



# 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. \_\_\_\_\_

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 \_\_\_\_\_ .  Other \_\_\_\_\_  
Hr./Day/Wk./etc. (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 4 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: \_\_\_\_\_

Case Name \_\_\_\_\_

Case Number/Cat/Seq. \_\_\_\_\_

**Section III – RECORD OF PAY RECEIVED**

List the gross amounts and dates of checks or cash, which were paid for the last four 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

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Address

\_\_\_\_\_  
Date Completed