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:
CareerSource Tampa Bay - Fax: 727-328-3394

DCF - Fax: 866-886-4342

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 __hour_____ . ☐ 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 _____

_____

* Pursuant to 42 C.F.R. § 435.910, the Department is requesting you provide the social security number (SSN), but you are not required to provide us the SSN under the law. However, if you give us the SSN we can determine eligibility for assistance or services faster and more accurately. Social security numbers are used by the Department for identity verification, income and eligibility verification and other purposes related to administration of our programs.