**S.C. DEPARTMENT OF EMPLOYMENT AND WORKFORCE**

**COVID-19 Support Payment Plan Application**

|  |  |  |  |  |  |  |  |
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| SECTION 1: Employer Contact Information | | | | | | | |
| 1. Legal Name | | | | | 1. Trade Name (DBA) | | |
| 1. Street Address in S.C. (If out of state, provide registered agent’s address) | | | **3a**. City | | **3b**. State | | **3c**. Zip Code |
| 1. Mailing Address (if different than street address) | | | **4a**. City | | **4b**. State | | **4c**. Zip Code |
| 1. Federal Employer Identification Number (FEIN) | | 1. Business Telephone | | | | 1. SCDEW Account# | |
| **8**. Name of Contact: | | | | | | | |
| **8a**. Title: | | | | **8b**. Telephone: | | | |
| **8c**. Email for : | | | |
|  | SECTION 2: COVID-19 Plan Details | | | | | | | |
| 1. Enter DATE employees will be furloughed:   **MM / DD / YYYY** | | | | | | | | |
| 1. Enter names of employees who will received COVID-19 Support Payments (Attach additional sheets if necessary): | | | | | | | | |
| 1. Will the employees receive weekly payments? Yes or No Circle One | | | | | | | | |
| 1. Will the employees receive a lump sum payment? Yes or No Circle One | | | | | | | | |
| 1. Will the payment be made in response to furloughing the employee because of COVID-19? Yes or No Circle One | | | | | | | | |
| 1. Will the payment be made for services rendered in the past? Yes or No Circle One | | | | | | | | |
| 1. Will the payment be made free from any obligation for employees (or their estates) to repay it? Yes or No Circle One | | | | | | | | |
| 1. Will the payment be made free from any obligation for the employee to perform or not perform any act? Yes or No Circle One | | | | | | | | |
| 1. Do you agree to file unemployment for Employees via the Employer Filed Claim process? Yes or No Circle One | | | | | | | | |
| |  |  | | --- | --- | |  | SECTION 3 : Signature | | | | | | | | | | |
| **THIS FORM MUST BE SIGNED BY AN OWNER, PARTNER, CORPORATE OFFICER, OR OTHER EMPLOYEE WITH SUFFICIENT AUTHORITY TO BIND THE EMPLOYER.** | | | | | | | | | |
| **I certify that the information entered on this application is true and accurate, and that I am authorized by the named employing unit to submit this application for a COVID-19 Payment Plan.** | | | | | | | | | |
| **Signature:** | | | | | | | | | |
| **Print Name and Title:** | | | | | | | | | |
| **Telephone:** | | | | | | | | | |
| **Date: MM / DD / YYYY** | | | | | | | | | |

Please email this form to legal@dew.sc.gov.