



City of New Orleans

Mayor LaToya Cantrell

2021 Subsidized Summer Youth Employment Program Application

REQUIRED SUPPORTIVE DOCUMENTS

Each applicant must bring the completed application and copies of each of the following documents to his/her appointment for faster processing. Failure to bring all required information will result in you having a longer registration experience and may impact your ability to participate in the program as space is limited and granted on a first come first serve basis. *Only0 applicants with complete applications and copies of all supportive documentation will be registered in the Mayor's Summer Youth Employment Program while there is space available.*

☐ **Applicant Photo ID** *One of the following items accepted.*

_____ 2020 – 2021 School Photo ID

_____ Military ID

_____ State ID/Driver's License

_____ US Passport

☐ **Applicant Birth Certificate or Birth Card**

☐ **Applicant Social Security Card** *Letters will not be accepted.*

☐ **Applicant 2020-2021 School Status** *One of the following items accepted.*

_____ 2020 – 2021 Report Card

_____ 2020 – 2021 Progress Report

_____ Home School Documentation

_____ School Withdrawal Form/Dropout Documentation

_____ High School Diploma

_____ 2019 – 2020 College Class Schedule

☐ **Parent/Guardian Photo ID (for applicants ≤ 17)**

☐ **Proof of Income** *Must include ALL income received in the last 30 days.*

_____ 2021 Consecutive Check Stubs

_____ Food Stamps/SNAP Award Letter

_____ Unemployment Benefits

_____ Retirement Benefits

_____ Child Support

_____ Notarized Letter of Unemployment/Self Employment

☐ **Proof of Address/Residency** *One of the following items accepted.*

_____ Address on Check Stub

_____ Utility Bill

_____ Mortgage Payment Form

_____ Voter's Registration Card

_____ Home Insurance Bill

_____ Signed Residential Lease Agreement

☐ **Stipend and Direct Deposit Information Acknowledgement**

☐ **Direct Deposit Form**

☐ **COVID-19 Releases**

Information provided may be used by the City of New Orleans to improve city services, or to access additional funding. Keep in mind that **SUBMISSION OF AN APPLICATION DOES NOT GUARANTEE ELIGIBILITY OR ENROLLMENT INTO THE PROGRAM.**



City of New Orleans

Mayor LaToya Cantrell

2021 Subsidized Summer Youth Employment Program Application

The Mayor's Summer Youth Employment Program transforms communities by cultivating responsible, career ready youth. Through meaningful summer opportunities offered to participants ages 13 – 21 who explore careers and entrepreneurship, gain technical and soft job skills development, and have fun. The program helps youth define and advance their career goals. For consideration, applications must be fully completed, and **copies of all supportive documentation** must be submitted.

APPLICANT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH (MM/DD/YYYY): ____/____/____ AGE: _____

SOCIAL SECURITY NUMBER: ____ - ____ - ____

RACE/ETHNICITY: _____ GENDER: ☐ Male ☐ Female

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMAIL: _____

PHONE NUMBER: (____) ____ - ____ PARENT/GUARDIAN NUMBER: (____) ____ - ____

ARE YOU CURRENTLY IN SCHOOL? ☐ Yes ☐ No

IF YES, SCHOOL CURRENTLY ATTENDING: _____

CURRENT GRADE: _____ HIGHEST GRADE COMPLETED: _____

PLEASE SELECT ALL THAT APPLY:

☐ HIGH SCHOOL DROPOUT ☐ OFFENDER (MISDEMEANOR OR FELONY)

☐ DISABLED ☐ PREGNANT/PARENTING ☐ HOMELESS/RUNAWAY/FOSTER CARE

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

PLEASE LIST ALL MEDICATIONS YOU ARE ALLERGIC TO:

PLEASE LIST ANY PHYSICAL CONDITION(S) THAT MAY RESTRICT YOU FROM CERTAIN ACTIVITIES AND AMOUNT OF WORK YOU ARE ABLE TO PERFORM. IF ANY, PLEASE EXPLAIN:



City of New Orleans

Mayor LaToya Cantrell

2021 Subsidized Summer Youth Employment Program Application

APPLICANT INFORMATION

NUMBER OF FAMILY MEMBERS CURRENTLY LIVING IN YOUR HOUSEHOLD: _____

TOTAL FAMILY INCOME IN THE LAST SIX (6) MONTHS: _____

IF SUPPORTED BY PUBLIC ASSISTANCE, PLEASE CHECK AND SHOW PROOF FROM THE LIST BELOW:

☐ CURRENT OR RECENT AWARD LETTER FROM DCFS (SNAP AMOUNT)

OR

☐ CURRENT FITAP AWARD LETTER – TANF

OR

☐ OFFICIAL LETTER FROM SOCIAL SERVICES (MUST INCLUDE APPLICANT’S NAME, BENEFIT AMOUNT, AND BENEFIT DATES)

OR

☐ OTHER (SPECIFY): _____

IF NOT SUPPORTED BY PUBLIC ASSISTANCE, PLEASE CHECK AND SHOW PROOF FROM THE LIST BELOW:

☐ ALL INCOME RECEIVED IN THE LAST 30 DAYS FULL MONTH (MUST INCLUDE PAYEE NAME AND GROSS INCOME)

OR

☐ CURRENT PENSION AWARD

OR

☐ UNEMPLOYMENT BENEFITS DOCUMENT DATED WITHIN CURRENT YEAR

OR

☐ IF SELF EMPLOYED 2020 NOTARIZED LETTER W/ MONTHLY INCOME

OR

☐ OTHER (SPECIFY): _____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE THE CITY OF NEW ORLEANS TO EXAMINE AND COLLECT ALL PERSONAL RECORDS FOR THE PURPOSE OF DETERMINING ELIGIBILITY ON ANY CHILD, ANY FAMILY MEMBERS, AND MY SELF LISTED ON THIS APPLICATION FOR CITY PROGRAMS. I AM AWARE THAT IN- CORRECT OR FALSE INFORMATION MAY RESULT IN TERMINATION FROM THIS PROGRAM, THE REPAYMENT OF FUNDS AND/OR PROSECUTION FOR PERJURY OR FRAUD.

APPLICANT’S SIGNATURE

_____/_____/_____
DATE

PARENT/LEGAL GUARDIAN/INSTITUTION SIGNATURE
(FOR APPLICANTS 17 AND YOUNGER)

_____/_____/_____
DATE

Second Injury Fund Questionnaire • EMPLOYEE MEDICAL HISTORY

Please answer the following questions by circling either YES or NO.

FAILURE TO ANSWER TRUTHFULLY MAY RESULT IN FORFEITURE OF YOUR WORKERS' COMPENSATION BENEFITS UNDER LA R.S.23:1208.1.

1. Have you ever had a disease or disability arising from your occupation? YES NO

If YES, please explain: _____

2. Have you ever received workers' compensation benefits for an injury that occurred at work? YES NO

If YES, when? _____

How long were you on compensation? _____

Name of employer: _____

Name of injury: _____

3. Have you ever been rejected for employment, insurance, or military service because of your health? YES NO

If YES, please explain: _____

4. Have you ever had back trouble or injury to you back, head or neck? YES NO

If YES, please explain: _____

5. Do you have any restrictions or limitations upon your physical activities? YES NO

If YES, please explain: _____

6. What operations, accidents, broken bones, strains or serious illnesses have you had?

Have you had any of the following? Put an "X" in the box for YES. Leave blank for NO.

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Amputation (foot, leg, arm, hand or total loss thereof) | <input type="checkbox"/> Chronic Osteomyelitis | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Psychoneurotic Disability (following treatment in a recognized institution) |
| <input type="checkbox"/> Ankylosis of Joints | <input type="checkbox"/> Communicable Disease | <input type="checkbox"/> Ionizing Radiation Injury | <input type="checkbox"/> Reflex Sympathetic Dystrophy |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Compressed Air Sequelae | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Repetitive Motion Injury |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Loss of Hearing (more than 75%) | <input type="checkbox"/> Residual Disability from Polio |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Sight (of one or both eyes or a partial loss of uncorrected vision) | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Back/Neck Problem | <input type="checkbox"/> Double Vision (Blurred Sight) | <input type="checkbox"/> Loss of Use of Limbs | <input type="checkbox"/> Rotator Cuff Injury |
| <input type="checkbox"/> Brain Damage | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Ruptured Intervertebral Disc |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Sclerosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Spinal Fusion |
| <input type="checkbox"/> Cardiac Disease | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Muscle, Ligament or Tendon Injury | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Heavy Metal Poisoning | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Sugar In Urine |
| <input type="checkbox"/> Cerebral Vascular Accident | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Surgical Removal of Intervertebral Disc |
| <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Numbness of Extremities | <input type="checkbox"/> Thrombophlebitis |
| | <input type="checkbox"/> Hodgkin's Disease | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Thoracic Outlet Syndrome |
| | <input type="checkbox"/> Hyperinsulinism | | |

If YES, please explain: _____

7. Do you have any other long-term health problems or adverse physical condition? YES NO

If YES, please explain: _____

Signature: _____ Date: _____

Name Printed: _____



City of New Orleans

Mayor LaToya Cantrell

2021 Subsidized Summer Youth Employment Program Application

EMERGENCY CONTACT INFORMATION

Applicant's Name: _____ Date of Birth: ____/____/____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: (____)____-____ Email: _____

Emergency Contact: _____ Relationship: _____

Home Phone: (____)____-____ Cell Phone: (____)____-____

Work Phone: (____)____-____ Email: _____

Emergency Contact: _____ Relationship: _____

Home Phone: (____)____-____ Cell Phone: (____)____-____

Work Phone: (____)____-____ Email: _____

Emergency Contact: _____ Relationship: _____

Home Phone: (____)____-____ Cell Phone: (____)____-____

Work Phone: (____)____-____ Email: _____

ALL applicants **MUST** provide at least **three (3) emergency contacts** who may be contacted in the event of an emergency.

Information provided may be used by the City of New Orleans to improve city services, or to access additional funding. Keep in mind that **SUBMISSION OF AN APPLICATION DOES NOT GUARANTEE ELIGIBILITY OR ENROLLMENT INTO THE PROGRAM.**



City of New Orleans
Mayor LaToya Cantrell

2021 Subsidized Summer Youth Employment Program Application
CONSENT AND RELEASE FORM PICTURE-VIDEO RECORDINGS

Participant Name: _____

Activity Name and Date: NORD Teen Career Camp 06/07/2021 thru 07/16/2021

I am the applicant or the parent/guardian of the above-named applicant. I have been informed by the City of New Orleans ("City") that during the Mayor's Summer Employment Program and other program sponsored activities, the participant might be photographed, videotaped, filmed or recorded.

I understand that all activities associated with the Mayor's Summer Employment Program have been approved by the City. I understand this is a learning experience to participate in these activities or events as stated in this Consent and Release Form ("Form").

I authorize the City, or any third party it has approved to record the applicant's name, likeness, image, voice and performance through film, photograph, pictures, videotape, digitally, or through any other process as part of the activity or event. I further agree that any recording may be edited at the sole discretion of the City, or any third party the City approves, and used in whole or in part by the City, or any third party the City approves, for any and all broadcasting, publication, distribution, training, audio/visual, or exhibition purposes in any manner or media, within or outside of the City.

I understand that I and/or the applicant shall have no intellectual property or other legal rights or interest in or arising from the recording in any way, including but not limited to any royalty or other economic right or interest that could arise from any publication, broadcast, or reproduction of the recording or the activity or event.

I also agree to release and hold harmless the City from and against all actions, claims, demands, lawsuits, damages, losses, expenses and liabilities of every kind or nature, including but not limited to reasonable attorney's fees, arising out of this activity, or arising out of or any use of recording.

I understand this Form contains the entire agreement and understanding between the City, the applicant, and me and may not be amended unless mutually agreed to in writing by the City and me. I further understand that the laws of the State of Louisiana govern this form.

I hereby consent and agree to my child's participation in the Teen Career Camp activities or events and to the recording of my child's participation, and use of that recording, under the terms stated above.

Student Name (Print Name): _____

Parent/Guardian Name (Print Name): _____

Parent/Guardian Signature: _____ **Date:** ____ / ____ / ____

**COMMUNITY DEVELOPMENT BLOCK GRANT (CDBG)
PROGRAM BENEFIT QUESTIONNAIRE 2021**

AGENCY NAME: NORD

PROJECT NUMBER: _____

NORD have received federal funding assistance from the City of New Orleans, Office of Community Development. The funds are made available by the U. S. Department of Housing and Urban Development (HUD) through the Community Development Block Grant program. A primary national objective of HUD is to make certain eligible services available to persons of low and moderate income. In order to help us to monitor our progress toward this goal, we request your assistance in completing the following:

PARENT/GUARDIAN NAME: _____

PARENT/GUARDIAN SOCIAL SECURITY NUMBER: ____ - ____ - ____

ADDRESS: _____ **CITY:** _____ **STATE:** ____ **ZIP:** _____

In addition to this Questionnaire, a copy of support documentation such as most recent check stub, welfare card, etc. will be required to complete the eligibility process.

(Household means all person(s) who occupy a housing unit. The occupants may be a single family, one person living alone, two or more families living together, or any other group unrelated or unrelated persons who share a living arrangement.)

Please check only one space in each column that most accurately describes your household size and gross income.

FAMILY HOUSEHOLD SIZE

- ☐ 1
☐ 2
☐ 3
☐ 4
☐ 5
☐ 6
☐ 7
☐ 8
☐ 9
☐ OTHER (*Specify*): _____

GROSS INCOME

- ☐ \$ 0.00 – 36,750.00
☐ \$36,751.00 – 42,000.00
☐ \$42,001.00 – 47,250.00
☐ \$47,250.00 – 52,500.00
☐ \$52,501.00 – 56,700.00
☐ \$56,701.00 – 60,900.00
☐ \$60,901.00 – 65,100.00
☐ \$65,101.00 – 69,300.00
☐ \$69,301.00 – 73,600.00
☐ OTHER (*Specify*): _____

I certify that all the information provided herein is true and correct and that all household income is reported. I understand that this information is subject to verification by the City of New Orleans and the U.S. Department of Housing and Urban Development (HUD) or its agent for the purpose of determining my eligibility for participation in the HUD-funded program that is administered by the **New Orleans Recreation Development (NORD) Commission**. I further understand that deliberate misrepresentation of the required information may subject me to prosecution under applicable local, state, and federal laws.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** ____/____/____



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 (<i>Family Name</i>) | | First Name (<i>Given Name</i>) | | Middle Initial | Other Last Names Used (<i>if any</i>) | |
| Address (<i>Street Number and Name</i>) | | | Apt. Number | City or Town | | State ZIP Code |
| Date of Birth (<i>mm/dd/yyyy</i>) | 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):

| | |
|--|--|
| <input type="checkbox"/> 1. A citizen of the United States | |
| <input type="checkbox"/> 2. A noncitizen national of the United States (<i>See instructions</i>) | |
| <input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____ | |
| <input type="checkbox"/> 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. (<i>See instructions</i>) | |
| <i>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.</i> | |
| 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 (<i>mm/dd/yyyy</i>) |
|-----------------------|------------------------------------|

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 (<i>mm/dd/yyyy</i>) | |
| Last Name (<i>Family Name</i>) | | First Name (<i>Given Name</i>) | |
| Address (<i>Street Number and Name</i>) | | City or Town | State ZIP Code |



Employer Completes Next Page



Employee's Withholding Certificate

OMB No. 1545-0074

► **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.**

2021

| | | | |
|---|--|-----------|--|
| 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) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying widow(er) <input type="checkbox"/> 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 estimator at www.irs.gov/W4App, 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 2021 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 total 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) |

**Employee Withholding Exemption Certificate (L-4)**

Louisiana Department of Revenue

Purpose: Complete form L-4 so that your employer can withhold the correct amount of state income tax from your salary.

Instructions: Employees who are subject to state withholding should complete the personal allowances worksheet indicating the number of withholding personal exemptions in Block A and the number of dependency credits in Block B.

- Employees must file a new withholding exemption certificate within 10 days if the number of their exemptions decreases, except if the change is the result of the death of a spouse or a dependent.
- Employees may file a new certificate any time the number of their exemptions increases.
- Line 8 should be used to increase or decrease the tax withheld for each pay period. Decreases should be indicated as a negative amount.

Penalties will be imposed for willfully supplying false information or willful failure to supply information that would reduce the withholding exemption.

This form must be filed with your employer. If an employee fails to complete this withholding exemption certificate, the employer must withhold Louisiana income tax from the employee's wages without exemption.

Note to Employer: Keep this certificate with your records. If you believe that an employee has improperly claimed too many exemptions or dependency credits, please forward a copy of the employee's signed L-4 form with an explanation as to why you believe that the employee improperly completed this form and any other supporting documentation. The information should be sent to the Louisiana Department of Revenue, Criminal Investigations Division, PO Box 2389, Baton Rouge, LA 70821-2389.

Block A

- Enter "0" to claim neither yourself nor your spouse, and check "*No exemptions or dependents claimed*" under number 3 below. You may enter "0" if you are married, and have a working spouse or more than one job to avoid having too little tax withheld.
- Enter "1" to claim yourself, and check "*Single*" under number 3 below. If you did not claim this exemption in connection with other employment, or if your spouse has not claimed your exemption. Enter "1" to claim one personal exemption if you will file as head of household, and check "*Single*" under number 3 below.
- Enter "2" to claim yourself and your spouse, and check "*Married*" under number 3 below.

A.**Block B**

- Enter the number of dependents, not including yourself or your spouse, whom you will claim on your tax return. If no dependents are claimed, enter "0."

B.

Cut here and give the bottom portion of certificate to your employer. Keep the top portion for your records.

Form **L-4**Louisiana
Department of
Revenue**Employee's Withholding Allowance Certificate**

| | | | |
|---|--|--|-----|
| 1. Type or print first name and middle initial | | Last name | |
| 2. Social Security Number | | 3. Select one <input type="checkbox"/> No exemptions or dependents claimed <input type="checkbox"/> Single <input type="checkbox"/> Married | |
| 4. Home address (number and street or rural route) | | | |
| 5. City | | State | ZIP |
| 6. Total number of exemptions claimed in Block A | | | 6. |
| 7. Total number of dependents claimed in Block B | | | 7. |
| 8. Increase or decrease in the amount to be withheld each pay period. Decreases should be indicated as a negative amount. | | | 8. |

I declare under the penalties imposed for filing false reports that the number of exemptions and dependency credits claimed on this certificate do not exceed the number to which I am entitled.

| | |
|----------------------|------|
| Employee's signature | Date |
|----------------------|------|

The following is to be completed by employer.

| | |
|--------------------------------|---|
| 9. Employer's name and address | 10. Employer's state withholding account number |
|--------------------------------|---|