Application for Authority to Employ Workers with Disabilities at Special Minimum Wages

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division
230 South Dearborn Street, Room 514
Chicago, Illinois 60604

U.S. Wage and Hour Division

Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

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This is an application for the authority to employ workers with disabilities at special minimum wage rates under the Fair Labor Standards Act (FLSA), Walsh–Healey Public Contracts Act (PCA), or McNamara–O'Hara Service Contract Act (SCA). An instruction sheet for completing this form is contained on page 4. Please submit one copy of the completed form, and any attachments, to the address shown above. Retain a completed copy for your records. A certificate may not be granted by the Department of Labor unless a properly completed application has been received and approved. 29 U.S.C. § 201, *et seq.*

1. a. This Is a Request for Authority to Employ Workers with Disabilities for *(Check All Boxes that Apply)*:

- ☐ Community Rehabilitation Center (Work Center)
- ☐ Hospital/Residential Care Facility (Patient Workers)
- ☐ Business Establishment (Special Workers)
- ☐ School Work Experience Program (SWEP)

b. This Is *(Check One)*:

- ☐ Initial Application *(Complete All Items)*
- ☐ Renewal Application *(Please Make Any Necessary Corrections to Reprinted Information)*

Current Certificate Number: _____

2. Name of Employer: _____

Street Address: _____

Mailing Address *(If Different than Street Address):* _____

City: _____ County: _____

State: _____ ZIP Code: _____

Federal Employer Identification Number (EIN): _____

Person USDOL Should Contact: _____

Telephone: (_____) _____

3. Parent Organization if Different from that Listed in #2:

Name: _____

Address: _____

_____

☐ Check Here if Mail Is to Be Sent to Parent Organization Rather than #2.

4. Status *(Check One)*:

- ☐ Public (State or Local Government)
- ☐ Private, For Profit
- ☐ Private, Not For Profit
- ☐ Other _____

For USDOL Use Only

Certificate Number: _____

Effective Date: ____/____/____ Expiration Date: ____/____/____

RO: _____ DO: _____

Remarks: _____

Employees: _____ Paying SMW's: ☐ Yes ☐ No

Number of Sites to Receive a Certificate: _____

Print Certificate: ☐ Yes ☐ No **WS:** _____

6. List the name and address(es) of all branch establishments (BR), supported employment sites, including enclaves (SE), or school work experience program sites (SWEP) to be covered by this certificate. ***Note:*** A separate *Supplemental Data Sheet* (WH-226A) must be completed for every establishment where you employ workers with disabilities at special minimum wages (including your main establishment and each establishment listed below). See page 4 of this application for definitions of BR, SE and SWEP. Attach additional sheets if necessary.

Indicate if BR, SE or SWEP	Name & Address of Site

7. Do you manufacture items for the Federal Government under PCA?
☐ Yes ☐ No

Do you perform any services for the Federal Government under SCA?
☐ Yes ☐ No

✓ *Remember to attach copies of all current SCA Wage Determinations for those contracts upon which workers with disabilities are employed and earning special minimum wages.*

5. Primary Disability Group Employed *(Check One)*:

- ☐ Mental Retardation (MR)
- ☐ Mental Illness (MI)
- ☐ Visual Impairment (VI)
- ☐ Hearing Impairment (HI)
- ☐ Alcoholism (AL)
- ☐ Drug Addictions (DA)
- ☐ Neuromuscular (NM)
- ☐ Developmental Disability (DD) Specify: _____
- ☐ General — No Primary Group (GI)
- ☐ Age Related (AR)
- ☐ Other (OT) Specify: _____

(continued on next page)

8. FOR RENEWAL APPLICATIONS ONLY

Please provide the number of workers with disabilities (whose productive capacities were impaired by their disabilities and were paid special minimum wages) that your firm employed during your most recently completed fiscal year. Please provide this data using the categories listed below.

Number of Workers Employed in or as *(Complete Each Item as Applicable):*

Work Center _____ **Patient Worker** _____ **Business Establishment** _____ **SWEP** _____

Also Provide the Date Your Most Recently Completed Fiscal Year Ended: _____ /_____ /_____

9. PREVAILING WAGE DETERMINATION

Please provide the following information on the four largest current contracts whether the workers with disabilities are paid an hourly rate or a piece rate. The prevailing rate should reflect the rate paid to experienced workers in the vicinity who do not have disabilities and utilize similar methods and equipment. If more than 3 sources were used, attach an additional sheet headed "Prevailing Wage Determination" and provide the information obtained from these sources (FLSA section 14 (c)(2)(B) and 29 C.F.R. § 525.10).

Description of Work ***(e.g., Collating, Hand Assembly, Janitorial)***	**Sources** ***(Name of Firm and Person Contacted)***	**Date of Contact**	**Prevailing Wage Provided by Source**	**Prevailing Wage Determined by Applicant**
	1. _____	_____	$ _____	
	2. _____	_____	$ _____	$ _____
	3. _____	_____	$ _____	
	1. _____	_____	$ _____	
	2. _____	_____	$ _____	$ _____
	3. _____	_____	$ _____	
	1. _____	_____	$ _____	
	2. _____	_____	$ _____	$ _____
	3. _____	_____	$ _____	
	1. _____	_____	$ _____	
	2. _____	_____	$ _____	$ _____
	3. _____	_____	$ _____	

10. FOR RENEWAL APPLICATIONS ONLY — HOURLY RATES

a. How many workers with disabilities employed under the terms of this certificate received special minimum wages and were paid hourly rates during the fiscal year cited in Block 8 above? *(If the answer is 0, go on to question 11.)* _____

b. How frequently do you rate/evaluate the productivity of each hourly paid worker with a disability who is paid a special minimum wage? _____

c. Attach to this application productivity rating/evaluation forms for three currently employed workers with disabilities who are paid hourly rates *(if you employ workers with disabilities at special minimum wages on an SCA contract, one of the three employees for whom data is submitted must pertain to an SCA service employee).* Include all material relating to the evaluation which shows the worker's individual productivity in proportion to the wage and productivity of an experienced worker, who does not have disabilities, performing essentially the same type, quality and quantity of work in the vicinity.

11. FOR RENEWAL APPLICATIONS ONLY — PIECE RATES

a. How many workers with disabilities employed under the terms of this certificate received special minimum wages and were paid piece rates during the fiscal year cited in Block 8 above? *(If the answer is 0, go on to question 12.)* _____

b. Please provide the following information about the four largest current contracts on which workers with disabilities earning special minimum wages are paid piece rates and attach supporting time studies or work measurements.

Description of Work ***(e.g., Packaging, Shrink Wrapping, Labeling)***	**Prevailing Wage Determined for This Job** ***(Expressed in a Rate per Hour)***	**Standard Productivity** ***(Units/Hour)***	**Piece Rate Paid to Workers** ***(Rate per Unit)***

(continued on next page)

12. TEMPORARY AUTHORITY: To be completed **only** by a vocational rehabilitation program administered by a State agency or the U.S. Veterans Administration.

☐ Check if this is a request for temporary authority to employ workers with disabilities at special minimum wages pursuant to a vocational rehabilitation program of the Veterans Administration for veterans with a service-incurred disability or a vocational rehabilitation program administered by a State agency. A copy of the signed application will constitute the temporary authority provided the application is mailed to the Department of Labor at the address listed at the top of page 1 of this form within ten days of the signing. Temporary authority will exist for 90 days from the date the application is signed and cannot be extended or renewed by the issuing agency. (See 29 C.F.R. § 525.8 and instructions on page 4 of this application.)

13. REPRESENTATIONS AND WRITTEN ASSURANCES

I certify that I have read this form and to the best of my knowledge and belief, all answers and information given in the application and attachments are true; that the representations set forth in support of this application to obtain or continue the authorization to pay workers with disabilities at subminimum wage rates are true; and I acknowledge that the authorization, if issued or continued, is subject to revocation in accordance with the provisions of 29 C.F.R. part 525.

I represent that as set forth in the regulations governing the employment of workers with disabilities, the following conditions exist and will continue to exist:

1) Workers employed under the authority in 29 C.F.R. part 525 have disabilities for the work to be performed;

2) Wage rates paid to workers with disabilities under the authority in 29 C.F.R. part 525 are commensurate with those paid experienced workers, who do not have disabilities, in industry in the vicinity for essentially the same type, quality, and quantity of work;

3) The operations are and will continue to be in compliance with the FLSA, PCA, SCA, and Contract Work Hours and Safety Standards Act (CWHSSA), an overtime statute for federal contract work, as applicable;

4) No deductions will be made from the commensurate wages earned by a patient worker to cover the cost of room, board or other services provided by the facility;

5) Records required under 29 C.F.R. part 525 with respect to documentation of disability, productivity, time studies or work measurements, and prevailing wage surveys will be maintained.

Further, I certify that:

1) The wage rates of all hourly-rated employees paid in accordance with FLSA section 14(c) will be reviewed at least every six months; and

2) Wages paid to all employees under FLSA section 14(c) will be adjusted at periodic intervals, at least once a year, to reflect changes in the prevailing wage paid to experienced workers, who do not have disabilities, employed in the vicinity for essentially the same type of work.

14. SIGNATURE OF AUTHORIZED REPRESENTATIVE

Name *(Print or Type)*_____ Title _____

Signature _____ Date _____

Public Burden Statement

The Department of Labor estimates it will take an average of 45 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.**

INSTRUCTION SHEET

GENERAL INSTRUCTIONS

1) This application is to be used to apply for a subminimum wage certificate under the Fair Labor Standards Act (FLSA), the Walsh–Healey Public Contracts Act (PCA), and the McNamara–O'Hara Service Contract Act (SCA). Payment of subminimum wages to workers with disabilities is authorized only under certificates issued under FLSA section 14(c). State Agencies and the Veterans Administration may also request immediate temporary certificate authority by completing this application.

2) This application process is authorized by FLSA section 14(c). While completion of this form is voluntary, authority to pay less than the applicable minimum wage will not be granted unless a properly completed application is submitted.

3) Complete one copy of this form and send it to the following address: U.S. Department of Labor, Employment Standards Administration, Wage and Hour Division, 230 South Dearborn Street, Room 514, Chicago, Illinois, 60604. Keep a copy of the application for your records.

4) For item #1: A **community rehabilitation center** (often in the past referred to as a *sheltered workshop*) is a facility that is engaged primarily in providing rehabilitation and employment opportunities to workers with disabilities. A **patient worker** is a worker with a disability who is employed by a hospital or institution that provides residential care where such worker receives treatment and care. A **business establishment**, for purposes of this application, is an employer in private industry (who is not a work center or employer of patient workers) that is seeking permission to employ workers with disabilities at special minimum wages. A **school work experience program** (SWEP) is a school operated program by which students with disabilities may be placed in jobs with private industry within the community.

5) Do not submit a separate application for each branch establishment, supported employment work site (including enclaves), or school work experience site. Instead, report these in the spaces provided in Item 6 and **complete and submit a separate form WH-226A for each site where workers with disabilities are (will be) employed at special minimum wages**. If you operate a work center and employ patient workers, you will receive two separate certificates. Likewise, you will receive separate certificates for each branch establishment and school work experience program site for which you completed a WH-226A. Workers with disabilities paid special minimum wages who work at supported employment sites, including enclaves, however, are covered by the certificate issued the main establishment of the supervising work center.

   For Item #6: A **branch establishment** is a physically separate establishment of the same enterprise. A **supported employment work site** is a location, outside of the work center or rehabilitation center, often on the premises of an enterprise separate from the work center or rehabilitation center, where workers with disabilities paid special minimum wages are placed in employment settings along with work center staff (job coaches). An **enclave** is a supported employment work site where a group of workers with disabilities is working and supervised by staff from the work center. A **school work experience program** (SWEP) site is a workplace in the community in which a school system has placed a student(s) with disabilities to work in a job(s) at special minimum wages.

SPECIAL INSTRUCTIONS FOR SCHOOL WORK EXPERIENCE PROGRAMS (SWEPS)

The rehabilitation counselor or coordinating official of the school may submit a group application covering all of the students with disabilities and all of the employers participating in a school work experience program. Employers are responsible for compliance with all applicable child labor laws, minimum wage standards, certificate and recordkeeping requirements. The students participating in a school work experience program must be paid commensurate wage rates based upon the students' productivity in proportion to the wage and productivity of experienced workers who do not have disabilities performing essentially the same type, quality, and quantity of work in the vicinity in which the students are employed. Complete all items except 12.

Item 1(A)	Check "School Work Experience Program"
Item 2	Enter Identifying Information for School
Item 3	Enter School District Information
Item 4	Check "Other" and Enter "SWEP"
Items 9 and 11	Complete for the four types of work in which the greatest number of students with disabilities are employed at special minimum wages. If fewer than four types of jobs exist, enter "n/a" in the "Description of Work" blocks which are not used.
Item 14	Must Be Signed by the Counselor or Coordinating Official of the School

SPECIAL INSTRUCTIONS FOR VOCATIONAL REHABILITATION COUNSELORS OR VETERANS ADMINISTRATION TRAINING OFFICERS REQUESTING IMMEDIATE TEMPORARY CERTIFICATION TO PAY SPECIAL MINIMUM WAGES

Complete All Items of This Application.

Item 1(A)	Check "Business Establishments (Special Worker)"
Item 2	Enter Name and Location of Employer Where Workers with Disabilities Are to Be Placed
Item 3	Enter the Name and Address of the Veterans Administration Office or State Vocational Rehabilitation Agency Which Is Seeking Temporary Authority
Item 4	Check "Other" and Enter the Type of Business in Which the Worker with a Disability Is Being Placed
Items 9 and 11	Complete for the Work Sites Where the Workers with Disabilities Will Be Employed at Special Minimum Wages
Item 12	Check the Box
Item 14	Must Be Signed by the Vocational Rehabilitation Counselor or Veterans Administration Training Officer