NEW YORK STATE | Office of Addiction Services and Supports

Recovery Friendly Workplace Tax Credit Program Application For Employers

Continuous Application Process

Annual Deadline for Submission – January 15 for prior tax year applications

www.oasas.ny.gov

Employer Application – Preliminary Approval as an Eligible Employer

Instructions: This application is a required first step to receive a tax credit certificate. Please fill out the application below to document that you meet the requirements as set forth in Part W of Chapter 59 of the Laws of 2019 to be an eligible employer for the Recovery Tax Credits. Once this application is reviewed, and OASAS has verified that minimum employment requirements are satisfied, your organization will be eligible to receive a tax credit for every eligible individual hired within the tax year the application was filed and the year immediately prior to that.

Employer Name: _____

Employer Tax ID: _____

Employer Address:

Building Number and/or Suite (STE): _____

Street Address: _____

City: _____ State: **NY** Zip Code: _____

CEO/Owner Name: _____

Telephone Number(s): _____

E-mail Address: _____

Recovery Tax Credit Contact Name: _____

Phone Number(s): _____

E-mail Address: _____

Please also complete the following forms included in this RFA:

- Additional locations (if applicable)
- Substance Use Disorder Recovery Resource and Training Agreement
- Eligible Employees for this Tax Year
- Eligible Employee Application

Additional Employment Locations (if needed)

Please complete the address for each additional location you would like deemed eligible for the program.

Employer Name: _____

Employer Tax ID: _____

Employer Address:

Building Number and/or Suite (STE): _____

Street Address: _____

City: _____ State: **NY** Zip Code: _____

CEO/Owner Name: _____

Telephone Number(s): _____

E-mail Address: _____

Recovery Tax Credit Contact Name: _____

Phone Number(s): _____

E-mail Address: _____

Additional Employment Locations (if needed)

Employer Name: _____

Employer Tax ID: _____

Employer Address:

Building Number and/or Suite (STE): _____

Street Address: _____

City: _____ State: **NY** Zip Code: _____

CEO/Owner Name: _____

Telephone Number(s): _____

E-mail Address: _____

Recovery Tax Credit Contact Name: _____

Phone Number(s): _____

E-mail Address: _____

Please attach as many sheets as necessary.

Substance Use Disorder Recovery Resource Agreement Form

Employer Name: _____

County: _____

I, _____ attest that _____

CEO/Executive Director Name Company Name

has agreements with the following Recovery Resources: (check all that apply and provide organization name)

☐ OASAS certified Outpatient Clinic:
REQUIRED _____

☐ OASAS funded Peer Navigator: _____

☐ OASAS funded Family Navigator: _____

☐ OASAS funded Recovery Center: _____

I, _____ attest that at least one of the

CEO/Executive Director Name

organizations above will provide an annual training on How to Support a Recovery Friendly Workplace.

Does your organization have an Employee Assistance Program (EAP)?

☐ Yes
☐ No

If yes, please complete the following:

EAP Name: _____

I, _____ attest that I have provided

CEO/Executive Director Name

our EAP with information about the Recovery Resources we have agreements with and apprised them of the Recovery Tax Credit project application. I also agree to have the EAP provide a training for all employees on Utilizing the Employee Assistance Program and all Supervisors on Using Formal Supervisory EAP Referrals.

Signature of CEO/Executive Director	Signature of HR Director
Name	Name
Title	Title
Date	Date

Current Eligible Employees

Instructions:

Eligible Employees: Please list all current employees that meet the definition of an eligible employee. All employees hired within the year the tax credit is being claimed or the year immediately prior to that, and have worked the minimum number of hours required, may be eligible for a tax credit.
Each eligible employee listed below must also complete the Eligible Employee Application on page 12. Please include the completed Eligible Employee Application forms for current eligible employees with the initial application. Please send additional Eligible Employee Application forms to OASAS as they are hired so they may be added to your application.

Employer Name			
Employee Name	**Hire Date**	**Job Title**	**Employee works:**
			☐ FT ☐ PT ☐ Per diem Hours:
			☐ FT ☐ PT ☐ Per diem Hours:
			☐ FT ☐ PT ☐ Per diem Hours:
			☐ FT ☐ PT ☐ Per diem Hours:
			☐ FT ☐ PT ☐ Per diem Hours:
			☐ FT ☐ PT ☐ Per diem Hours:
			☐ FT ☐ PT ☐ Per diem Hours:

Total Estimated Tax Credit Request: Please estimate the number of eligible employees and hours you plan to request tax credits for in the current tax year. OASAS will use this for planning purposes. If you will exceed or not achieve the projected tax credits, please contact OASAS to make the necessary adjustments.

Total Number of Eligible Employees Expected by the end of the tax year applying for credit.	Total number of hours those employees are projected to work for the eligible time frame. (not to exceed 2,000 hours per employee)	Verify Average Employee Hours is 2,000 or less:

# of Eligible Employees:	Hours worked:	Tax Credit Projected for Tax Year: $

Eligible Employee Application

Please have each eligible employee fill out this application at the time of submission of your initial application or when they are hired.

Employee Name: _____

Street Address: _____

City and State: _____ _____ Zip Code: _____

Employer Name _____

Position Title _____

Hours Worked ☐ FT ☐ PT ☐ Per diem Hours: _____

By signing the bottom of this form, I attest that I have been diagnosed with a Substance Use Disorder (SUD) and that I have completed treatment and aftercare recommendations or am currently receiving treatment. I also attest that I am not currently experiencing signs and symptoms of my SUD that would prevent me from successfully doing this job and my most recent treatment plan includes employment as a goal.

Name of Most Recent Treatment Provider Program you completed, or you are currently attending: _____

Date of Most Recent Treatment Appointment: _____

Did you or are you currently completing all aftercare recommendations?

☐ Yes

☐ No

If not please explain:

I am currently using the following recovery resources to strengthen my recovery from a SUD:

☐ Peer Navigator ☐ Recovery Center

☐ Support Groups ☐ Others please list:

Please attach documentation of completion of the most recent SUD treatment program you attended or are currently attending. (Certificate of Completion or other such documentation from the Treatment Provider will suffice).

I attest that all information provided is true and complete to the best of my knowledge:

Signature _____ Print/Type Name _____ Date _____

SUBMIT APPLICATION