ***OR***
Is employee an elected official who will be paid irregularly? ..... ☐ No ☐ Yes

If employee will hold a seasonal position and the seasonal employer is **not** a school district, park district, or recreation association, ***OR*** if employee is an elected official who will be paid irregularly, check the months the employee will **not** be paid:

☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ Jun ☐ Jul ☐ Aug ☐ Sept ☐ Oct ☐ Nov ☐ Dec

13. Is employee:
A. Police chief eligible for transfer into IMRF for SLEP coverage?
☐ **No** ☐ **Yes** ***(attach Form 6.22)***
B. Performing police duties? ..... ☐ **No** ☐ **Yes**
C. Performing fire protection duties? ..... ☐ **No** ☐ **Yes**
D. Performing teacher aide duties? ..... ☐ **No** ☐ **Yes**
(see instructions for examples)
E. City hospital worker?
☐ **No** ☐ **Yes** ***(attach Form 6.21)***

14. Elected official or appointed to elected office?
☐ **No** ☐ **Yes** ***(attach Form 6.21)***

15. For County employers only: Has member elected to participate in the Elected County Offical (ECO) plan?
☐ **No** ☐ **Yes** ***(attach Form 6.21B)***

I certify this information is correct to the best of my knowledge and belief, and that the person named above is employed in a position which qualifies him or her for membership in IMRF with the above employer.

Authorized Agent signature **(write; do not print or type)**
X

Date

Illinois Municipal Retirement Fund
2211 York Road, Suite 500, Oak Brook Illinois 60523-2337
Member Services Representatives 1-800-ASK-IMRF (1-800-275-4673)
www.imrf.org

DESIGNATION OF BENEFICIARY

IMRF Form 6.11 (Rev. 10/07)

Want to better ensure this designation will be accepted? **Be sure to review the instructions on pages 1 and 2, as well as the information on the back of the form.** If you have any questions, please call 1-800-ASK-IMRF (1-800-275-4673).

Who can complete this form

We can accept the signature of the member only to designate or change a beneficiary. If someone other than the member submits a designation of beneficiary form, including an agent under a power of attorney, **it will not be accepted.**

If you make any changes to this form

If you enter information on this form and later change that information before submitting the form, you must initial the change. For example, if you enter the name of a beneficiary and then cross it out, you must write your initials next to the change. If you do not, **this designation will not be accepted.**

Benefits payable upon your death

If you die while participating in IMRF, IMRF will pay your beneficiary(ies) either:

a. a lump sum death benefit, which can be equal to one year's salary, plus a refund of the balance in your IMRF member account, **OR**

b. a monthly pension, plus $3,000. Only your spouse would be eligible to receive a monthly pension. (A child's pension is payable if a member was participating in the Elected County Official (ECO) Plan, and the member's spouse is not eligible for a surviving spouse pension, but the deceased ECO member has unmarried children under the age of 18.)

How to complete this form

Box 1. Member Information

Please print the information requested. You may also include a telephone number where you can be reached. Also, please check the appropriate box indicating whether you want correspondence from IMRF (e.g., your annual Member Statement) to include information regarding your beneficiary(ies).

Box 2. Primary Beneficiary(ies)

How your marital status affects your beneficiary(ies)

- **If you are married,** your spouse is automatically your Primary Beneficiary **unless** you exclude your spouse by checking the small box in Box 4. See page 2 for more information on excluding spouses.

- **If you divorce** after filing this form, your former spouse will not be paid any benefit unless you file a new form after the date of the divorce and indicate your former spouse as the beneficiary. Otherwise, your secondary beneficiary or estate will receive the benefit.

- **If you are not married,** but marry after filing this form, your spouse automatically becomes your Primary Beneficiary. The person or organization you name as your Primary Beneficiary on this form becomes your Secondary Beneficiary. If you want any other arrangement, you will need to complete a new form.

continued on next page...

Naming a beneficiary(ies)

- ***If you are naming someone under the age of 18 (a minor) as a Primary Beneficiary(ies)***
  If you are naming a minor(s) as a Primary Beneficiary(ies), death benefits will be paid in care of the minor's guardian. If you want someone other than the guardian to receive the IMRF benefit on behalf of the minor, you may name a custodian, **who is 21 years of age or older**, under the Illinois Uniform Transfers to Minors Act. **This is done by entering the name of the individual you wish to appoint as custodian followed by "as custodian for _____ (name of minor) under the Illinois Uniform Transfers to Minors Act."**

- ***Options for beneficiary(ies)***
  In Box 2, please print the name(s) of the person(s) you wish to receive your IMRF death benefits. You can name any person, trust, church, charity, or organization. **It is important that you state your relationship to the beneficiary(ies) you designate.** (If you name a trust, please provide the number and/or date of the trust.) If the person(s) you list in Box 2 does not survive you, the IMRF death benefit will be paid to the person(s) you name in Box 3, "Secondary Beneficiary(ies)," or to your estate.

- ***If you are naming more than one Primary Beneficiary***
  If you name more than one Primary Beneficiary, the persons listed become "co-beneficiaries" and will share the death benefit according to the percentages you enter in the space provided. If you leave the percentages blank, the persons listed will share equally. If you name your spouse as co-beneficiary, he or she will **not** be eligible for a surviving spouse pension; only a lump sum death benefit will be paid. **If you want your spouse to be eligible for a surviving spouse pension, enter his or her name alone in Box 2.**

Box 3. Secondary Beneficiary(ies)

Your Secondary Beneficiary(ies) will receive the death benefit payable by IMRF if no Primary Beneficiary survives. Any person, church, trust, charity or organization may be named as your Secondary Beneficiary. You may also name more than one Secondary Beneficiary.

Box 4. Excluding your spouse as a Primary Beneficiary (married members only)

According to the Illinois Pension Code, if you are married, your spouse is automatically your Primary Beneficiary. However, some married members may not want their spouse named as their Primary Beneficiary. If you want to name some other person(s) as your Primary Beneficiary(ies), you would:

1. Enter the name(s) in Box 2, along with the other requested information. You can name any person(s), whether or not a relative, or any church, trust, charity, or organization as your Primary Beneficiary(ies).
2. "Exclude" your spouse from the IMRF death benefit by checking the small box in Box 4.

Please note: If you exclude your spouse as your Primary Beneficiary, your spouse will **not** be eligible for a surviving spouse pension. If you exclude your spouse as your Primary Beneficiary, you may still name your spouse as a Secondary Beneficiary.

Box 5. Signature, date and returning the completed form

You must sign, date, and file this form with IMRF for it to be effective.

You can mail the completed form to IMRF directly, or you can give the completed form to your employer, who will mail it to IMRF. The information on this form does not become effective **until it is *on file* in IMRF's Oak Brook or Springfield office, even if your employer has a copy.**

NOTE: Please refer to the **back of the form**, "Conditions of IMRF Designation of Beneficiary" for more complete information on your IMRF death benefit provisions.

DESIGNATION OF BENEFICIARY

IMRF Form 6.11 (Rev. 10/07)

Please refer to instructions when completing this form.

Please print or type — use black ink and do not use a highlighter on the form.

1. Member Information

Employee Name

Mailing Address

Social Security Number
_____ - _____ - _____

MID (office use only)

Home Telephone
( ) _____ - _____

Birthdate (*month/day/year*)
_____/ _____ / _____

Gender
☐ Male ☐ Female

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Last Name First Middle Initial Maiden (if applicable) Jr., Sr., II, etc.

Marriage Date (month/day/year)

Do you want information regarding your beneficiary(ies) listed on IMRF correspondence? ☐ Yes ☐ No

2. Primary Beneficiary(ies) *(Will receive IMRF death benefits **first.**)* *Please refer to instructions when naming a minor.*

First Name	Last Name	Social Security Number *(optional)*	Relationship	% Share to each
			TOTAL	**100%**

Important: If the total of all primary beneficiary shares does not equal 100%, IMRF will allocate equal shares totaling 100%.

3. Secondary Beneficiary(ies) *(Will receive IMRF death benefits **if no Primary Beneficiary survives.**)*

First Name	Last Name	Social Security Number *(optional)*	Relationship	% Share to each
			TOTAL	**100%**

Important: If the total of all primary beneficiary shares does not equal 100%, IMRF will allocate equal shares totaling 100%.

4. Exclusion of spouse as Primary Beneficiary (Refer to instructions for Box 4.)

CHECK BOX *IF YOU DID **NOT** NAME YOUR SPOUSE AS **PRIMARY** BENEFICIARY IN BOX 2 ABOVE.*

☐ I do **not** want my spouse to receive IMRF death benefits as **Primary** Beneficiary. I understand and intend that my spouse will **not** be eligible for a surviving spouse pension.

BOX 5 - Signature (WRITE, DO NOT TYPE OR PRINT) of **member only**
(The designation **will not be accepted** if someone other than the member signs this form.)

X Date

Read the conditions on the reverse side.

Illinois Municipal Retirement Fund
2211 York Road, Suite 500, Oak Brook, IL 60523-2337
1-800-ASK-IMRF (1-800-275-4673) Fax 1-630-706-4289

Conditions of IMRF Designation of Beneficiary

This is a brief summary of your IMRF death benefit provisions.
Your rights and obligations as an IMRF member are governed by Article 7 of the Illinois Pension Code.

This designation of beneficiary:

- provides for payment of IMRF death benefits and revokes (cancels) any prior beneficiary designation.
- will be effective when you sign it and it is ***on file*** in IMRF's Oak Brook or Springfield office.
- is subject to Illinois law and to rules and regulations established by the IMRF Board of Trustees.

The acceptance of this designation by IMRF does not mean that a death benefit will be payable if you are not otherwise entitled to one. Whether a benefit is payable and the amount paid will be determined at the time of death under laws and regulations then applicable.

Your creditor (such as a bank, credit union, or loan company) may not be named as beneficiary as a means of providing security for a debt.

Death benefit payments

IMRF death benefits are paid to:

- the Primary Beneficiary designated by the member on the most recent designation of beneficiary form on file with IMRF
- the spouse of the married member or to the estate of an unmarried member, if no designation form is on file.

If no Primary Beneficiary(ies) survives, the benefit will be paid to your Secondary Beneficiary(ies).

If no Primary or Secondary Beneficiary(ies) survives, the benefit will be paid to your estate.

A child's pension is payable if the member was participating in the Elected County Official (ECO) Plan and the member's spouse is not eligible for a surviving spouse pension, but the deceased has unmarried children under the age of 18.

Exclusion of spouse

Under the IMRF statute, a spouse is the Primary Beneficiary of a married member, unless the member excludes the spouse in writing (see Box 4 on the form).

You may:

- name your spouse as "co-beneficiary" with any other person(s), or
- totally exclude your spouse by completing Box 4 and naming any person(s), or any church, trust, charity or organization as your Primary Beneficiary(ies).

If your spouse is **not** your **only** Primary Beneficiary, or if you completely exclude your spouse,

- the right to **a Surviving Spouse pension is forfeited** (lost).
- only **a lump sum benefit is payable** (which can be equal to one year's salary, plus a refund of the balance in your IMRF member account). **In the case of the member with many years of service credit, the forfeited Surviving Spouse pension may be of greater value than the lump sum benefit.**

After you retire and start receiving your IMRF pension, your spouse is again eligible for a Surviving Spouse pension, even if you previously excluded him or her.

A member receiving an IMRF pension may exclude his or her spouse from receiving the $3,000 lump sum benefit payable upon the death of a retiree, but not from the Surviving Spouse pension.

Naming a minor(s) as beneficiary(ies)

Death benefits payable to a minor (under the age of 18) are paid in care of the minor's guardian. If you want someone other than the minor's guardian to receive the IMRF benefit on behalf of the minor, you may name a custodian (who is 21 years of age or older) under the Illinois Uniform Transfers to Minors Act. This is done by entering the name of the individual you wish to appoint as custodian followed by "as custodian for _____ (name of minor) under the Illinois Uniform Transfers to Minors Act."

Shares to each named beneficiary

If more than one person is named beneficiary, they will share equally in the benefit unless specific shares are written in.

If specific shares (percentages) are written in, the benefit will be distributed as directed.

- If a named beneficiary does not survive, his or her shares will be distributed among any surviving beneficiaries.
- If you add "per stirpes" after a beneficiary's name and that beneficiary does not survive, his or her share will be distributed to his or her heirs by blood line (not a spouse).

Lemont-Bromberek Combined School District 113A Job Description

POSITION:	Substitute for Assistant and Paraprofessional
MINIMUM QUALIFICATIONS:	Valid Illinois Educator License with Stipulations: Paraprofessional Educator; or Valid Illinois Professional Educator License; or Valid Illinois Substitute License; and Able to lift, carry and move students and objects weighing over 20 pounds; and Able to perform all essential job functions with or without reasonable accommodations
TYPE:	Temporary
CATEGORY:	Non-exempt (Fair Labor Standards Act)
WORK YEAR:	As assigned
REPORTS TO:	Principal/s and Assistant Principal/s

ESSENTIAL JOB FUNCTIONS:

1. Under the direction of a certified teacher or administrator, conducts instructional activities designed to increase academic achievement for individuals and small groups of students.
2. Under the direction of a certified teacher or administrator, uses technology and other designated programs and strategies to implement instructional interventions, collect data and report data.
3. Under the direction of a certified teacher or administrator, implements academic and behavioral supports with students.
4. Engages in tasks that support school or District projects or programs.
5. Provides personal care for students, including diapering and toileting assistance, as needed.
6. Lifts carries or otherwise physically manages students, as necessary.
7. Uses a computer keyboard and monitor to enter, retrieve or transform data.
8. Uses current available technologies appropriately and effectively for instructional, job-related and communication purposes.
9. Develops and maintains positive and active relations and effective communications with students, staff, parents, community members and community organizations.
10. Notifies the administration immediately of evidence of substance abuse, severe medical or social conditions, potential suicide or individuals appearing to be under the influence of illegal substances.
11. Takes all necessary and reasonable precautions to protect the health and safety of students, staff, equipment, materials and facilities.

2003;2005;2007;2011; 2013

12. Complies with all assigned duties, Board of Education policies and administrative procedures; adheres to state and federal laws and regulations.

13. Exhibits ethical behavior and integrity and maintains confidentiality for all school-related responsibilities.

14. Maintains a positive attitude towards job related growth and development.

15. Performs other duties as assigned by supervisor/s or Superintendent.

By signing this job description, I affirm that I have read and understand the contents of this document.

Employee's Name: _____

_____ _____

Signature of Receipt Date

2003;2005;2007;2011; 2013

Lemont-Bromberek Combined School District 113A Job Description

POSITION:	Professional Nurse Substitute
MINIMUM QUALIFICATIONS:	Registered Nurse license (LPN license does NOT qualify); CPR/AED certified as Healthcare Provider; First Aid trained; Able to use a computer keyboard and to enter, retrieve and transform data; Able to view and read data on a computer monitor; Able to lift, carry and move students and objects weighing over 20 pounds; and Able to perform all essential job functions with or without reasonable accommodations
TYPE:	Professional
CATEGORY:	Non-exempt (Fair Labor Standards Act)
WORK SCHEDULE:	As Assigned
REPORTS TO:	Principal/s and Assistant Principal/s

ESSENTIAL JOB FUNCTIONS:

1. Provides services and implements medical procedures for temporarily ill, chronically ill and injured students and staff.
2. Administers medication to students and/or supervises the students' self administration of medication per District policy.
3. Supports and contributes to a healthy, safe and sanitary educational environment.
4. Implements Board policy on exclusion and readmission of students, as directed by building administrator.
5. Communicates in a positive and effective manner regarding students' health conditions among parents, students, medical professionals, teachers, administrators and other health personnel.
6. Proofreads and checks documents for accuracy.
7. Provides general assistance in the school office, as needed.
8. Provides personal care for students, including diapering and toileting assistance, as needed.
9. Lifts, carries or otherwise physically manages students, as necessary.
10. Uses current available technologies appropriately and effectively for job-related and communication purposes.
11. Notifies the administration immediately of evidence of substance abuse, severe medical or social conditions, potential suicide or individuals appearing to be under the influence of illegal substances.

12. Takes all necessary and reasonable precautions to protect the health and safety of students, staff, equipment, materials and facilities.

13. Complies with all Board of Education policies and administrative procedures; adheres to local, county, state and federal laws and regulations.

14. Develops and maintains positive and active relations and effective communications with students, staff, parents, community members and community organizations.

15. Exhibits ethical behavior and integrity and maintains confidentiality for all school-related responsibilities.

16. Maintains a positive attitude toward job related growth and development.

17. Performs other duties as assigned by supervisor/s or Superintendent.

By signing this job description, I affirm that I have read and understand the contents of this document.

Employee's Name: _____

_____ _____

Signature of Receipt Date

Lemont-Bromberek Combined School District 113A Job Description

POSITION:	Substitute for Secretary/Administrative Assistant
MINIMUM QUALIFICATIONS:	High school diploma or equivalent; Strong oral, written and interpersonal communication skills; Able to effectively operate office machines and use current technology applications such as word processing, spread sheet, database; Previous experience receiving and serving the public strongly preferred; Able to lift, carry and move objects weighing up to 20 pounds; Able to view and read data on a computer monitor; Able to use a computer keyboard to enter, retrieve and transform data; and Able to perform all essential job functions with or without reasonable accommodations
TYPE:	Temporary
CATEGORY:	Non-exempt (Fair Labor Standards Act)
WORK YEAR:	As assigned
REPORTS TO:	Principal and Assistant Principal

ESSENTIAL JOB FUNCTIONS:

1. Uses current available technologies appropriately and effectively for job-related and communication purposes.
2. Completes reports per supervisor's requirements.
3. Conducts student registration, attendance and disenrollment processes, as needed.
4. Performs secretarial functions.
5. Proofreads and checks documents for accuracy.
6. Uses a computer keyboard and monitor to enter, retrieve and transform data.
7. Develops and maintains positive and active relations with effective communications with students, staff, parents, community members and community organizations.
8. Takes all necessary and reasonable precautions to protect the health and safety of students, staff, equipment, materials and facilities.
9. Complies with all assigned duties, Board of Education policies and administrative procedures; adheres to state and federal laws and regulations.
10. Exhibits ethical behavior and integrity and maintains confidentiality for all school-related responsibilities.
11. Maintains a positive attitude toward job related growth and development.

12. Performs other duties as assigned by supervisor/s or Superintendent.

By signing this job description, I affirm that I have read and understand the contents of this document.

Employee's Name: _____

_____ _____

Signature of Receipt Date

State of Illinois
Department of Employment Security

New Hire Reporting Form

Employers must report each new hire within 20 days. **Assistance: 1 800 327-HIRE (4473)**

Please print or type

EMPLOYER NAME AND ADDRESS

Federal Employer ID Number - FEIN 36 - 6004334

Company Name Lemont-Bromberek CSD 113A

Street Address 16100 W 127th Street

Street Address

City Lemont State IL Zip Code 60439 -

EMPLOYER ADDRESS FOR CHILD SUPPORT WAGE WITHHOLDING ORDERS

Street Address

Street Address

City State Zip Code -

NEW EMPLOYEE NAME AND ADDRESS

Social Security Number Date of Hire (MM-DD-YYYY) - -

First Name *MI* *Last Name*

Street Address

City State Zip Code -

NEW EMPLOYEE NAME AND ADDRESS

Social Security Number Date of Hire (MM-DD-YYYY) - -

First Name *MI* *Last Name*

Street Address

City State Zip Code -

Report new hires online, or by returning your completed form either by FAX 1-217-557-1947, or by U.S. mail to IDES, P.O. Box 19473, Springfield, IL 62794-9473.

Lemont-Bromberek Combined School District 113A

U.S. Department of Education Race and Ethnicity Data Standards

Staff Identification Form

INSTRUCTIONS: Please complete this form by responding to both questions below. Part A asks about your ethnicity and Part B asks about your race. Thank you for your cooperation.

Name:
School/s:

Part A: Are you Hispanic/Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.) **Choose only one.**

- ☐ **No, not Hispanic/Latino**
- ☐ **Yes, Hispanic/Latino**

The question above is about ethnicity, not race. No matter which answer you selected, continue and respond to the question below by marking one or more boxes to indicate what you consider your race to be.

Part B: What is your race? Choose one or more.

- ☐ **American Indian or Alaska Native** (A person having origins in any of the original peoples of North and South America, including Central America, and who maintain tribal affiliation or community attachment.)
- ☐ **Asian** (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)
- ☐ **Black or African American** (A person having origins in any of the black racial groups of Africa.)
- ☐ **Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
- ☐ **White** (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

Signature _____ Date _____

Resource: Illinois State Board of Education, Division of Data Analysis and Progress Reporting, December 2009

DO: 4/2010

Lemont-Bromberek Combined School District 113A

Sexual Harassment Policy – Documentation of Receipt

By signing this form, I certify that I have received and read the District policies and procedures related to Sexual Harassment (Policy 5:20 – Personnel and Policy 7:20 – Students). I understand the information contained therein and have had the opportunity to ask questions about the contents of the policies.

Further, I have been advised that any employee who wishes to file a complaint related to sexual harassment may file the complaint with any member of the administrative team. With respect to concerns about general work practices, policies and procedures, employees will continue to take the first step to attempt to resolve a concern with their immediate supervisor. However, concerns related to sexual harassment are not limited to the typical progressive steps used to present a grievance; any district administrator will accept a complaint regarding sexual harassment.

If I have any questions about the district's sexual harassment policies, I may contact the Nondiscrimination Coordinator, Daniela Fountain, Assistant Superintendent, at the District Office (630-257-2286 extension 4618).

_____ / _____

Employee's Name | Position

_____ / _____

Employee's Signature | Date

Illinois Department of Revenue

Form IL-W-4

Employee's and other Payee's Illinois Withholding Allowance Certificate and Instructions

Note: These instructions are written for employees to address withholding from wages. However, this form can also be completed and submitted to a payor if an agreement was made to voluntarily withhold Illinois Income tax from other (non-wage) Illinois income.

Who must complete Form IL-W-4?

If you are an employee, you must complete this form so your employer can withhold the correct amount of Illinois Income Tax from your pay. The amount withheld from your pay depends, in part, on the number of allowances you claim on this form.

Even if you claimed exemption from withholding on your federal Form W-4, U.S. Employee's Withholding Allowance Certificate, because you do not expect to owe any federal income tax, you may be required to have Illinois Income Tax withheld from your pay (see Publication 130, Who is Required to Withhold Illinois Income Tax). If you are claiming exempt status from Illinois withholding, you must check the exempt status box on Form IL-W-4 and sign and date the certificate. Do not complete Lines 1 through 3.

If you are a resident of Iowa, Kentucky, Michigan, or Wisconsin, or a military spouse, see Form W-5-NR, Employee's Statement of Nonresidence in Illinois, to determine if you are exempt.

Note If you do not file a completed Form IL-W-4 with your employer, if you fail to sign the form or to include all necessary information, or if you alter the form, your employer must withhold Illinois Income Tax on the entire amount of your compensation, without allowing any exemptions.

When must I submit this form?

You should complete this form and give it to your employer on or before the date you start work. You must submit Form IL-W-4 when Illinois Income Tax is required to be withheld from compensation that you receive as an employee. You may file a new Form IL-W-4 any time your withholding allowances increase. If the number of your claimed allowances decreases, you **must** file a new Form IL-W-4 within 10 days. However, the death of a spouse or a dependent does not affect your withholding allowances until the next tax year.

When does my Form IL-W-4 take effect?

If you do not already have a Form IL-W-4 on file with your employer, this form will be effective for the first payment of compensation made to you after this form is filed. If you already have a Form IL-W-4 on file with this employer, your employer may allow any change you file on this form to become effective immediately, but is not required by law to change your withholding until the first payment of compensation is made to you after the first day of the next calendar quarter (that is, January 1, April 1, July 1, or October 1) that falls at least 30 days after the date you file the change with your employer.

Example: If you have a baby and file a new Form IL-W-4 with your employer to claim an additional allowance for the baby, your employer may immediately change the withholding for all future payments of compensation. However, if you file the new form on September 1, your employer does not have to change your withholding until the first payment of compensation is made to you after October 1. If you file the new form on September 2, your employer does not have to change your withholding until the first payment of compensation made to you after December 31.

How long is Form IL-W-4 valid?

Your Form IL-W-4 remains valid until a new form you have submitted takes effect or until your employer is required by the Department to disregard it. Your employer is required to disregard your Form IL-W-4 if

- you claim total exemption from Illinois Income Tax withholding, but you have not filed a federal Form W-4 claiming total exemption, or
- the Internal Revenue Service (IRS) has instructed your employer to disregard your federal Form W-4.

What is an "exemption"?

An "exemption" is a dollar amount on which you do not have to pay Illinois Income Tax that you may claim on your Illinois Income tax return.

What is an "allowance"?

The dollar amount that is exempt from Illinois Income Tax is based on the number of allowances you claim on this form. As an employee, you receive one allowance unless you are claimed as a dependent on another person's tax return (*e.g.*, your parents claim you as a dependent on their tax return). If you are married, you may claim additional allowances for your spouse and any dependents that you are entitled to claim for federal income tax purposes. You also will receive additional allowances if you or your spouse are age 65 or older, or if you or your spouse are legally blind.

Note: For tax years beginning on or after January 1, 2017, the personal exemption allowance, and additional allowances if you or your spouse are age 65 or older, or if you or your spouse are legally blind, may **not** be claimed on your Form IL-1040 if your adjusted gross income for the taxable year exceeds $500,000 for returns with a federal filing status of married filing jointly, or $250,000 for all other returns. You may complete a new Form IL-W-4 to update your exemption amounts and increase your Illinois withholding.

How do I figure the correct number of allowances?

Complete the worksheet on the back of this page to figure the correct number of allowances you are entitled to claim. Give your completed Form IL-W-4 to your employer. Keep the worksheet for your records.

Note If you have more than one job or your spouse works, your withholding usually will be more accurate if you claim all of your allowances on the Form IL-W-4 for the highest-paying job and claim zero on all of your other IL-W-4 forms.

How do I avoid underpaying my tax and owing a penalty?

You can avoid underpayment by reducing the number of allowances or requesting that your employer withhold an additional amount from your pay. Even if your withholding covers the tax you owe on your wages, if you have non-wage income that is taxable, such as interest on a bank account or dividends on an investment, you may have additional tax liability. If you owe more than $500 tax at the end of the year, you may owe a late-payment penalty or will be required to make estimated tax payments. For additional information on penalties see Publication 103, Uniform Penalties and Interest. Visit our website at **tax.illinois.gov** to obtain a copy.

Where do I get help?

- Visit our website at **tax.illinois.gov**
- Call our Taxpayer Assistance Division at **1 800 732-8866** or **217 782-3336**
- Call our TDD (telecommunications device for the deaf) at **1 800 544-5304**
- Write to
  ILLINOIS DEPARTMENT OF REVENUE
  PO BOX 19044
  SPRINGFIELD IL 62794-9044

Illinois Withholding Allowance Worksheet

General Information

Use this worksheet as a guide to figure your total withholding allowances you may enter on your Form IL-W-4.

Complete Step 1.

Complete Step 2 if

- you (or your spouse) are age 65 or older or legally blind, or
- you wrote an amount on Line 4 of the Deductions Worksheet for federal Form W-4.

If you have more than one job or your spouse works, your withholding usually will be more accurate if you claim all of your allowances on the Form IL-W-4 for the highest-paying job and claim zero on all of your other IL-W-4 forms.

You may reduce the number of allowances or request that your employer withhold an additional amount from your pay, which may help avoid having too little tax withheld.

Step 1: Figure your basic personal allowances (including allowances for dependents)

Check all that apply:

☐ No one else can claim me as a dependent.

☐ I can claim my spouse as a dependent.

1 Enter the total number of boxes you checked. 1 _____

2 Enter the number of dependents (other than you or your spouse) you will claim on your tax return. 2 _____

3 Add Lines 1 and 2. Enter the result. This is the total number of basic personal allowances to which you are **entitled**. You are not required to claim these allowances. The number of basic personal allowances that you choose to claim will determine how much money is withheld from your pay. See Line 4 for more information. 3 _____

4 Enter the total number of basic personal allowances you choose to claim on this line and Line 1 of Form IL-W-4 below. This number may not exceed the amount on Line 3 above, however you can claim as few as zero. Entering lower numbers here will result in more money being withheld(deducted) from your pay. 4 _____

Step 2: Figure your additional allowances

Check all that apply:

☐ I am 65 or older. ☐ I am legally blind.

☐ My spouse is 65 or older. ☐ My spouse is legally blind.

5 Enter the total number of boxes you checked. 5 _____

6 Enter any amount that you reported on Line 4 of the Deductions Worksheet for federal Form W-4 plus any additional Illinois subtractions or deductions. 6 _____

7 Divide Line 6 by 1,000. Round to the nearest whole number. Enter the result on Line 7. 7 _____

8 Add Lines 5 and 7. Enter the result. This is the total number of additional allowances to which you are **entitled**. You are not required to claim these allowances. The number of additional allowances that you choose to claim will determine how much money is withheld from your pay. 8 _____

9 Enter the total number of additional allowances you elect to claim on Line 2 of Form IL-W-4, below. This number may not exceed the amount on Line 8 above, however you can claim as few as zero. Entering lower numbers here will result in more money being withheld(deducted) from your pay. 9 _____

IMPORTANT: If you want to have additional amounts withheld from your pay, you may enter a dollar amount on Line 3 of Form IL-W-4 below. This amount will be deducted from your pay in addition to the amounts that are withheld as a result of the allowances you have claimed.

✂ — — — — — — — — Cut here and give the certificate to your employer. Keep the top portion for your records. — — — — — — — — ✂

Illinois Department of Revenue

IL-W-4 Employee's Illinois Withholding Allowance Certificate

___ ___ ___ - ___ ___ - ___ ___ ___ ___
Social Security number

Name

Street address

City State ZIP

Check the box if you are exempt from federal and Illinois Income Tax withholding and sign and date the certificate. ☐

1 Enter the total number of basic allowances that you are claiming (Step 1, Line 4, of the worksheet). 1 _____

2 Enter the total number of additional allowances that you are claiming (Step 2, Line 9, of the worksheet). 2 _____

3 Enter the additional amount you want withheld (deducted) from each pay. 3 _____

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

Your signature Date

Printed by the authority of the State of Illinois - web only, 1 copy
IL-W-4 (R-12/19)

This form is authorized under the Illinois Income Tax Act. Disclosure of this information is required. Failure to provide information may result in this form not being processed and may result in a penalty.

Employer: Keep this certificate with your records. If you have referred the employee's federal certificate to the IRS and the IRS has notified you to disregard it, you may also be required to disregard this certificate. Even if you are not required to refer the employee's federal certificate to the IRS, you still may be required to refer this certificate to the Illinois Department of Revenue for inspection. See Illinois Income Tax Regulations 86 Ill. Adm. Code 100.7110.

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

2020

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) **Social security number**
Address		▶ **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*.
City or town, state, and ZIP code		

(c) ☐ **Single or Married filing separately**
☐ **Married filing jointly** (or Qualifying widow(er))
☐ **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.)

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, when to use the online estimator, and privacy.

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 most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **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 accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ▶ ☐

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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 Dependents

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

Multiply the number of qualifying children under age 17 by $2,000 ▶ $ _____

Multiply the number of other dependents by $500 . . . . ▶ $ _____

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): 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. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

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

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	First date of employment	Employer identification number (EIN)

General Instructions

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505.

Exemption from withholding. You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 **and** you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2020 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2021.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Expect to work only part of the year;

2. Have dividend or capital gain income, or are subject to additional taxes, such as the additional Medicare tax;

3. Have self-employment income (see below); or

4. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

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

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

If you (and your spouse) have a total of only two jobs, you may instead check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. Step 3 of Form W-4 provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2020 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . **1** $

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . **2a** $

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . **2b** $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3**

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . **4** $

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $24,800 if you're married filing jointly or qualifying widow(er)
- $18,650 if you're head of household
- $12,400 if you're single or married filing separately

. . . . . **2** $

3 If line 1 is greater than line 2, subtract line 2 from line 1. If line 2 is greater than line 1, enter "-0-" . . **3** $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040 or 1040-SR)). See Pub. 505 for more information **4** $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . **5** $

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 with no other entries on the form; 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.

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$220	$850	$900	$1,020	$1,020	$1,020	$1,020	$1,020	$1,210	$1,870	$1,870
$10,000 - 19,999	220	1,220	1,900	2,100	2,220	2,220	2,220	2,220	2,410	3,410	4,070	4,070
$20,000 - 29,999	850	1,900	2,730	2,930	3,050	3,050	3,050	3,240	4,240	5,240	5,900	5,900
$30,000 - 39,999	900	2,100	2,930	3,130	3,250	3,250	3,440	4,440	5,440	6,440	7,100	7,100
$40,000 - 49,999	1,020	2,220	3,050	3,250	3,370	3,570	4,570	5,570	6,570	7,570	8,220	8,220
$50,000 - 59,999	1,020	2,220	3,050	3,250	3,570	4,570	5,570	6,570	7,570	8,570	9,220	9,220
$60,000 - 69,999	1,020	2,220	3,050	3,440	4,570	5,570	6,570	7,570	8,570	9,570	10,220	10,220
$70,000 - 79,999	1,020	2,220	3,240	4,440	5,570	6,570	7,570	8,570	9,570	10,570	11,220	11,240
$80,000 - 99,999	1,060	3,260	5,090	6,290	7,420	8,420	9,420	10,420	11,420	12,420	13,260	13,460
$100,000 - 149,999	1,870	4,070	5,900	7,100	8,220	9,320	10,520	11,720	12,920	14,120	14,980	15,180
$150,000 - 239,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,190	16,050	16,250
$240,000 - 259,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,520	17,170	18,170
$260,000 - 279,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	13,120	15,120	17,120	18,770	19,770
$280,000 - 299,999	2,040	4,440	6,470	7,870	9,190	10,720	12,720	14,720	16,720	18,720	20,370	21,370
$300,000 - 319,999	2,040	4,440	6,470	8,200	10,320	12,320	14,320	16,320	18,320	20,320	21,970	22,970
$320,000 - 364,999	2,720	5,920	8,750	10,950	13,070	15,070	17,070	19,070	21,290	23,590	25,540	26,840
$365,000 - 524,999	2,970	6,470	9,600	12,100	14,530	16,830	19,130	21,430	23,730	26,030	27,980	29,280
$525,000 and over	3,140	6,840	10,170	12,870	15,500	18,000	20,500	23,000	25,500	28,000	30,150	31,650

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$460	$940	$1,020	$1,020	$1,470	$1,870	$1,870	$1,870	$1,870	$2,040	$2,040	$2,040
$10,000 - 19,999	940	1,530	1,610	2,060	3,060	3,460	3,460	3,460	3,640	3,830	3,830	3,830
$20,000 - 29,999	1,020	1,610	2,130	3,130	4,130	4,540	4,540	4,720	4,920	5,110	5,110	5,110
$30,000 - 39,999	1,020	2,060	3,130	4,130	5,130	5,540	5,720	5,920	6,120	6,310	6,310	6,310
$40,000 - 59,999	1,870	3,460	4,540	5,540	6,690	7,290	7,490	7,690	7,890	8,080	8,080	8,080
$60,000 - 79,999	1,870	3,460	4,690	5,890	7,090	7,690	7,890	8,090	8,290	8,480	9,260	10,060
$80,000 - 99,999	2,020	3,810	5,090	6,290	7,490	8,090	8,290	8,490	9,470	10,460	11,260	12,060
$100,000 - 124,999	2,040	3,830	5,110	6,310	7,510	8,430	9,430	10,430	11,430	12,420	13,520	14,620
$125,000 - 149,999	2,040	3,830	5,110	7,030	9,030	10,430	11,430	12,580	13,880	15,170	16,270	17,370
$150,000 - 174,999	2,360	4,950	7,030	9,030	11,030	12,730	14,030	15,330	16,630	17,920	19,020	20,120
$175,000 - 199,999	2,720	5,310	7,540	9,840	12,140	13,840	15,140	16,440	17,740	19,030	20,130	21,230
$200,000 - 249,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$250,000 - 399,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$400,000 - 449,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,450	19,940	21,240	22,540
$450,000 and over	3,140	6,230	8,810	11,310	13,810	15,710	17,210	18,710	20,210	21,700	23,000	24,300

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$830	$930	$1,020	$1,020	$1,020	$1,480	$1,870	$1,870	$1,930	$2,040	$2,040
$10,000 - 19,999	830	1,920	2,130	2,220	2,220	2,680	3,680	4,070	4,130	4,330	4,440	4,440
$20,000 - 29,999	930	2,130	2,350	2,430	2,900	3,900	4,900	5,340	5,540	5,740	5,850	5,850
$30,000 - 39,999	1,020	2,220	2,430	2,980	3,980	4,980	6,040	6,630	6,830	7,030	7,140	7,140
$40,000 - 59,999	1,020	2,530	3,750	4,830	5,860	7,060	8,260	8,850	9,050	9,250	9,360	9,360
$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,780	10,980	11,180	11,580	12,380
$80,000 - 99,999	1,900	4,300	5,710	7,000	8,200	9,400	10,600	11,180	11,670	12,670	13,580	14,380
$100,000 - 124,999	2,040	4,440	5,850	7,140	8,340	9,540	11,360	12,750	13,750	14,750	15,770	16,870
$125,000 - 149,999	2,040	4,440	5,850	7,360	9,360	11,360	13,360	14,750	16,010	17,310	18,520	19,620
$150,000 - 174,999	2,040	5,060	7,280	9,360	11,360	13,480	15,780	17,460	18,760	20,060	21,270	22,370
$175,000 - 199,999	2,720	5,920	8,130	10,480	12,780	15,080	17,380	19,070	20,370	21,670	22,880	23,980
$200,000 - 249,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$250,000 - 349,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$350,000 - 449,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,900	25,200
$450,000 and over	3,140	6,840	9,560	12,140	14,640	17,140	19,640	21,530	23,030	24,530	25,940	27,240