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: ____

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