WAGE VERIFICATION FORM

_____ Department of Social Services

DATE: _____

TO: _____
_____
_____
_____

Case Name: _____
Case No.: _____
Case ID: _____
Dist. No.: _____

Employee Name:_____
SSN (optional):_ _ _ _ **(last four digits only)**

This person has applied for social services assistance. By signing the application, permission was given to contact you to verify certain information. Please verify employment information for the above. Return this form by _____.

This form must be completed by the employer.

Please answer the questions for boxes that are checked.

[ ] Is this person currently employed by you or your company? [ ] Yes [ ] No

Beginning date of employment: _____
Date first check received or anticipated: _____
How many days did the individual work during the first pay period? _____
How many days will the individual normally work during a pay period? _____

Do you expect any changes in income? [ ] Yes [ ] No If yes, explain _____
_____

[ ] Pay Rate: $_____ Estimated number of hours to be worked weekly: _____

[ ] Please complete the following information for the months of _____

Date Pay Received Month & Day	Number of Hours	Rate of Pay	Bonus or Vacation Pay	**Gross Pay**	Tips	EITC

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[ ] How often is the pay received?

[ ] Daily [ ] Weekly [ ] Every 2 weeks [ ] Twice a month [ ] Monthly [ ] Other

[ ] What day of the week is the pay received?

[ ] Sunday [ ] Monday [ ] Tuesday [ ] Wednesday [ ] Thursday [ ] Friday [ ] Saturday

[ ] Does your company help pay for child care? If yes,

How much? _____
How often? _____

[ ] Does this individual have health insurance coverage? [ ] Yes [ ] No If yes, complete the following information:

Insurance company name: _____
Certificate number: _____ Effective date of coverage: _____
Persons included in coverage: _____

[ ] If the individual is no longer employed by you, complete the following information:

Reason for termination of employment:
[ ] Quit [ ] Fired [ ] Laid off [ ] Other: _____

Date the employment terminated: _____
Date final pay received: _____
Amount of gross income received during the last month of employment: $_____

If the employee quit, what was the reason given by the employee? _____
_____

Thank you for your assistance in this matter. If you have any questions regarding this form, please contact _____ at _____

EMPLOYER, PLEASE SIGN BELOW AND RETURN USING THE ENCLOSED ENVELOPE OR FAX TO_____.

_____ _____ _____
Company Name Name and Title of Person Completing Form Date

_____ (___)_____
Company Address Telephone Number

_____
City State Zip Code

Distribution: Original(s) to employer