DEPARTMENT OF HUMAN RESOURCES
AMERICAN SAMOA GOVERNMENT
A.P. Lutali Executive Office Building
PAGO PAGO, AMERICAN SAMOA
Telephone: 684/ 633-4485
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AMERICAN SAMOA **PANDEMIC UNEMPLOYMENT ASSISTANCE (PUA)** **&** **FEDERAL PANDEMIC UNEMPLOYMENT COMPENSATION (FPUA)** **WEEKLY REQUEST FOR PAYMENT**	**Claim For Week:** **From (Sunday)_____** **To (Saturday)_____**
APPLICANT'S NAME (Last, First, Middle)	**SOCIAL SECURITY NUMBER**
ADDRESS: P.O. Box	**Village**
TELEPHONE NO.# **HOME:**	**CELL**
CONTACT PERSON:	**TELEPHONE #:**

A. APPLICANT REQUEST

For the week claimed above, answer the following questions and complete the information required in the space to the right of the question if applicable.

1a. Did you perform any work or telework for another person or company, or engage in any self-employment during this week? ( ) YES ( ) NO

If YES, complete the following and provide in #7 on the reverse side the name of the employer or business, the date you started, whether you are working part-time or full-time and if you are still employed.

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THRUSDAY	FRIDAY	SATURDAY
HOURS WORKED							

1b. How much did you earn this week? (If you worked for someone else, report your total gross wages earned, whether you were paid or not. If you were self-employed, report your gross income received during the week, if any.)	**$**

1c. Were you self-employed during this week? . . . . ( ) YES ( ) NO
If YES, describe in detail below your activities during the week:

2. Indicate whether you applied for or are receiving any of the following:			**MONTHLY AMOUNT**	**PERIOD COVERED From**	**To**
2a. Unemployment compensation under any state or federal law? If Yes, what state?	**YES**	**NO**			
2b. Any compensation for loss of wages due to illness or disability?					
2c. Any type of private income protection insurance? If Yes, name:					
2d. Any supplemental unemployment benefits pursuant to a collective bargaining agreement?					
2e. Any worker's compensation?					
2f. Any amounts payable to you from any retirement, pension or annuity under a public or private plan or system?					
2g . Did you receive Holiday Pay or Vacation Pay during the week claimed above?					
2h. Did you receive paid sick leave?					
3. Were you able and available for work during the week claimed above?			**If No, explain in #8 on reverse.**		
4. Did you accept all work offered during the week claimed above?			**If No, explain in #8 on reverse.**		
5. Did you refuse any work or referral to work during the week claimed above?			**If Yes, explain in #8 on reverse.**		
6. Did you contact your last employer to check if work was available during the week claimed above?			**If YES, explain results in #8 on reverse. If NO, explain why not in #8 on reverse.**		

7. Name of the Employer/Business:_____

Date Started: _____

( ) Part-time ( ) Full-time ( ) Still Employed

8. Please check which of the following categories applies to you for the week you are claiming (may be multiple):

a) **You have been diagnosed with COVID-19 or is experiencing symptoms of COVID-19 and are seeking a medical diagnosis ( )**
b) **A member of your household has been diagnosed with COVID-19 ( )**
c) **You are providing care for a family member or a member of your household, who has been diagnosed with COVID-19 ( )**
d) **A child or other person in the household for which your are the primary caregiving responsibility is unable to attend school or another facility that is closed as a** PUA WBA FORM 2-4 **COVID-19 public health emergency and such school or facility care is required for you to work. ( )**
e) **You are unable to reach the place of employment because of a quarantine imposed as a direct result of the COVID-19 public health emergency. ( )**
f) **You are unable to reach the place of employment because you have been advised by a health care provider to self-quarantine due to concerns related to COVID-19. ( )**
g) **You were scheduled to commence employment and do not have a job or are unable to reach the job as a direct result of the COVID-19 public health emergency. ( )**
h) **You have become the breadwinner or major support for a household because the head of the household has died as a direct result of COVID-19. ( )**
i) **You quit your job as a direct result of COVID-19. ( )**
j) **Your place of employment is closed as a direct result of the COVID-19 public health emergency ( )**
k) **You are an independent contractor who is unemployed, (total or partial) or is unable or unavailable to work because the COVID-19 public health emergency has severely limited your ability to continue performing your customary job. ( )**
l) **I <u>no</u> longer have COVID-19 related reasons affecting my unemployment, partial unemployment, or inability, unavailability to work. ( )**

8. Claimant's comments and explanations: _____

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B. APPLICANT CERTIFICATION

CERTIFICATION: I CERTIFY that all of the information regarding my loss of employment, self-employment, or inability, unavailability to work during the week I am claiming is due to COVID-19. I further understand that the information I have provided in this weekly request for payment will be used to determine my eligibility for Pandemic Unemployment Assistance, and that my statements are true and correct to the best of my knowledge. I understand that I am subject to administrative penalties, including the penalties for perjury, or legal action, including prosecution under the law, if it is determined that I withheld or provided false information to obtain assistance payments to which I am not entitled.

SIGNATURE OF APPLICANT:	**DATE (Month/ Day/Year):**

C. STATE AGENCY DETERMINATION

OFFICE USE ONLY - DO NOT WRITE IN THIS SPACE

( ) Amount of PUA payment authorized for the week:..... $_____

( ) PUA reduced or denied for the week claimed above.

( ) PUA termination date. . . . . _____

REASON FOR DETERMINATION:

PUA WBA was reduced by :

( ) Gross income in excess of $ $182.00……

( ) **Pension or retirement paid in the amount of _____**

( ) Child Support in the amount of _____

( ) Federal Withholding Tax in the amount of _____

( ) Other deductible income reported in Section 2: _____

OTHER REASONS:

SIGNATURE OF STATE AGENCY REPRESENTATIVE:	**DATE (Month/Day/Year):**

D. APPEAL RIGHTS

If you are denied full payment for this week and you disagree with this decision, you have the right to request a reconsideration or any appeal. Your appeal or request for reconsideration must be in writing on a department form or by letter, and filed in person or by mail. You must state the reasons you disagree with this decision. If you request reconsideration, the Department of Human Resources will review its prior decision and consider any new information you provide. If you wish to request reconsideration, you must submit the request within 15 days after the date this notice was delivered or mailed. If you request an appeal, a hearing will be scheduled with an appeals referee from the Department of Human Resources has been designated to hear your case.

The Department of Human Resources will forward all claim records to the referee. The appeal must be submitted within 15 days from the date this notice was mailed. The Administrative Law Judge will send you additional information on the hearings process.

Either request should be directed to: Marie A. Alailima, Administrative Law Judge, Tolu Street, Lions Park Road, Nuuuli, American Samoa 96799.