SOUTH DAKOTA DEPARTMENT OF LABOR AND REGULATION

REEMPLOYMENT ASSISTANCE

P.O. Box 4730, Aberdeen, SD 57401 Fax: 605.626.3172 raclaims.sd.gov

PUA CLAIMANT REQUEST FOR WEEKLY PAYMENT

Use this form or **request online at raclaims.sd.gov**

CLAIMANT NAME: _____ SSN: _____

Requesting payment for the week *(week=Sunday-Saturday)*:_____ (use Saturday's Date)
MM/DD/YYYY

SECTION A	
During the week that ended in that date in the row above, did you work for an employer or in self-employment? ***(If yes**, add information for each employer on Pg 2)*	☐ YES ☐ NO **If no, skip to Section B** (Starts with Holiday Pay)
Total number of hours you worked during the week (with all employers or self-employment):	_____ hrs
Gross wages you earned in dollars and cents (If self-employed, use NET)	$ _____
If worked but had no earnings, was it because you attempted commission sales, were self-employed, or have other unpaid hours?	☐ YES ☐ NO
Are you still working?	☐ YES ☐ NO

SECTION B ***Did you or will you receive any of the following for this week?***

HOLIDAY PAY?	☐ YES ☐ NO. If **yes**, gross amount:
VACATION PAY OR ANNUAL LEAVE?	☐ YES ☐ NO. If **yes**, gross amount:
SICK PAY?	☐ YES ☐ NO. If **yes**, gross amount:
SEVERANCE PAY/WAGES IN LIEU OF NOTICE?	☐ YES ☐ NO. If **yes**, gross amount:

Will you begin receiving **pension**, **disability payments** or **workers' compensation** or did the amount previously reported change?	☐ YES ☐ NO *If **yes**, explain in remarks*
Are you on call to return to work for your regular employer?	☐ YES ☐ NO
Were you physically and mentally able to work?	☐ YES ☐ NO *if **no**, explain in remarks*
Were you available to accept a job if offered?	☐ YES ☐ NO *if **no**, explain in remarks*
Did you refuse any offer of work or referral to work?	☐ YES ☐ NO *if **no**, explain in remarks*
Did you begin school or did your class schedule change during the week?	☐ YES ☐ NO
For each week, identify the reason**(s)** that **best** describes your situation from the list on the next page (Section C). If "Other" (M) add reason **in "Remarks"**	
You are responsible for reading and knowing the information in your claimant handbook about benefit eligibility. Attempting to claim or receive benefits by entering false information could mean a loss of benefits, fine, and imprisonment. Please note you are agreeing to have your responses become part of your account record and the information your provide may be verified through matching programs. ***Do you understand?***	☐ YES ☐ NO

REMARKS:

CERTIFICATION: I certify that my statements are true and correct and I am aware of the penalties for all false statements on my claim.

Claimant's Signature _____ Date: _____

Section C **Reason that best describes your situation during the week requesting should be entered in the last box on Page 1.**

A = You tested positive or you are experiencing symptoms of COVID-19 and seeking a medical diagnosis.

B = A member of your household tested positive for COVID-19.

C = You are providing care to a family member or member of your household who has tested positive for COVID-19.

D = You are the primary caregiver for a child or other person who is unable to attend school or another care facility that is closed as a direct result of COVID-19 and the school or facility is necessary in order for you to work.

E = You are unable to reach your place of employment because of a quarantine imposed as a result of COVID-19

F = You are unable to work because you have been advised by a health care provider to self-quarantine because of COVID-19.

G = You were scheduled to start a job and now do not have that job or are unable to reach that job because of COVID-19.

H = You have become the breadwinner or major support for a household because the head of household has died because of COVID-19.

I = You have to quit your job because you were diagnosed with COVID-19 by a qualified medical professional, and although you no longer have COVID-19, the illness caused health complications that render you objectively unable to perform essential job functions, with or without a reasonable accommodation.

J = Your place of employment closed because of COVID-19.

K = Your employer reduced your hours of work because of COVID-19.

L = You are self-employed or an independent contractor and now unable to work because COVID-19 has severely limited your ability to continue performing your customary work activities.

M = Other:

Section D If you have worked during this week, complete the information below. If you need more employers, use the remarks box.

Employer Name:_____ Still Working? ☐ YES ☐ NO

Worked: _____hrs for week: _____ (week end date) And _____ hrs for week: _____. (week end date) And _____ hrs for week: _____ (week end date)

Wages: Hourly Rate: _____ Total Wages (including tips): _____

Employer Address:_____

Employer Name:_____ Still Working? ☐ YES ☐ NO

Worked: _____hrs for week: _____ (week end date) And _____ hrs for week: _____. (week end date) And _____ hrs for week: _____ (week end date)

Wages: Hourly Rate: _____ Total Wages (including tips): _____

Employer Address:_____

Send Completed Form to:

Mail
DLR RA Benefits
PO Box 4730
Aberdeen SD 57402-4730

Email: DLRRAClaims@state.sd.us
**Note there are two R's in this email address*