Employment Security Department
WASHINGTON STATE

Application for Self-Employment Assistance Program (SEAP)

Name	SSN or claimant ID number	Phone number ( )

Address:

Return this form by fax at 800-301-1796 or mail it to:

Employment Security Department
PO Box 19019
Olympia, WA 98507-0019

We need this information to make a decision about your unemployment claim. After we receive your response, we will contact you by phone if we need additional information.

You have the right to an interview by telephone or in person before a decision is made. If you want an interview, contact the claims center. You may have any person, including an attorney, assist you at the interview. You may present evidence, documents, or witnesses; cross-examine witnesses or parties present; and ask for a copy of all records or documents on the issue.

Please complete and return this questionnaire to the address above.

You may be eligible to participate in the Self-Employment Assistance Program (SEAP) while receiving unemployment benefits. For a list of approved providers, go to www.esd.wa.gov/jobs-and-training/SEAP-approved-providers or contact your nearest WorkSource employment center.

If approved for SEAP, you do not have to look for work while participating in the training program. We will decide if you can be approved based on your answers to these questions.

Note: We do not pay for books, tuition or program-related fees. Approval does not extend the number of weeks you can collect unemployment benefits. Your unemployment benefits may run out before the end of your program. If you have questions about SEAP or this application you may call the Training Benefit Unit at 877-600-7701 or email your questions to trainingbenefits@esd.wa.gov.

Section 1 -- Self-Employment Assistance Program information

1. Program provider information:
   - Name: _____
   - Address: _____
   - Phone number: _____
   - Program contact person: _____
2. Program name: _____
3. Program start date: _____
4. Program end date: _____
   (This includes all elements of the program: structured curriculum, business counseling, technical assistance, and requirements to engage in activities relating to setting up a business and becoming self-employed.)

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5. What business are you going to pursue? _____

6. Do you already have a business? _____

7. What is your Unified Business Identifier (UBI)#? _____

8. List the occupation in which you have the most experience: _____

   How many years did you work in this occupation? _____

9. Do you have any factors that prevent you from returning to your main occupation? For example: physical limitations, injuries, illnesses, or criminal history. If you have documentation to support this, please attach a copy (not required).

   ❒ Yes ❒ No If yes, please explain:

   _____

   _____

10. List any other significant occupation and years of experience: _____

11. List your last three jobs, beginning with the most recent:

	Business name	Occupation	Start date	End date
1.				
	Job duties:			
2.				
	Job duties:			
3.				
	Job duties:			

12. How will you cover your living and training expenses if your benefits run out?

    _____

    _____

    _____

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Section 2 -- Applicant certification

I am applying for approval to participate in SEAP. I understand this information may be verified and that I must immediately report any changes in my training plan to the Training Benefit Unit at 877-600-7701. If I am approved for benefits, I understand that if I later change my training program without prior approval from the Employment Security, I may be denied benefits and have to pay back any benefits I was not entitled to receive.

I understand that I may be contacted by the department in the future and I agree to provide information to the research team regarding my SEAP participation.

I authorize my program provider to release information to Employment Security about my enrollment and participation in the program.

I understand that I must continue to look for work unless I am notified that I am approved.

The information I provided is true to the best of my knowledge.

Signature _____ Date _____

Phone _____

Program provider certification

I have reviewed Section 1 of this application. The information provided is correct to the best of my knowledge. The applicant has the skills, ability, aptitude and resources to successfully complete our self-employment assistance program.

We will certify to the applicant's *full-time* participation in our program as required.

Signature _____ Date _____

Title/Position _____ Phone _____

Email address _____

The Employment Security Department is an equal-opportunity employer and provider of programs and services. Auxiliary aids and services are available upon request to people with disabilities. Auxiliary aids may include qualified interpreters and telecommunication devices (TTY) for hearing- or speech-impaired individuals. Individuals with limited English proficiency may request free interpretive services to conduct business with the department.