

MONTGOMERY COUNTY DEPARTMENT OF JOB AND FAMILY SERVICES
1111 S. Edwin C. Moses Blvd.
Dayton, Ohio 45422
EMPLOYMENT VERIFICATION

Dear Employer:

This is a request for confidential wage and employment information which will be used to determine eligibility for Public Assistance/Food Stamps and supportive services on the person named below. We appreciate your cooperation and have enclosed a self-addressed, stamped envelope for your convenience.

MCDJFS EMPLOYEE: Complete all information in black boxes below and have customer sign the release of information.

Employer's Name:			Employee's Name:		
Address:			Social Security Number:		
City:	State:	Zip:	AG Name:		
MCDJFS Worker's Signature:			AG Number:		
Phone:	UNID	Date:	DATE INFORMATION IS NEEDED:		

RELEASE OF INFORMATION

I authorize the employer above to release information to the Montgomery County Department of Job and Family Services regarding my employment. I am aware of my responsibilities to report, completely and fully, all facts which bear upon my eligibility for public assistance and supportive services. I realize if the requested information reveals I have improperly reported my situation, the information may be given to the prosecuting attorney for possible civil action or criminal prosecution.

Applicant's/Customer's Signature	Date
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EMPLOYER: Please complete the information below as it appears in your files. Return to the worker listed above by the date entered in the "DATE INFORMATION IS NEEDED" box above.

Employee's Full Name:				Position:		Currently employed? ~ No; ~ Yes																									
Address:				Is position permanent? ~ No; ~ Yes		Federal Work Study? ~ No; ~ Yes																									
Date(s) employment began:		Date(s) terminated:		Date last check received:		Type of separation: ~ Discharge ~ Laid off ~ Illness/Injury ~ Quit																									
Social Security Number:		Rate of Pay: (hourly)		Eligible for rehire? ~ No ~ Yes, When?		Reason for quit or discharge:																									
Date of Birth:		Union member? (If yes, list name/local.) ~ No ~ Yes		Paid: ~ weekly; ~ biweekly; ~ daily; ~ other: _____ What day of week paid? (circle) S M T W TH F S Does pay include overtime? ~ No; ~ Yes If yes, how long will it continue?																											
Does employee receive tips? ~ No; ~ Yes		Do you record tips? ~ No; ~ Yes		Does employee receive EITC? ~ No; ~ Yes		Was a W-2 filed the preceding year? ~ No; ~ Yes																									
Is employee scheduled to work a set # of hours per week? ~ Yes - # of hours scheduled per week: _____ ~ No - Average # of hours worked per week: _____			Are these hours? ~ Actual ~ Proposed		<table border="1"> <tr> <td>HOURS</td> <td>S</td> <td>M</td> <td>T</td> <td>W</td> <td>TH</td> <td>F</td> <td>S</td> </tr> <tr> <td>Begin:</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>End:</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table>			HOURS	S	M	T	W	TH	F	S	Begin:	_____	_____	_____	_____	_____	_____	_____	End:	_____	_____	_____	_____	_____	_____	_____
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Begin:	_____	_____	_____	_____	_____	_____	_____																								
End:	_____	_____	_____	_____	_____	_____	_____																								
Type of current Medical Insurance coverage?			Medical Insurance:																												
Policy No.:			~ Went into effect: (Date) _____; Monthly cost to employee: \$ _____																												
Deadline date for continuation of insurance under COBRA:			~ Will become effective: (Date) _____; Monthly cost to employee: \$ _____																												
			~ Expired/will expire: (Date) _____																												
Eligible for severance pay? ~ No; ~ Yes		Date check issued:		Gross amount of check: \$ _____		Any deductions? ~ No; ~ Yes; \$ _____																									
Eligible for sick benefits? ~ No; ~ Yes		Date of first sick benefit check:		Gross amount of check: \$ _____		Any deductions? ~ No; ~ Yes; \$ _____																									
Eligible for Unemployment Compensation? ~ No; ~ Yes			Worker's Compensation Claim Filed? ~ No; ~ Yes; Claim # _____			Date filed:																									
Year-to-date earnings: (Year) _____ \$ _____			Total earnings for the last 2 most recent years of employment: (Year) _____ \$ _____; (Year) _____ \$ _____																												

Signature of Person Supplying Information:	Title:	Employer I.D. #	Phone:	Date:
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Please complete the information on the reverse for the period _____ thru _____.

T Please complete the following information for the time period indicated in the black box at the bottom of the front of this form;
T Or, if more convenient, you may substitute copies of your payroll records.

Pay Period Ending	Date Pay Received	Number of Hours Worked	Rate Per Hour	Gross Earnings & Tips
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Please attach additional pages if necessary.