Early Childhood Education and Out of School Time Program Assistance
Verification of Earnings

TO EMPLOYER: The information listed below is requested to determine eligibility and correct benefits for your employee. This will enable us to ensure that public funds are used only for the actual benefits to which a household may be eligible.
PLEASE COMPLETE THE FORM IN ITS ENTIRETY AND THE SIGNATURE SECTION AT THE BOTTOM OF THIS FORM.
If you need this material in a different format such as large print, contact your local DHS county office.

Family Support Specialist:
Telephone Number:
TDD #:
Fax #:
Email:

Department of Human Services
Division of Child Care & Early Childhood Education

Employee Name _____ **Employee SSN** _____

1. The above employee began work _____ and earns $ _____ per hour.
   Employee works an average of (Insert number of hours) _____ **hours per week**.
   First pay date (insert a date): _____ Anticipated gross amount of the 1st pay: $ _____
2. Employee is paid: ☐ **Weekly** ☐ **Bi-Weekly** ☐ **Twice a month** ☐ **Monthly** ☐ **Annually**
3. Please show GROSS EARNINGS (before any deductions) PAID to this employee as indicated. Please list each pay check separately including vacation pay and bonuses. Current earnings must be listed if employed more than 30 days

Pay Period Beginning	Pay Period Ending	Date Received	Hours Worked	Gross Wages	Tips/ Bonus

4. **Earnings:** Are any of the employee's earnings funded by JTPA - On the Job Training Program? ☐ Yes ☐ No
5. **Termination:** If employee is no longer employed by you, what was the last date of employment? _____
   Date last check will be received: _____ Gross amount: $ _____
6. **Additional Information/Expected Changes:** (such as layoffs, raises, increased or reduced hours, vacation pay, bonuses, and sick pay): _____

* I do hereby certify that the above information is factual and correct to the best of my knowledge.

Employer/Payroll Clerk Printed Name _____ Date _____

Employer/Payroll Clerk Signature _____ Telephone # _____

Place of Business _____ Address _____

Employer email address _____

Department of Human Services Office Use ONLY

Family Support Specialist: _____ Date(s)Called: _____
Verified by: _____ Case Number: _____
Additional Info: _____
_____

VOE (5-1-19)

The Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act.