KANSAS DEPARTMENT OF LABOR
www.dol.ks.gov

SHARED WORK PLAN - APPLICATION

K-BEN 101 (Rev. 10-18)

MAIL: Kansas Department of Labor
Shared Work Program
401 SW Topeka Blvd.
Topeka, KS 66603-3182

FAX: (785) 296-1858

Employer Information:

Name: _____ Serial number: _____

Mailing address: _____

City: _____ State: _____ ZIP: _____ Phone: ( ) _____

Affected Unit:

Department, shift, etc. that is impacted: _____

Number of employees who work in the unit: _____ Number of employees whose hours will be reduced under the plan: _____

Normal weekly hours for the affected employees will be reduced by _____ percent; from _____ (current normal weekly hours) to _____ (reduced shared work hours).

Will any employee benefits (health insurance, retirement or pension, paid days off, sick leave, holiday pay, etc.) be impacted by the reduction in hours? ☐ YES ☐ NO If YES, explain which benefits will be impacted and how they will be impacted:

_____

_____

☐ **Attach a typed list of all affected employees in the unit that includes both full name and Social Security number.**

Certification

I certify that the information I have provided is true and correct, and that this action is taken to avoid layoffs that would impact at least 10 percent of the affected unit. I understand that under the plan I will be responsible for submitting weekly certifications to the Kansas Department of Labor (KDOL) for those workers whose hours were reduced, and that I must make that submission on the form provided by KDOL. I understand that errant submissions by me could result in overpayments to my employees which they would have to repay to KDOL. I further understand that my Shared Work Plan may be terminated if KDOL determines the plan is not being executed according to the terms and intent of the Shared Work Program, and that KDOL may audit my participation in the program in order to make this determination.

Name of individual submitting application: _____

Position or title: _____ Phone: ( ) _____ Email: _____

Signature: _____ Date: _____

Collective Bargaining Agent Approval (if applicable)

Agent name: _____ Agent title: _____

Agent phone: ( ) _____ Agent email: _____

Union name: _____ Local number: _____

Signature: _____ Date: _____

KDOL USE ONLY

☐ Denied - Reason: _____

☐ Approved plan number: _____ Sub Plan number: _____ Plan effective: _____