FLORIDA DEPARTMENT OF CHILDREN & FAMILIES

VERIFICATION OF EMPLOYMENT/LOSS OF INCOME

Date: _____

_____

_____

_____

In order to determine the eligibility of _____ for public assistance, please assist us by answering the questions below and returning this form to us by _____ .

_____
Case Name

_____
Case Number/Cat/Seq./SSN

Office Address / Phone Number:

Please complete each section which has been marked on PAGE 1 and PAGE 2 of this form.

☐ **Section I – GENERAL INFORMATION**

1. Name of Employee:_____ Social Security Number:_____
   Address:_____
2. Job Title:_____ Type of Work Performed:_____
3. Number of Hours Worked Per Week:_____ Number of Days Worked Per Week:_____
4. A. How often is/was the employee paid? ☐ Day ☐ Week ☐ Bi-Weekly ☐ Monthly
   B. Rate of pay: $_____ per _____ (Hr./Day/Wk./etc.) ☐ Other _____ (Explain)
5. Date current employment began:_____ Date previously employed:_____
6. Does/did employee receive tips? ☐ Yes ☐ No ***(If yes, please show tips in Section III.)***
7. Is/was employment seasonal? ☐ Yes ☐ No If yes, season begins:_____ ends:_____
8. Is/was the employee covered by health insurance? ☐ Yes ☐ No
   If yes, name of insurance company:_____
9. Number of dependents covered:_____
10. Does/did the employee participate in any type of payroll savings plan or profit sharing? ☐ Yes ☐ No
    If yes, what is the balance? $_____
11. Does the person perform their job duties: ☐ in their home ☐ in your home ☐ N/A

☐ **Section II – LOSS OF INCOME**

1. Date employment ended:_____
2. Reason for termination:_____
3. Is the loss of income ☐ Permanent or ☐ Temporary? If temporary, when do you expect the employee to return to work? _____
4. Date employee received final check:_____ Gross amount: $_____
   (Please list last 8 weeks in Section III.)
5. Will employee receive any vacation pay, retirement refund, or other? ☐ Yes ☐ No
   If yes, what type? _____ Date received:_____ Amount: $_____
6. Is employee eligible for any type of benefits from your company, such as extended insurance coverage, workers' compensation, or other? ☐ Yes ☐ No If yes:
   A. Name of insurance company:_____
   B. Reason for benefits:_____

☐ Section III – RECORD OF PAY RECEIVED

List the gross amounts and dates of checks or cash, which were paid for the last eight weeks in the space below.

Pay Period Ending	Date Pay Received	GROSS Earnings	No. of Regular Hours Worked	Rate of Pay	No. of Overtime Hours	Rate of Pay for Overtime	Tips $$	Earned Income Credit (EIC)

If hours or rate of pay has varied in the above period, please state why.

☐ Section IV – EMPLOYER INFORMATION

What I have written on this form is true to the best of my knowledge. I know that if I give false information on purpose, I may be subject to prosecution for fraud.

Signature of Employer

Employer's Title

Name of Business

( ) (ext.)
Telephone Number

Address

Date Completed

Back to CF-ES 2620