

On the Main Menu please select **Apply for Short-Time Compensation Benefits** and then **Continue**

Options	
<input type="radio"/>	To file a new/additional Initial Unemployment Claim (It is recommended that you do not file using a cell phone or tablet.)
<input type="radio"/>	To file your weekly certification for benefits (All Devices Supported)
<input type="radio"/>	To update your Payment Method
<input type="radio"/>	For local claim office location and hours
<input type="radio"/>	If you are a claimant and want specific information about your claim (Tax Information 1099G)
<input type="radio"/>	To access and download important forms
<input type="radio"/>	For the amount of benefits you may be paid per week
<input type="radio"/>	For general information on Unemployment Benefits
<input type="radio"/>	To report suspected fraud, please email <a href="mailto:reportunemploymentfraud@wv.gov">reportunemploymentfraud@wv.gov</a>
<input type="radio"/>	If you are an employer, starting a new business or needing information, click here to access online services.
<input type="radio"/>	Change your information (address, phone or email)
<input type="radio"/>	Apply for Trade Readjustment Allowances (TAA/TRA – If eligible, apply three days after establishing regular claim.)
<input checked="" type="radio"/>	Apply for Short Time Compensation (STC) Benefits



Please select **Employer**

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Once Employer is selected, a new drop-down menu will appear as seen below. Please **select I am applying to participate in the Short-Time Compensation Program** and then select **Continue**.

Claimant  Employer

I am applying to participate in the Short-Term Compensation Program  
 I have a STC Employer Login



The next screen is the STC Plan Application. Please fill in all fields marked with an asterisk

\*Unemployment Account # [HELP](#)

\*Business Name [HELP](#)

DBA [HELP](#)

**Mailing Address**

\*Mailing Address [HELP](#)

\*City [HELP](#)

\*State [HELP](#)  
Please select a state or territory

\*Zip Code [HELP](#)

**Physical Address(if different from mailing)**

Physical Address [HELP](#)

City [HELP](#)

State [HELP](#)  
Please select a state or territory

Zip Code [HELP](#)

### Primary Employer Representative

\*Name [HELP](#)

\*Job Title [HELP](#)

\*Email\* This will be your login

\*Phone Ext [HELP](#)

 ### ### ####

Fax [HELP](#)

 ### ### ####

### Alternate Employer Representative

\*Name [HELP](#)

\*Job Title [HELP](#)

\*Email [HELP](#)

\*Phone Ext [HELP](#)

 ### ### ####

Fax [HELP](#)

 ### ### ####

### If not located at address above, provide location:

Address [HELP](#)

City [HELP](#)

State [HELP](#)

Zip Code [HELP](#)

\*Is your business experiencing an economic downturn [HELP](#)  
 Yes  No


\*What is the affected Unit? [HELP](#)


\*Number of employees in the unit [HELP](#)


\*Percentage of employees in the affected unit covered by the plan [HELP](#)

What weeks do you regularly not provide work, including incidences due to a holiday or other work closure? [HELP](#)

\*Percentage of hours reduction: [HELP](#)

\*What date did you or will you reduce hours? [HELP](#)  
  MM/DD/YYYY

Preferred plan start date [HELP](#)  
  MM/DD/YYYY

Preferred plan end date [HELP](#)  
  MM/DD/YYYY

\*Estimate how many jobs will be saved by using the STC Program? [HELP](#)

\*How will you give advance notice to affected employees whose hours are or will be reduced? [HELP](#)

If advanced notice is not possible, please state why. [HELP](#)

**Once the application has been filled out, you may upload any additional documentation that is pertinent to the STC Plan Application. If there is none, please select *Continue*.**

Please upload any additional documentation you would like WFWV to review.

Choose a file to attach

No file chosen

**Attachments**  
No files uploaded

Please list each employee who will be participating in the STC program and answer the corresponding questions. Select the *Add Employee* button to add more employees to the list. Once all employees have been added, please select *Continue*.

*Please note: Only employees who are listed here will be eligible to participate in this STC Plan. Employers will not be able to add any new employees to their STC plan once this application has been submitted.*

Row Number	Name	SSN	Usual Weekly Hours Worked	Date of Hire	Hourly Rate of Pay
1	<input type="text" value="Enter Name"/>	<input type="text" value="9 digit SSN"/>	<input type="text"/>	<input type="text" value="mm/dd/yyyy"/>	<input type="text"/>
					<input type="button" value="Add Employee"/>

Please read the certification page, check the *I certify* box, and put *Name, Title, and Date* in the boxes listed and then select *Continue*

Certification Page:

I certify that:

Affected employees were hired on a permanent basis.

I have at least two permanent employees enrolled in the STC plan.

Health benefits will continue to be provided under the same terms and conditions as though the employee's usual weekly hours of work were not reduced unless health benefits are changed for all employees.

Retirement benefits and contributions under defined plans will continue to be provided under the same terms and conditions as though the employee's usual weekly hours of work were not reduced unless retirement benefits and contributions are changed for all employees.

Paid vacation, holidays, and sick leave will continue to be provided under the same terms and conditions as though the employee's usual weekly hours or work were not reduced.

This aggregate reduction in work hours is in lieu of layoffs.

New employees will not be hired in or transferred to an affected unit for the duration of this STC plan.

STC will not be used to subsidize seasonal employees during the off season, temporary part-time employment, or intermittent employment

To the best of my knowledge, participation in this STC plan and its implementation is consistent with my obligations under applicable federal and state law.

If there are any changes to the information on this application or employee list, I will notify STC staff immediately.

I will furnish reports to the commissioner relating to the proper conduct of an STC plan. I will allow the commissioner access to all records necessary to approve or disapprove the STC plan application.

After approval of an STC plan, I will monitor and evaluate the plan and follow any other directives the commissioner deems necessary for the agency to implement the plan, and which are consistent with the requirements for plan applications.

Any other provision added to the application by the commissioner that the U.S. Secretary of Labor determines to be appropriate for purposes of an STC plan.

By Checking the box and filling in the below information, you are certifying that you are authorized to sign this document on behalf of the business and that all information provided on this application is true and correct.

I certify:

Name: [HELP](#)

Title : [HELP](#)

Date : [HELP](#)

 MM/DD/YYYY

**Continue**

**Once you select Continue, the Employer Plan Application has been submitted. A confirmation screen will pop up with a Reference Number. Employers can expect to be contacted within 10 business days.**

**Thank you for your interest in STC!**