Comptroller of Public Accounts FORM 89-100 (Rev.9-11/7)

CLEAR FORM | PRINT FORM

2. ■

Employer Application for Refund of Taxes Paid to the State of Texas

Temporary Assistance for Needy Families (TANF)

1. T code ■ **58100**

NOTE: Complete a separate form for each eligible employee, to be filed ONLY on or after January 1, 2012 and before April 1, 2012 (for wages paid in 2011).

TWC #1098

Employer Information

3. Texas taxpayer number ■	Period of claim m m d d y y — **4.** Begin date ■	**5.** End date ■ m m d d y y
6. Taxpayer name		**8.** Blacken this box if your address has changed..... ☐ 1 ■ **FM**
7. Address City / State / ZIP code		**9.** FOR COMPTROLLER USE ONLY ☐ 2 ■ **INV** ☐ 3 ■ **SD**
Contact person		Telephone *(area code and number)*
Contact person street address *(if different from above)*	City	State / ZIP code

NOTE: *If this form is being completed by an agent of the taxpayer, a power of attorney must be attached to this form.*

Employee Information / Release Authorization

10. Name (Last) ■	**11.** First ■	**12.** Middle initial ■	**13.** Social Security number ■
14. Employment start date ■	**15.** Employment termination date (if applicable)		

I hereby give my permission to the Texas Workforce Commission to certify to this employer or to the Texas Comptroller of Public Accounts that I was a recipient of financial assistance under TANF or MEDICAID any month within 6 months of my beginning date of employment.

sign here ▶ **16.** Employee's signature	**17.** Date

Refund Calculation

18. Total Wages paid DURING Claim Period in Items 4 and 5 above ..... 18. ■ _____

19. Eligible Wages *[Multiply Item 18 by 20% (.20)]* ..... 19. _____

20. Maximum Claim allowed per employee 20. **$2,000.00**

21. Refunds previously claimed for this employee ..... 21. _____

22. Maximum eligible refund for employee *(Item 20 minus Item 21)* ..... 22. _____

23. Refund claimed for 2011 *(Enter the smaller of Item 19 or Item 22)* ..... 23. ■ _____

NOTE: *The refund issued for all employees will not exceed net taxes paid and postmarked for state sales and use, franchise, boat and boat motor, inheritance, PUC gross receipts, hotel and/or manufactured housing after any applicable credits, in the calendar year that this claim covers.*

Employer's Statement Regarding Insurance

24. I certify that this taxpayer/employer provides to and pays for the benefit of this employee a part of the cost of health insurance provided under:

Check all that apply: ☐ HMO Plan ☐ Self-Funded or Self-Insured ERISA Plan ☐ Health Plan approved by Commissioner of Insurance

HEALTH INSURANCE PROVIDER

25. Name	**27.** Group no.
26. Street address	**28.** Policy no. and effective date
City, State, ZIP code	**29.** Telephone *(area code and number)*

I further certify under penalty of perjury that the information I have provided on this application is true and complete to the best of my knowledge and belief.

sign here ▶ **30.** Employer or authorized person	Date

ALL RECORDS ARE SUBJECT TO AUDIT REVIEW. Employer must maintain records to support all information. If supporting documentation is needed to verify your claim, you will be contacted.

TWC Certification

I hereby certify that the above named individual was a recipient of TANF or Medicaid any month within 6 months of the start date.

sign here ▶ **31.** Authorized TWC Employee	Date

Application for Refund of Taxes Paid for an Eligible Employer of a Certified Recipient of Temporary Assistance for Needy Families (TANF) or Medicaid

Who may file: Any Employer:

- Who pays eligible taxes that are administered by the Comptroller of Public Accounts;
- Who pays wages during the first year of employment to an employee who is a resident of Texas **and** was a certified recipient of TANF or Medicaid any month within 6 months of the start date; **and**
- Provides and pays for the employee a part of the cost of a HMO health plan, a self-funded or self-insured plan under ERISA, or health benefit plan approved by the Commissioner of Insurance.

Note: *An employer who requests a refund for wages paid to an employee must provide the same insurance coverage to that employee as is provided to other employees in their employment.*

What taxes can be refunded: The following taxes credited to the general revenue fund paid by the taxpayer may be refunded: state sales and use, franchise, boat and boat motor, inheritance and/or PUC gross receipts, hotel and/or manufactured housing. An employer may apply for a refund of taxes paid and postmarked in the same calendar year in which wages are paid to a certified employee.

When to file: The employer may apply for a tax refund for wages paid an employee in a calendar year only on or after January 1 and before April 1 of the calendar year following the year the taxes/wages were paid. For example: A refund request for wages paid in calendar year 2011 must be submitted on or after January 1, 2012 but before April 1, 2012.

How to file: After completing all items through Item 30, send the original application to:

Texas Workforce Commission
WOTC/State Tax Refund Unit—Room 202T
101 E. 15th St.
Austin, TX 78778-1442

Properly completed forms postmarked on or after January 1st and before April 1st will be accepted. Incomplete forms will be returned. After receiving certification from the Texas Workforce Commission, this application will be forwarded to the Comptroller of Public Accounts for further verification and, if applicable, refund issuance.

Specific Instructions

Employer Information

Item 3 - Enter the employer's Texas taxpayer number. If the employer does not have a taxpayer number for doing business in Texas, enter the employer's Federal Employer Identification Number (FEIN). Use the FEIN or Texas taxpayer number associated with the employee's W-2 form.

Items 4 & 5 - Enter the beginning and ending dates of the period in which the taxes and wages were paid. A separate claim must be filed for each calendar year. NOTE: The ending date will be the earlier of the employee's termination date, the employee's first anniversary date, or the end of the calendar year.

EXAMPLES:

DATE OF HIRE	WHEN TO FILE	CLAIM BEGIN DATE	CLAIM END DATE
01/01/10	01/01/11 through 03/31/11	01/01/10	12/31/10
06/01/10	01/01/11 through 03/31/11 01/01/12 through 03/31/12	06/01/10 01/01/11	12/31/10 05/31/11

Item 6 - Enter employer's name.

Item 7 - Enter the street address, city, state, ZIP code of the employer. Also, include a name, telephone number and complete address for a contact person, if different.

Employee Information / Release Authorization

Items 10, 11, & 12 - Enter the last name, first name and middle initial of the employee who was a recipient of TANF during their first month of employment.

Item 13 - Enter the Social Security number of the employee listed in Items 10-12.

Item 14 - Enter the employment start date of the employee listed in Items 10-12 (MM/DD/YY).

Item 15 - Enter the termination date of the employee (if applicable) in Items 10-12. (MM/DD/YY).

Item 16 - The employee listed in Items 10, 11, 12 & 13 MUST sign here authorizing the Texas Workforce Commission to certify that the employee was a recipient of financial assistance under TANF or Medicaid any month within 6 months of the beginning date of employment.

Item 17 - Enter date signed.

Refund Calculation

Item 18 - Enter the amount of TOTAL WAGES paid within the first year of employment to the employee during the claim period in Items 4 & 5.

Item 19 - Enter the amount calculated by multiplying the amount in Item 18 by 20%.

Item 21 - If this is the second claim for wages paid to an employee during their first year of employment, enter the refund amount of the first claim.

Item 22 - Enter the difference of Item 20 minus Item 21. A maximum refund of $2,000 may be claimed for each eligible employee. A prior claim filed for the same employee reduces the maximum amount allowed on this claim by the amount paid on the prior claim.

Item 23 - Enter the smaller of Item 19 or Item 22. This is the refund you are claiming.

Employer's Statement Regarding Insurance

Item 24 - Check the block that applies to the type of medical insurance coverage that is paid for and provided to the eligible employee.

Item 25 - Enter name of Health Insurance Provider.

Item 26 - Enter address of Health Insurance Provider.

Item 27 - Enter the group number, if applicable.

Item 28 - Enter the policy number, if applicable, and effective date of the policy.

Item 29 - Enter the telephone number of the Health Insurance Provider.

Item 30 - By signing, the taxpayer/employer certifies that they meet the eligibility requirements listed in the certification. If the form is completed by a duly authorized agent of the taxpayer/employer, a Power of Attorney or other written authorization must be on file with the Texas Workforce Commission WOTC/State Tax Refund Unit. Attach a copy of the Power of Attorney or other written authorization to each claim filed.

Item 31 - Signature of authorized TWC employee.

DO NOT SEND THIS FORM TO THE STATE COMPTROLLER

For Tax Refund assistance please call:

Texas Workforce Commission	1-800-695-6879
Comptroller of Public Accounts	1-800-531-5441, ext. 34545 or 512-463-4545

Individuals may receive, review, and correct information that TWC collects about the individual by emailing to open.records@twc.state.tx.us or writing to TWC Open Records, 101 East 15th St., Rm. 266, Austin, TX 78778-0001.