

APPLICATION FOR HARDSHIP ASSISTANCE
UNDER THE *LIVING WAGE* LAW

TO BE COMPLETED BY COVERED EMPLOYER AND FORWARDED TO MANAGING AGENCY

ORGANIZATION NAME _____ REPRESENTATIVE _____

ADDRESS _____ TELEPHONE _____

TOTAL ESTIMATED ANNUAL BUDGET:

PRE-LIVING WAGE _____ **POST-LIVING WAGE** _____

SOURCE(S) OF FUNDING _____ AMOUNT(S) _____

ANNUAL COST OF APPLICATION OF THE *LIVING WAGE* LAW _____

PERCENTAGE INCREASE OF TOTAL ANNUAL BUDGET _____

NUMBER OF EMPLOYEES AFFECTED BY THE *LIVING WAGE* REGULATIONS _____

Rationale for application for additional, hardship assistance from the County of Suffolk: _____

ATTACH ADDITIONAL SHEETS AS NECESSARY

I/we hereby declare under penalty of perjury under the Laws of the State of New York that the undersigned is/are authorized to provide this certification, and that all accompanying attestations are true and correct.

Signature

Date

Print Name & Title

County Vendor # (if known)

Company Name

Phone #

Federal Employer ID#