(Please print single sided)

WENATCHEE VALLEY COLLEGE

Application for Employment Packet

Part-Time Faculty

This application packet should ONLY be filled out if an individual has been offered a job as a part-time faculty member.

The following checklist is provided to help the new employee and the college. All forms must be completed—and required documentation provided—before the application is considered complete.

- ❑ **Application for Employment – Part-Time Faculty (must be signed)**
  - For liberal arts and sciences faculty:
    - ❑ Transcripts required (unofficial are fine)
  - For vocational faculty:
    - ❑ Copies of transcripts and/or current certification in area of specialization required
    - ❑ Copies of professional development certificates indicating current training in area of specialization are appreciated but not required
  - For continuing education and basic skills faculty: the department will contact you if there is other documents required.
- ❑ **Employee Affirmative Action & Demographic Data Profile Form**
  This information allows the college to complete statistical reports on the composition of applicant and employee pools for federal and state agencies. Although this information is optional for applicants, it is required for all employees of WVC.
- ❑ **SBCTC Verification of Retirement Plan Status Form (must be signed)**
  This information tells us if you are or ever have been a member of a Washington state retirement system or if you are concurrently working for another employer who is covered by these systems. You may be eligible for contributions into the system while you are an employee at Wenatchee Valley College.
- ❑ **I-9 Form – Employment Eligibility Verification (must be signed)**
  Federal law requires that employers see certain identification documents that establish both the identity and the eligibility of a potential employee to work in the United States. Although the documentation requirement for the I-9 can be met with a variety of documents (most use a social security card and driver's license), it is the policy of human resources that **a copy of the individual's social security card must be provided to the human resources office** (or the card is viewed by an HR staff member). This requirement allows the college to make sure the name and number on the card is entered into our payroll system correctly.
- ❑ **Public Employees Benefit Board (PEBB) Benefit Eligibility Worksheet A-3 (must be signed)**
  The worksheet has been completed with the assumption the new employee is not teaching for another college concurrently or is not transferring from another college to WVC. Contact human resources for questions regarding this worksheet.
- ❑ **Safety Information (must be signed).** This information must be provided to all employees for the college.
- ❑ **Declaration Regarding Sexual Misconduct (must be signed)**
  By law, post-secondary education institutions cannot hire an applicant who does not complete this form
- ❑ **Employer Notice of Medical Insurance Exchange (information only—no need to return)**
- ❑ **W-4 Form (information only)** Employees fill out the W-4 form once hired and set up in ctcLink under Employee Self Service.
- ❑ **Electronic Fund Transfer (EFT) Form (information only)**
  Employees fill out this form once hired and set up in ctcLink under Employee Self Service. This form is needed if you want your pay electronically deposited in your bank account. If not, your pay will be loaded to a prepaid card called The Focus Card*, issued by U.S Bank.

*The Focus Card is issued by U.S. Bank National Association pursuant to a license from Visa U.S.A. Inc. ©2022 U.S. Bank. Member FDIC.

Completed application materials must be received by the college, a completed background check must be performed and the employee must be processed in ctcLink before the individual can begin work.

Questions regarding any part of the application process can be directed to human resources at 509-682-6440.

WENATCHEE VALLEY COLLEGE

Application for Employment

Part-Time Faculty

Assistance will be made available in the application and pre-employment screening processes for applicants with disabilities who request such assistance in advance

1300 Fifth Street, Wenatchee WA 98801-1799

Wenatchee (509) 682-6440 – TDD (509) 682-6837
Omak (509) 422-7800 – TDD (509) 422-7802

Please type or print clearly

PERSONAL DATA

Last Name		First	MI	Home Phone
Home Address				Work Phone
City	State	ZIP	Email Address	Cell Phone

POSITION APPLIED FOR

Title	Location (campus)	Date

Have you ever worked for this college or any other Washington state agency? ❑ No ❑ Yes If yes, when ______________________________

EMPLOYMENT HISTORY **(List most recent experience first–You may attach a résumé instead but it** must **list dates of employment)**

Employer		City, State	From (month/year) to (month/year)
Job Title	Hours/Week	Supervisor (name/title)	Telephone
Specific Duties			
Employer		City, State	From (month/year) to (month/year)
Job Title	Hours/Week	Supervisor (name/title)	Telephone
Specific Duties			
Employer		City, State	From (month/year) to (month/year)
Job Title	Hours/Week	Supervisor (name/title)	Telephone
Specific Duties			
Employer		City, State	From (month/year) to (month/year)
Job Title	Hours/Week	Supervisor (name/title)	Telephone
Specific Duties			
Employer		City, State	From (month/year) to (month/year)
Job Title	Hours/Week	Supervisor (name/title)	Telephone
Specific Duties			

May we contact all employers/supervisors listed? ❑ Yes ❑ No *Indicate exceptions:*

EDUCATION Check the following diploma/degrees you have earned:

❑ High School or GED ❑ AA/AAS ❑ Bachelor's ❑ Master's ❑ Doctorate

List colleges and business, trade, and other schools you have attended, beginning with the *most recent*. Attach additional pages if necessary.

Name and Location	Major	Degree	Dates Attended
Name and Location	Major	Degree	Dates Attended
Name and Location	Major	Degree	Dates Attended

OTHER TRAINING — SEMINARS, WORKSHOPS and LECTURES (Indicate length of training)

Please answer the following questions and sign below.

Are you a citizen or do you have a visa which permits you to work in the United States? ❑ Yes ❑ No

Do you have any relatives who work for WVC? ❑ Yes ❑ No If Yes, please list their name(s) _____

Within the past 10 years, have you been convicted of, or released from prison for any crimes excluding parking tickets or traffic citations? ❑ Yes ❑ No

If yes, give all conviction dates, prison release dates and the nature of the offenses. Criminal history background checks will be conducted where required by law. Please note that a conviction/criminal history record does not necessarily disqualify an individual from employment at Wenatchee Valley College.

In adherence to provisions of the Immigration Reform and Control Act, Wenatchee Valley College hires only United States citizens and aliens authorized to work in the United States. As a condition of employment, new employees must provide acceptable proof of identity and employment eligibility within three days of initial hire.

The information I have supplied is true to the best of my knowledge. I understand that false statements on this application may be considered sufficient cause for elimination of my application from consideration, or, if employed, for dismissal. If employment is obtained under this application, I will comply with all rules and regulations of Wenatchee Valley College.

I agree to be responsible for any college property and equipment issued to me until returned to the college and agree to pay for any property and equipment which I do not return.

I authorize and release from liability my current and former employers and personal references to provide any information they may have about me, unless I specifically request otherwise.

Signature	Date

Equal Opportunity Employer: Wenatchee Valley College is committed to a policy of equal opportunity in employment and student enrollment. All programs are free from discrimination and harassment against any person because of race, creed, color, national or ethnic origin, sex, sexual orientation, gender identity or expression, the presence of any sensory, mental, or physical disability, or the use of a service animal by a person with a disability, age, parental status or families with children, marital status, religion, genetic information, honorably discharged veteran or military status or any other prohibited basis per RCW 49.60.030, 040 and other federal and laws and regulations, or participation in the complaint process.

The following persons have been designated to handle inquiries regarding the non-discrimination policies and Title IX compliance for both the Wenatchee and Omak campuses:

- To report discrimination or harassment: Title IX Coordinator, Wenatchi Hall 2322M, (509) 682-6445, title9@wvc.edu.
- To request disability accommodations: Student Access Coordinator, Wenatchi Hall 2133, (509) 682-6854, TTY/TTD: Dial 711, sas@wvc.edu.

Employee Affirmative Action and Demographic Data Form

Government agencies provide state and federal periodic reports about the state workforce for equal opportunity and affirmative action efforts. **The demographic information from this form also helps us make better decisions about how we increase representation of underrepresented groups and make our workforce more diverse and inclusive.**

Providing any of this information is **voluntary**, and information will be kept confidential to the extent possible. As of June 11, 2020, the following information collected on this form is **protected from public disclosure** at the individual level: month and year of birth, race and ethnicity, sexual orientation and gender identity (RCW 49.60.040(26)), and status as a person with a disability.

1. Name (Last, First, Middle Initial)	2. Personnel ID Number	3. Date

Please see next page for definitions

4. Are you age 40 years or older?
Yes ☐ No ☐ **Birthdate** _____

5. Gender Identity
Female ☐ Male ☐ X/Non-binary ☐

6. Gender Designation for Health Insurance Purposes
(Used by doctors for billing)
Female ☐ Male ☐

7. Are you a person with a disability?
Yes ☐ No ☐
Veterans with a service-connected disability may also meet the definition of a person with a disability. Select both if applicable.

8. Do you identify as LGBTQ+?
Yes ☐ No ☐
Information used to account for workforce representation.

9. What race and/or ethnicity do you consider yourself? Select all that apply.

☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander
☐ Hispanic or Latino
☐ Black or African-American
☐ Asian
☐ White

Veteran and Military Spouse Information – Employment preference is given to veterans. The state also provides support and assistance to military spouses in accordance with Executive Order 19-01. *Note: To qualify and receive veteran's preference, you may be asked to provide a record of discharge, DD214, NGB Form 22 or alternate verification of military service and a document from the U.S. Department of Veterans Affairs certifying a service-connected disability for disabled veterans.*

10. Veteran Status? Select all that apply.

Are you an Eligible Veteran?	Yes ☐	No ☐	If yes, discharge date: _____
Are you a Vietnam Era Veteran?	Yes ☐	No ☐	Type of discharge: _____
Are you a Veteran w/service-connected disability?	Yes ☐	No ☐	
Are you a Special Disabled Veteran?	Yes ☐	No ☐	

11. Are you currently a member of the reserve component, including the National Guard? Yes ☐ No ☐
Were you called to active duty from employment with the state? Yes ☐ No ☐

11a. If yes, dates: _____to _____ and **11b. Type of Discharge**: _____

12. Are you a military spouse or military registered domestic partner? Yes ☐ No ☐

13. Are you the spouse or registered domestic partner of an honorably discharged deceased veteran OR honorably discharged 100% service-connected disabled veteran? Yes ☐ No ☐

Signature	Date

Submit completed form to your agency's Human Resources Office.

For more information on HRMS entry of this form: OFM Personal Data Job Aid.

For Imaging Only	Personnel ID	Doc Date	Section	Doc Type	Sub Doc Type	HR Rep
			AA	Form	AA Profile	

Employee Affirmative Action and Demographic Data Definitions

Person with a Disability (U.S. EEOC & ADA Amendments Act of 2008, September 2008):

For affirmative action data reporting purposes, people with disabilities are individuals with a permanent, physical, mental or sensory impairment that substantially limits one or more major life activities. Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, and communicating. A major life activity also includes the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

The impairment must be both permanent and material rather than slight, but not necessarily require a workplace accommodation. An impairment that is episodic or in remission is still a disability if it would substantially limit a major life activity when active. The determination of whether an impairment substantially limits a major life activity shall be made without considering temporary improvements made through mitigating measures such as medication, therapy, reasonable accommodation, prosthetics, technology, equipment, or adaptive devices (but not to include ordinary eyeglasses or contact lenses).

Gender Designation for Health Insurance Purposes (Used by doctors for billing): This data is used to meet current requirements for Medicare federal reporting and eligibility determinations, meet health plan vendor requirements, ensure coordination of benefits and efficient claims processing. Please choose the option in this field that you would like your medical provider(s) to use to determine insurance coverage and facilitate claims processing for your health care services.

Gender Identity (Washington State DEI Foundational Definitions)

A person's innermost concept of self as male, female, a blend of both or neither (gender "X" or non-binary). How individuals perceive themselves and what they call themselves. A person's gender identity can be the same or different from their sex assigned at birth.

Gender "X" (WA State Dept. of Health)

Gender X is intended to be an inclusive category to recognize the real diversity of gender identity. Gender X means a gender that is not exclusively male or female.

LGBTQ+ (Governor's Interagency Council on Health Disparities)

LGBTQ+ is an abbreviation for Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning. The + allows space for other diverse sexual orientation, gender identity, and gender expression groups.

Race and Culture (US Census Bureau, Race & Ethnicity, January 2017)

American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains a tribal affiliation or community attachment.

Asian: A person having origins in any of the original people of the Far East, Southeast Asia or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

Black or African American: A person having origins in any of the Black racial groups of Africa.

Hispanic or Latino/a/x: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

White: A person having origins in any of the original peoples of Europe, the Middle East or North Africa.

Veterans (Title 38 U.S.C., Executive Order 19-01)

Eligible Veteran, 38 U.S.C. 4211 (4): (1) served on active duty for a period of more than 180 days and was discharged or released therefrom with other than dishonorable discharge; (2) was discharged or released from active duty because of a service-connected disability; (3) as a member of a reserve component served on active duty during a period of war or in a campaign or expedition for which a campaign badge is authorized and was discharged or released from such duty with other than dishonorable discharge; or (4) discharged or released from active duty by reason of a sole survivorship discharge as defined in section 1174(i) of title 10.

Discharge Date: The most recent discharge date from active military service in any branch of the armed forces, as indicated on the employee's Certificate of Release or Discharge from Active Duty form DD214 or similar discharge paperwork.

Vietnam Era Veteran, 38 U.S.C. 4211 (2) (4): A veteran of the U.S. military, ground, naval or air service, any part of whose service was during the period August 5, 1964 through May 7, 1975, who served on active duty for a period of more than 180 days and was discharged or released with other than a dishonorable discharge, or was discharged or released from active duty because of a service-connected disability. Includes any veteran of the U.S. military, ground, naval or air service who served in the Republic of Vietnam between February 28, 1961 and May 7, 1975.

Disabled Veteran, 38 U.S.C. 4211 (3): A veteran who is entitled to compensation under laws administered by the Department of Veteran Affairs or a person who was discharged or released from active duty because of a service-connected disability.
This includes veterans who would be entitled to disability compensation if they were not receiving military retirement pay instead.

Special Disabled Veteran: A veteran who is entitled to compensation under laws administered by the Department of Veteran Affairs for:

- a disability rated at 30 percent or more; or
- a disability rated at 10 or 20 percent in the case of a veteran who has been determined under 38 U.S.C. 3106 to have a serious employment handicap; or
- a discharge or release from active duty because of a service-connected disability.

This includes veterans who would be entitled to disability compensation if they were not receiving military retirement pay instead.

Reserve Component, 38 U.S.C. 101 (7): Includes Army Reserve, Navy Reserve, Marine Corps Reserve, Air Force Reserve, Army National Guard of the United States, and Air National Guard of the United States.

Military Spouse or Registered Domestic Partner, Washington State Executive Order 19-01: A person currently or previously married to a military service member during the service member's time of active, reserve, or National Guard duty.

Retirement Status Verification

Employers can use this form to document the retirement status of all new employees.

DRS Contact Information
Employer Support Services (ESS)
360.664.7200, option 2
800.547.6657, option 6, option 2
drs.employersupport@drs.wa.gov

Employer Instructions

RCW 41.50.139 requires employers to obtain, in writing, the retirement status of all new employees. Your organization can document the status using your own process, or by using this form. If using this form:

- Ask the employee to complete and sign the Employee Information section below.
- Use the Member Management Process in the Employer Reporting Application (ERA) to verify the employee's retirement status.
- Record the results in the Employer Verification section below.
- Use Retiree Return to Work (RRTW) Reporting Charts to review reporting instructions as necessary.
- Sign and date this form. Retain for 60 years.

Employee Information		Employer Verification
Employee Name (Last, First, Middle)	Social Security Number	
Are you a retiree of one of Washington state's retirement systems? If yes, which one(s)? ☐ Yes, _____ ☐ No		☐ Yes ☐ No
If a retiree of PERS, SERS or TRS, did you retire using the 2008 early retirement factors (2008 ERF)? ☐ Yes ☐ No If yes, are you under age 65? ☐ Yes ☐ No		☐ Yes ☐ No
Have you retired or will you be eligible to retire from LEOFF Plan 2 in the future? ☐ Yes ☐ No		☐ Yes ☐ No If yes, and filling eligible position (not L2 position), have employee complete LEOFF Plan 2 Re-employment form.
Are you a retiree of a separate retirement plan covered by the city of Seattle, Spokane or Tacoma? If yes, which one(s)? ☐ Yes, _____ ☐ No		If the employee checked yes, stop. Contact ESS before enrolling the employee in a DRS retirement plan.
Are you currently employed by another public employer and contributing to a Washington state retirement system? That is, will you be working at the same time for two public employers? ☐ Yes ☐ No		If the employee checked yes, stop. Contact ESS before enrolling the employee in a DRS retirement plan.
Employee Signature	Date	

Employer Comments (optional)

Please enter any additional comments here. If you need more room, use the back of this form and check this box: ☐

Employer Signature

I verified the above information using ERA (or by contacting DRS). I acknowledge that failure to properly report a retiree to DRS can result in a liability to the employer.

Employer Signature	Date

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

Signature of Employee	Today's Date (mm/dd/yyyy)

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
Wenatchee Valley College	**1300 Fifth St, Wenatchee WA 98801**

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	**OR**	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

Supplement A,
Preparer and/or Translator Certification for Section 1

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

Supplement B,
Reverification and Rehire (formerly Section 3)

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

PEBB Benefit Eligibility

Washington State Health Care Authority

A-3 (Worksheet B): Completed by the employer and provided to the employee

Newly hired faculty

Employee Name: _____ Employee ID: not needed at this time

Date notice provided to employee: _____

EMPLOYEE ELIGIBILITY NOTIFICATION

1. Stacking Hours Across Employers *(WAC 182-12-114 (3)(b))*	**Enter a Y or N**
Faculty has informed you that:	
They are working as faculty at more than one institution of higher education.	N
If "**Yes**," include hours from all faculty workloads when determining eligibility. *(Faculty workloads may only be stacked with other faculty workloads to establish or maintain eligibility).*	

2. Eligibility Calculator

Enter the anticipated percentage of full-time **for each quarter or semester.** Include the anticipated percentage of faculty hours from other higher education institutions in the *Other Institutions* row. Also include any work in direct response to a governor-declared emergency.

Exclude any hours, standby hours, and any temporary increase in work hours, of 6 months or less, caused by training or emergencies (except governor-declared emergencies) that have not been or are not anticipated to be part of the faculty's regular work schedule or pattern. Employing agencies must request the PEBB Program's approval to include temporary training or emergency hours in determining eligibility.

Describe any excluded hours: _____

Quarter Review	**Fall**	**Winter**	**Spring**	**Summer**
Your Institution:				
Other Institutions:				
Total				

Semester Review	**Fall**	**Spring**	**Summer**
Your Institution:			
Other Institutions:			
Total			

3. Requirements for Eligibility *(WAC 182-12-114 (3)(a)(i))*	**Enter Y or N**
Employer anticipates the faculty will work:	
a. Half-time or more (include faculty hours from other institutions if stacking); and	N
b. For the entire instructional year or equivalent 9-month period.	N

4. Eligibility Decision	**Decision**
If the answer to all requirements is "YES", the faculty is benefits-eligible. Continue with #5 of this worksheet.	
If the answer to any of the requirements is "NO", the faculty is not benefits-eligible at this time. Skip to #9 of this worksheet. Routinely monitor the faculty's' eligible work hours on the B-2 worksheet to establish eligibility.	**No**
5. Date of Eligibility *(WAC 182-12-114 (3)(a)(i))*	**Date**
Faculty is eligible from the date of employment. This is typically the first day of work.	**Does not apply**
6. Benefits Begin: *(WAC 182-12-114 (3)(c)(i))*	**Date**
Medical, dental, basic life and accidental death and dismemberment (AD&D) insurance, and employer & employee paid long-term disabilty (LTD) insurance, and if eligible, benefits under the salary reduction plan: begin the first day of the month following the date the employee becomes eligible (see #5 above). • If the employee becomes eligible on the first working day of the month, then benefits begin on that date **Supplemental Life and AD&D insurance** begins on the first day of the month following the date the contracted vendor received the required form or approves the enrollment.	**Does not apply**
7. New Employee Resources to Enroll in PEBB Benefits	
The following resources are available for newly eligible faculty about PEBB benefits: • PEBB website www.hca.wa.gov/employee-retiree-benefits/public-employees • The PEBB Employee Enrollment Guide (which includes enrollment forms)	

8. Form Submission Dates: *(WAC 182-08-197 (1)(a))*	**Due Date**
The PEBB *Employee Enrollment/Change* form must be received by the employing agency no later than **31 days** after the employee becomes eligible for PEBB benefits.	**Does not apply**
The PEBB MetLife Enrollment/Change form must be received by MetLife or enrollment through the MetLife MyBenefits portal no later than **31 days** after the employee becomes eligible for PEBB benefits. If supplemental life insurance is requested after **31 days**, or the amounts requested are over the guaranteed issue amounts, evidence of insurability (statement of health) will be required. Note: Supplemental accidental death and dismemberment (AD&D) insurance will not require evidence of insurability (statement of health). www.metlife.com/wshca	**Does not apply**
Enrollment in employee-paid LTD at the 60% coverage level is automatic (unless declined during the 31 day election period). Declining or reducing to the 50% coverage level is done by submitting The PEBB *Long-Term Disability (LTD) Enrollment/Change* form* to the employing aggency. *Port Commissioners and seasonal employees who work a season of less than 9 months are eligible for basic LTD only.	**Does not apply**
If enrolling in the Medical or Limited Purpose FSA and/or DCAP*, the *PEBB Midyear Enrollment* form must be received by the employing agency no later than **31 days** after the employee becomes eligible for PEBB benefits. **Available to state and higher education institution employees only.*	**Does not apply**
If enrolling dependents, valid Dependent Verification (DV) documents must be received by the employing agency no later than **31 days** after the employee becomes eligible for PEBB benefits. A list of valid DV documents is available on the PEBB website: www.hca.wa.gov/employee-retiree-benefits/public-employees/verify-and-enroll-my-dependents	**Does not apply**
Auto or home insurance may be applied for at any time with Liberty Mutual. www.hca.wa.gov/employee-retiree-benefits/public-employees/auto-and-home-insurance	
***** The employee must have no less than ten calendar days after the date of notice to elect coverage. For example, if the employee's date of eligiblity is September 3 and is provided notice of eligibility: • No later than September 24, the employee has until October 4 to make elections. • On September 30, the employee will have until October 10 to make elections.	
Important: Failure by the employee to submit forms timely will result in a default enrollment as follows: Uniform Medical Plan Classic with a monthly premium of **$110**, Uniform Dental Plan, basic life, basic AD&D insurance, and the employer-paid and employee-paid (60%) LTD insurance, dependents will not be enrolled, and a $25 per account monthly tobacco use premium surcharge will be incurred (WAC 182-08-197 (1)(b)). Forms must be submitted even if the employee chooses to wavie medical coverage.	

9. Signature and Date: To be reviewed and signed by the employee and employer

- I (the employee) have reviewed the above information and acknowledge the decision made. I understand I can access PEBB rules and guidance on the above decision through the PEBB website **(www.hca.wa.gov/employee-retiree-benefits/rules and-policies/pebb-rules-and-policies**), specifically WAC 182-12-114 and 182-12-131.
- I understand if I have a change that affects my eligibility for PEBB benefits, my employer will notify me. I also understand I have the right to ask my employer to re-evaluate my eligibility at any time.
- I understand it is my responsibility to inform my employer immediately if I am returning from layoff status within 24 months of my original eligible position ending (date of layoff). (For the limited purpose of determining PEBB benefit eligibility, "layoff" is defined in WAC 182-12-109 and there are examples in WAC 182-12-129 and 182-12-133 (1)(b)(v)).
- I understand it is my responsibility to immediately inform my employer if I have or obtain multiple jobs or positions within the agency.
- I acknowledge I have the right to appeal this and any future eligibility decisions for PEBB benefits made by a PEBB-participating employing agency through the PEBB appeals process (Chapter 182-16 WAC).
- I understand the PEBB appeals process begins with requesting a review from my employer. (For a complete explanation of the appeals process and appeal forms, visit the PEBB website at **www.hca.wa.gov/about-hca/file-appeal-pebb**)

www.hca.wa.gov/about-hca/file-appeal-pebb

Stacking: Faculty may establish eligibility and maintain the employer contribution toward PEBB benefits by working as faculty for more than one institution of higher education. Faculty workloads may only be stacked with other faculty workloads to establish eligibility under WAC 182-12-114(3) or maintain eligibility as described in WAC 182-12-131(3). A faculty becomes eligible through stacking when they meet the requirements for eligibility as described in #3 above. When a faculty works for more than one institution of higher education, the faculty must notify their employing agencies that they work at more than one institution and may be eligible through stacking (WAC 182-12-114 (3)(b)).

Summer or off-quarter/semester coverage: All benefits-eligible faculty (eligible as described in WAC 182-12-114 (3)(a) and (b)) who work an average of half-time or more throughout the entire instructional year or equivalent nine-month period and work each quarter/semester of the instructional year or equivalent nine-month period are eligible for the employer contribution toward summer or off-quarter/semester PEBB benefits (WAC 182-12-131 (3)(c)).

Two-year averaging: All benefits-eligible faculty (eligible as described in WAC 182-12-114(3)(a) and (b)) who worked an average of half-time or more in each of the two preceding academic years are potentially eligible to receive uninterrupted employer contribution toward PEBB benefits. "Academic year" means summer, fall, winter, and spring quarters or summer, fall, and spring semesters and begins with summer quarter/semester. In order to be eligible for the employer contribution through two-year averaging, the faculty must provide written notification of their potential eligibility to their employing agency or agencies within the deadlines established by the employing agency or agencies (WAC 182-12-131 (3)(d)).

Faculty who lose eligibility for the employer contribution: All benefits-eligible faculty (eligible as described in WAC 182-12-114 (3)(a) and (b)) who lose eligibility for the employer contribution will regain it if they return to a faculty position where it is anticipated that they will work half-time or more for the quarter/semester no later than the twelfth month after the month in which they lost eligibility for the employer contribution. The employer contribution begins on the first day of the month in which the quarter/semester begins (WAC 182-12-131 (3)(e)).

Faculty Signature		Date
Agency Representative Signature	WVC/686 Agency/Sub Agency	Date

Place a signed copy in the employee's file and provide a copy of the **Employee Eligibility Notification** to the employee.

WVC EMERGENCY INFORMATION

Administration/WVC Incident Management Team: 682-6514

Security Patrol: 682-6911 Safety Officer 682.6659 or 679.2274

Facilities and Operations: 682-6450 Weekends and/or After 4:00 pm 860-2250

EVACUATION

1. Fire Alarm and/or your building point of contact verbally announces an evacuation.
2. Incident Management Team establishes an exterior Incident Command Post.
3. All employees with radios report to the Incident Command Post.
4. Employees without students report to the Evacuation Team Leader for possible assignment.
5. Instructors and Department Heads will organize students/employees for building departure:
   - Close all doors as you leave the building.
   - Leave the building via the closest -safe exit.
   - Gather your class/employees at your buildings “Evacuation Assembly Area”.
   - Conduct a roll call then forward information to your Evacuation Team Leader via runner.
   - Wait for a WVC Team authorization, before re-entering the building.
   - Check your classroom/work area and report anything unusual to administration.
   - Debrief your students/employees.

FIRE

1. If you discover smoke or fire, pull a fire alarm as you leave the building. Insure that 911 have been contacted with incident information.
2. Use the above evacuation procedure for any fire or suspected fire.
3. Leave room lights on and close all doors as you exit. Do not lock!
4. Employees choosing to use a Fire Extinguisher; use caution and apply your training.

LOCKDOWN

1. If an interior threat is discovered a Lockdown Alert will be made via an Emergency Text Alert.
2. Employees at exposed work stations, move to your predetermined safe room.
3. Employees occupying an office, classroom or storage area; lock or barricade yourself in and remain in place.
4. If inside, close, lock and cover all interior windows and glass panels.
5. Leave curtains/blinds open on exterior windows.
6. Move everyone away from interior doors and windows.
7. Turn off lights and keep quiet. Set your cell to vibrate only. Don’t open your door for any reason.
8. Anyone in transit between rooms shall immediately seek shelter in the closest room.
9. Anyone in transit between buildings shall immediately leave campus.
10. Lockdown is concluded when police or a WVC Team member enters your location.
11. Follow their instructions.

INJURY ACCIDENT

1. Call 911 if requested by injured party (victim) or if in your judgment, such assistance is obviously required.
2. Calling 911 with any campus phone also notifies the WVC Incident Management Team.
3. If a cell phone was used to call 911, now call Administration to alert the WVC Team.
4. Provide appropriate First Aid to the victim(s).
5. If alone with the victim, take actions that will assist the ambulance in finding your location.

SHELTER IN PLACE

1. You may be notified of this situation by phone, ETA or building point of contact.
2. If inside, stay inside.
3. If outside immediately enter any building.
4. Facility Department will:
    - Activate automatic door locking where available.
    - Stop all air exchanges in all buildings.
    - Instructors will close and lock all exterior classroom door(s) or window(s).
    - All employees will work with the Incident Management Team to secure all exterior doors.
    - Do not open exterior doors, for any reason, until the all-clear is given.

EARTHQUAKE

DROP To the floor.

COVER Take cover under a sturdy piece of furniture. Against a load bearing wall is best. Protect your head and neck with your arms. Avoid danger spots near windows, hanging objects, mirrors or tall furniture.

HOLD On to sturdy objects and be prepared to move with it. Hold until the ground stops shaking and it's safe to move.

EVACUATE When the shaking stops, leave the building via the closest - safe exit and follow evacuation procedures as described above.

BOMB THREAT

1. May be delivered in many formats.
2. Notify Administration to alert the WVC Team and they will call 911.
3. Turn off cell phones and/or walkie-talkies (radio waves could trigger a bomb).
4. Our Incident Management Team will coordinate with emergency responders.
5. Follow standard evacuation procedures if the alarm is sounded.
6. If you see something suspicious REPORT IT—DON'T TOUCH IT!

The items above are generally focused toward WVC campuses. Employees that work at sites other than WVC campuses are encouraged to learn the emergency information from the site where you are based. Additionally, to learn about the WVC safety committee, please go to WVC Commons, Sites A-Z, Safety, Shared Documents, Safety Committee.

If you are involved in an accident please contact administrative services at 682.6514.

_____ _____

Employee Signature (I have received this information) Date

Rev 5/15/13 tm

WENATCHEE VALLEY COLLEGE

Declaration Regarding Sexual Misconduct

RCW 28B.112.080, Postsecondary Educational Institutions – Sexual Misconduct

Pursuant to RCW 28B.112.080, employment applicants must declare whether they are the subject of any substantiated findings of sexual misconduct in any current or former employment or are currently being investigated for, or have left a position during an investigation into, a violation of any sexual misconduct policy at the applicant's current or past employers. By law, post-secondary education institutions cannot hire an applicant who does not complete this form.

Please complete this fillable form on the computer. Once completed, please print the form and sign the declaration. You may mail or scan the completed form to humanresources@wvc.edu. Incomplete information or inability to read the information provided in this declaration may result in delayed verification and/or withdrawal of the offer of employment.

Are you the subject of any substantiated findings of sexual misconduct in any current or former employment?

Sexual Misconduct, includes, but is not limited to, unwelcome sexual contact, unwelcome sexual advances, requests for sexual favors, other unwelcome verbal, nonverbal, electronic, and any misconduct that is in violation of that postsecondary educational institution's policies or has been determined to constitute sex discrimination pursuant to state or federal law. See RCW 28B.112.040(5).

☐ Yes

☐ No

Are you currently being investigated for sexual misconduct at a current employer?

☐ Yes

☐ No

Have you left a position during an investigation into your alleged violation of any sexual misconduct policy at current or past employers?

☐ Yes

☐ No

If you answered yes to any of the questions above, please explain the circumstances (you may attach additional pages if necessary):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Applicant's Previous Employer Contact Information:

For verification purposes, please list ***all*** of your previous and current employers and designate those that are postsecondary institutions.

Employer Name ______________________ Postsecondary Institution ☐

Address ______________________

Phone Number ______________ Email Address ______________

Employer Name ______________________ Postsecondary Institution ☐

Address ______________________

Phone Number ______________ Email Address ______________

Employer Name ______________________ Postsecondary Institution ☐

Address ______________________

Phone Number ______________ Email Address ______________

Employer Name ______________________ Postsecondary Institution ☐

Address ______________________

Phone Number ______________ Email Address ______________

Employer Name ______________________ Postsecondary Institution ☐

Address ______________________

Phone Number ______________ Email Address ______________

Employer Name ______________________ Postsecondary Institution ☐

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Employer Name ______________________ Postsecondary Institution ☐

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Phone Number ______________ Email Address ______________

Employer Name ______________________________ Postsecondary Institution ☐

Address ______________________________

Phone Number ______________ Email Address ______________

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Employer Name ______________________________ Postsecondary Institution ☐

Address ______________________________

Phone Number ______________ Email Address ______________

Employer Name ______________________________ Postsecondary Institution ☐

Address ______________________________

Phone Number ______________ Email Address ______________

Employer Name ______________________________ Postsecondary Institution ☐

Address ______________________________

Phone Number ______________ Email Address ______________

Declaration and Authorization to Release Information RCW 28B.112.080

I, _____, hereby certify and declare that the information on page 1 is true, complete, and accurate to the best of my knowledge. I understand failure to provide complete and accurate information in response to these questions will result in disqualification from employment at Wenatchee Valley College, withdrawal of any offer of employment, and/or termination from employment.

By my signature, I certify that I provided a complete list including addresses and phone numbers of my former and current employers to the College, and I authorize all current and former employers to disclose to the College information, if any, regarding sexual misconduct committed by me, and to make available all documents and information in my current or former personnel, investigative, or other files relating to any sexual misconduct, including sexual harassment, by me. I agree to execute any additional forms required by my current or former employer(s) to release such information to Wenatchee Valley College, and by my signature, I hereby release all current and former employers from any and all claims and liability arising from the disclosure of the information described in this paragraph.

I further authorize Wenatchee Valley College to contact my current or former employer(s) to verify the information I have furnished.

I declare under penalty of perjury of the laws of the state of Washington that the foregoing is true and correct. **I understand that I do not need to contact my current or previous employers and that, if verification is needed, Wenatchee Valley College will contact them on my behalf.**

Dated this _____ of _____, 20___at (city or county) _____

_____
Signature

<u>This section to be completed by former employer(s) only.</u>

☐ No sexual misconduct materials were found.

☐ Yes, sexual misconduct materials are available. Please contact for more information.

☐ No record of employment found.

Former Employer _____

Former Employer Representative Signature _____

Title _____

Date _____

<u>Please return all completed information to:</u>

College Wenatchee Valley College Attention Wendi Martin

Address 1300 Fifth St City Wenatchee State WA Zip 98801

Phone (509) 682-6440 Fax (509) 682-6441

Email wmartin@wvc.edu

WENATCHEE VALLEY COLLEGE
— HUMAN RESOURCES —

The Affordable Care Act (ACA) Notice of Health Insurance Marketplace Coverage Options and Your Public Employees Benefits Board (PEBB) Benefits General Information

In 2014, a new way to buy health insurance through the new health insurance Marketplace, also known as the Health Insurance Exchange, was introduced. Washington Healthplanfinder is the Marketplace serving Washington residents. This notice provides basic information about the Marketplace as well as Public Employees Benefits Board (PEBB) health plan coverage offered by your employer and is intended to assist you in evaluating options for you and your family.

1. **What is the Health Insurance Marketplace?**
   Under the Affordable Care Act (ACA), every state must have a health insurance Marketplace to help people buy health insurance. The Marketplace offers assistance to help you find and compare healt insurance options offered by private companies. The Marketplace will also help you find out if you qualify for premium tax credits or other financial assistance.

2. **When does open enrollment begin?**
   Open enrollment for the Marketplace may begin as early as October 1st for coverage starting as early as January 1st of the following year. However, please keep in mind that this can vary.

3. **Can I save money on my health insurance premiums in the Marketplace?**
   You may qualify to save money and lower your monthly premium, but only if you are not eligible for PEBB health plan enrollment as an employee. The amount of premium savings in the Marketplace will depend on your household income.

4. **Does being eligible for an employer contribution for PEBB medical coverage affect eligibility for premium savings through the Healthplanfinder?**
   Yes.

   - **Employees eligible for employer contribution:**
     All **eligible** state employees receive an employer contribution for PEBB medical plan enrollment and are not allowed to waive PEBB medical coverage to enroll in coverage through the Marketplace. All or a portion of this contribution may be excluded from income for Federal and State income tax purposes. These employees should enroll or remain enrolled in their PEBB medical plan.

     State employees who are eligible to receive an employer contribution cannot use the employer contribution to purchase coverage through the Marketplace, and will not be eligible for a premium tax credit if they purchase coverage through the Marketplace.

     However, if the cost of a PEBB health plan to cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or does not meet the “minimum value” standard set by the ACA, you may be eligible for a tax credit or other financial assistance. An employer-sponsored health plan meets the “minimum value standard” if the health plan’s share of the total allowed benefit costs covered by the health plan is no less than 60 percent of such costs.

   - **Employees <u>not</u> eligible for employer contribution:**
     Employees who are not eligible for the employer contribution for PEBB health plan enrollment should consider applying for health benefits in the Marketplace as they may qualify for a premium tax credit or other financial assistance. Your payments for coverage through the Marketplace are made on an after-tax basis.

5. **How do I get additional information about the Marketplace?**

The Marketplace simplifies your search for health coverage by gathering the options available in your area in one place. You can compare plans based on price, benefits, quality, and other features important to you before you make a choice.

Visit www.healthcare.gov or also get help by phone, or in person.

Call 1-800-318-2596, 24 hours a day, 7 days a week. (TTY: 1-855-889-4325).

6. **How do I contact the Washington Healthplanfinder?**
For Washington state residents, Washington Healthplanfinder can help you evaluate Marketplace coverage options and possible premium savings online, by phone, or in person:

Washington Healthplanfinder
521 Capitol Way South Olympia, WA 98501
Toll-free: 1-855-923-4633 (TTY: 1-855-627-9604)
Submit a question online

7. **How do I get more information about PEBB health plans?**
For more information about PEBB health plans offered by your employer, please check the Certificate of Coverage for your plan, or contact your benefits office.

You can also find complete information about PEBB employee or retiree benefits at the PEBB website: www.hca.wa.gov/employee-retiree-benefits/public-employees

Information about PEBB health coverage offered by your employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide the information shown below. This information is numbered to correspond to the Marketplace application.

<table>
<tr><td colspan="2">3. Employer name
Wenatchee Valley College</td><td>4. Employer Identification Number (EIN)
91-081775</td></tr>
<tr><td colspan="2">5. Employer address
1300 Fifth Street</td><td>6. Employer phone number
509.682.6440</td></tr>
<tr><td>7. City
Wenatchee</td><td>8. State
WA</td><td>9. ZIP code
98801</td></tr>
<tr><td colspan="3">10. Who can we contact about employee health coverage at this job?
Wendi Martin or Tim Marker</td></tr>
<tr><td colspan="2">11. Phone number (if different from above)</td><td>12. Email address
wmartin@wvc.edu or tmarker@wvc.edu</td></tr>
</table>

Here is some basic information about health coverage offered by Wenatchee Valley College:

- **As your employer, we offer a health plan to:**
  - ☐ All employees.
  - ☑ **Some employees.**

Eligible employees are described in Washington Administrative Code (WAC) 182-12-114:

How do employees establish eligibility for Public Employees Benefits Board (PEBB) benefits?
Eligibility for an employee whose work circumstances are described by more than one of the eligibility categories in subsections (1) through (5) of this section shall be determined solely by the criteria of the category that most closely describes the employee's work circumstances.

Hours that are excluded in determining eligibility include standby hours and any temporary increases in work hours, of six months or less, caused by training or emergencies (except governor-declared emergencies) that have not been or are not anticipated to be part of the employee's regular work schedule or pattern. Any hours

worked in direct response to a governor-declared emergency are not excludable and must be included in determining eligibility. In order to include excluded hours in determining eligibility, employing agencies must request and receive the Public Employees Benefits Board (PEBB) program's approval.

For how the employer contribution toward PEBB benefits is maintained after eligibility is established under this section, see WAC 182-12-131.

(1) Employees are eligible for PEBB benefits as follows, except as described in subsections (2) through (5) of this section:

(a) Eligibility. An employee is eligible if they are anticipated to work an average of at least 80 hours per month and are anticipated to work for at least eight hours in each month for more than six consecutive months.
(b) Determining eligibility.
(i) Upon employment: An employee is eligible from the date of employment if the employing agency anticipates the employee will work according to the criteria in (a) of this subsection.
(ii) Upon revision of anticipated work pattern: If an employing agency revises an employee's anticipated work hours or anticipated duration of employment such that the employee meets the eligibility criteria in (a) of this subsection, the employee becomes eligible when the revision is made.
(iii) Based on work pattern: An employee who is determined to be ineligible, but later meets the eligibility criteria in (a) of this subsection, becomes eligible the first of the month following the six-month averaging period.
(c) Stacking of hours. As long as the work is within one state agency, employees may "stack" or combine hours worked in more than one position or job to establish eligibility and maintain the employer contribution toward PEBB benefits. Employees become eligible through stacking when they meet the requirements described in (a) of this subsection. They must notify their employing agency if they believe they are eligible through stacking. Stacking includes work situations in which:
(i) The employee works two or more positions or jobs at the same time (concurrent stacking);
(ii) The employee moves from one position or job to another (consecutive stacking); or
(iii) The employee combines hours from a seasonal position with hours from a nonseasonal position or job. An employee who establishes eligibility by stacking hours from a seasonal position or job with hours from a nonseasonal position or job shall maintain the employer contribution toward PEBB benefits as described in WAC 182-12-131(1).
(d) When PEBB benefits begin. Medical, dental, basic life insurance, basic accidental death and dismemberment (AD&D) insurance, employer-paid long-term disability (LTD) insurance, employee-paid LTD insurance (unless the employee declines the employee-paid LTD insurance as described in WAC 182- 08-197(1)), and if eligible, benefits under the salary reduction plan begin on the first day of the month following the date an employee becomes eligible. If the employee becomes eligible on the first working day of a month, then coverage begins on that date. Supplemental life insurance and supplemental AD&D insurance begin on the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

(2) Seasonal employees, as defined in WAC 182-12-109, are eligible as follows:
(a) Eligibility. A seasonal employee is eligible if they are anticipated to work an average of at least 80 hours per month and are anticipated to work for at least eight hours in each month of at least three consecutive months of the season.
(b) Determining eligibility.
(i) Upon employment: A seasonal employee is eligible from the date of employment if the employing agency anticipates that they will work according to the criteria in (a) of this subsection.
(ii) Upon revision of anticipated work pattern. If an employing agency revises an employee's anticipated work hours or anticipated duration of employment such that the employee meets the eligibility criteria in (a) of this subsection, the employee becomes eligible when the revision is made.
(iii) Based on work pattern. An employee who is determined to be ineligible for benefits, but later works an average of at least 80 hours per month and works for at least eight hours in each month and works for more than six consecutive months, becomes eligible the first of the month following a six-month averaging period.
(c) Stacking of hours. As long as the work is within one state agency, employees may "stack" or combine hours worked in more than one position or job to establish eligibility and maintain the employer

contribution toward PEBB benefits. Employees become eligible through stacking when they meet the requirements described in (a) of this subsection. They must notify their employing agency if they believe they are eligible through stacking. Stacking includes work situations in which:
(i) The employee works two or more positions or jobs at the same time (concurrent stacking);
(ii) The employee moves from one position or job to another (consecutive stacking); or
(iii) The employee combines hours from a seasonal position or job with hours from a nonseasonal position or job. An employee who establishes eligibility by stacking hours from a seasonal position or job with hours from a nonseasonal position or job shall maintain the employer contribution toward PEBB benefits as described in WAC 182-12-131(1).
(d) When PEBB benefits begin. Medical, dental, basic life insurance, basic AD&D insurance, employer-paid LTD insurance, employee-paid LTD insurance (unless the employee declines the employee-paid LTD insurance as described in WAC 182-08-197(1)), and if eligible, benefits under the salary reduction plan begin on the first day of the month following the day the employee becomes eligible. If the employee becomes eligible on the first working day of a month, then coverage begins on that date. Supplemental life insurance and supplemental AD&D insurance begin on the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

Exception: Seasonal employees who work a recurring, annual season with a duration of less than nine months are not eligible for the employee-paid LTD insurance benefit.

(3) Faculty are eligible as follows:
(a) Determining eligibility. "Half-time" means one-half of the full-time academic workload as determined by each institution, except that half-time for community and technical college faculty employees is governed by RCW 28B.50.489.
(i) Upon employment: Faculty who the employing agency anticipates will work half-time or more for the entire instructional year, or equivalent nine-month period, are eligible from the date of employment.
(ii) For faculty hired on quarter/semester to quarter/semester basis: Faculty who the employing agency anticipates will not work for the entire instructional year, or equivalent nine-month period, are eligible at the beginning of the second consecutive quarter or semester of employment in which they are anticipated to work, or has actually worked, half-time or more. Spring and fall are considered consecutive quarters/semesters when first establishing eligibility for faculty that work less than half- time during the summer quarter/semester.
(iii) Upon revision of anticipated work pattern: Faculty who receive additional workload after the beginning of the anticipated work period (quarter, semester, or instructional year), such that their workload meets the eligibility criteria as described in (a)(i) or (ii) of this subsection become eligible when the revision is made.
(b) Stacking. Faculty may establish eligibility and maintain the employer contribution toward PEBB benefits by working as faculty for more than one institution of higher education. Faculty workloads may only be stacked with other faculty workloads to establish eligibility under this section or maintain eligibility as described in WAC 182-12-131(3). A faculty becomes eligible through stacking when they meet the requirements as described in (a) of this subsection. When a faculty works for more than one institution of higher education, the faculty must notify their employing agencies that they work at more than one institution and may be eligible through stacking.
(c) When PEBB benefits begin.
(i) Medical, dental, basic life insurance, basic AD&D insurance, employer-paid LTD insurance, employee-paid LTD insurance (unless the faculty declines the employee-paid LTD insurance as described in WAC 182-08-197(1)), and if eligible, benefits under the salary reduction plan begin on the first day of the month following the day the faculty becomes eligible. If the faculty becomes eligible on the first working day of a month, then coverage begins on that date. Supplemental life insurance and supplemental AD&D insurance begin on the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.
(ii) For faculty hired on a quarter/semester to quarter/semester basis under (a)(ii) of this subsection, medical, dental, basic life insurance, basic AD&D insurance, employer-paid LTD insurance, employee-paid LTD insurance (unless the faculty declines the employee-paid LTD insurance as described in WAC 182-08-197(1)), and if eligible, benefits under the salary reduction plan begin the first day of the month following the beginning of the second consecutive quarter/semester of half-time or more employment. If the first day of the second consecutive quarter/semester is the first working day of the month, then coverage begins at the beginning of the second consecutive quarter/semester. Supplemental life insurance and supplemental AD&D insurance begin on the first day of the month following the date the

contracted vendor receives the required form or approves the enrollment.

(4) Elected and full-time appointed officials of the legislative and executive branches of state government are eligible as follows:

(a) Eligibility. A legislator is eligible for PEBB benefits on the date their term begins. All other elected and full-time appointed officials of the legislative and executive branches of state government are eligible on the date their terms begin or the date they take the oath of office, whichever occurs first.

(b) When PEBB benefits begin. Medical, dental, basic life insurance, basic AD&D insurance, employer- paid LTD insurance, employee-paid LTD insurance (unless the employee declines the employee-paid LTD insurance as described in WAC 182-08-197(1)), and if eligible, benefits under the salary reduction plan begin on the first day of the month following the day the employee becomes eligible. If the employee becomes eligible on the first working day of a month, then coverage begins on that date. Supplemental life insurance and supplemental AD&D insurance begin on the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

(5) Justices and judges are eligible as follows:

(a) Eligibility. A justice of the supreme court and judges of the court of appeals and the superior courts become eligible for PEBB benefits on the date they take the oath of office.

(b) When PEBB benefits begin. Medical, dental, basic life insurance, basic AD&D insurance, employer-paid LTD insurance, employee-paid LTD insurance (unless the employee declines the employee-paid LTD insurance as described in WAC 182-08-197(1)), and if eligible, benefits under the salary reduction plan begin on the first day of the month following the day the employee becomes eligible. If the employee becomes eligible on the first working day of a month, then coverage begins on that date. Supplemental life insurance and supplemental AD&D insurance begin on the first day of the month following the date the contracted vendor receives the required form or approves the enrollment.

- **With respect to dependents:**
  - ☑ **We do offer coverage.**
  - ☐ We do not offer coverage.

Dependent eligibility is described in Washington Administrative Code (WAC) 182-12-260:

(1) Legal spouse. A former spouse is not an eligible dependent upon finalization of a divorce or annulment, even if a court order requires the subscriber to provide health insurance for the former spouse;

(2) State registered domestic partner. A former state registered domestic partner is not an eligible dependent upon dissolution or termination of a partnership, even if a court order requires the subscriber to provide health insurance for the former partner;

(3) Children. Children are eligible through the last day of the month in which their twenty-sixth birthday occurred except as described in (g) of this subsection. Children are defined as the subscriber's:

(a) Children based on establishment of a parent-child relationship as described in RCW 26.26A.100, except when parental rights have been terminated;

(b) Children of the subscriber's spouse, based on the spouse's establishment of a parent-child relationship, except when parental rights have been terminated. The stepchild's relationship to the subscriber (and eligibility as a dependent) ends on the same date the marriage with the spouse ends through divorce, annulment, dissolution, termination, or death;

(c) Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;

(d) Children of the subscriber's state registered domestic partner, based on the state registered domestic partner's establishment of a parent-child relationship, except when parental rights have been terminated. The child's relationship to the subscriber (and eligibility as a dependent) ends on the same date the subscriber's legal relationship with the state registered domestic partner ends through divorce, annulment, dissolution, termination, or death;

(e) Children specified in a court order or divorce decree for whom the subscriber has a legal obligation to provide support or health care coverage;

(f) Extended dependent in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or subscriber's state registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. Extended dependent child does not include a foster child unless the subscriber, the subscriber's spouse, or the subscriber's state registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption; and

(g) Children of any age with a developmental or physical disability that renders the child

incapable of self-sustaining employment and chiefly dependent upon the subscriber for support and maintenance provided such condition occurs before the age of twenty-six:

(i) The subscriber must provide proof of the disability and dependency within sixty days of the child's attainment of age twenty-six;

(ii) The subscriber must notify the PEBB program, in writing, when the child is no longer eligible under this subsection as described in WAC 182-12-262 (2)(a);

(iii) A child with a developmental or physical disability who becomes self-supporting is not eligible under this subsection as of the last day of the month in which they become capable of self-support;

(iv) A child with a developmental or physical disability age twenty-six and older who becomes capable of self-support does not regain eligibility if they later become incapable of self-support; and

(v) The PEBB program with input from the applicable contracted vendor will periodically verify the eligibility of a dependent child with a disability beginning at age twenty-six, but no more frequently than annually after the two-year period following the child's twenty-sixth birthday. Verification will require renewed proof of disability and dependence from the subscriber.

☑ **If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.**

Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.