

## **VERIFICATION OF EMPLOYMENT/LOSS OF INCOME**

olease assist us by answering the questions below and returning this form to us by  Office Address / Phone Number:	MYFLFA	AMILIES.COM	Date:
Dease assist us by answering the questions below and returning this form to us by    Office Address / Phone Number:			
Decide as assist us by answering the questions below and returning this form to us by    Office Address / Phone Number:		<del></del>	
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Dease assist us by answering the questions below and returning this form to us by    Office Address / Phone Number:	n ord	der to determine the eligibility of	for public assistance.
Please complete each section which has been marked on Page 1 AND Page 2 of this form.    Section I - GENERAL INFORMATION		· ,	•
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Please complete each section which has been marked on Page 1 AND Page 2 of this form.    Section I - GENERAL INFORMATION	`aca N	lumber/Cat/Sea	
Section I – GENERAL INFORMATION  1. Name of Employee:	ase ivi	umberroavoeq.	
Section I – GENERAL INFORMATION  1. Name of Employee:		Please complete each section which has been may	rked on Page 1 AND Page 2 of this form
1. Name of Employee:	г	_	Thea off rage 1 AND rage 2 of this form.
Address:  2. Job Title:	L	Section I – GENERAL INFORMATION	
Address:  2. Job Title:	1.	Name of Employee:	*Social Security Number:
2. Job Title:			
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: \$	2.		
A. How often is/was the employee paid?	3.	Number of Hours Worked Per Week: Numb	per of Days Worked Per Week:
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:			
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: ends: ends:		B. Rate of pay: \$ per	r
6. Does/did employee receive tips?	5		
7. Is/was employment seasonal?			• • • • • • • • • • • • • • • • • • • •
8. Is/was the employee covered by health insurance?			
If yes, name of insurance company:			
9. Number of dependents covered:	0.		
10. Does/did the employee participate in any type of payroll savings plan or profit sharing?	9	• • •	
If yes, what is the balance? \$		•	plan or profit sharing?
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:			plant of prome chaining.
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:  (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: \$	11.	•	☐ in your home ☐ N/A
1. Date employment ended:		· · · · · · · · · · · · · · · · · · ·	
<ol> <li>Reason for termination:</li></ol>	<u>L</u>	Section II – LOSS OF INCOME	
<ol> <li>Reason for termination:</li></ol>	1.	Date employment ended:	
<ol> <li>Is the loss of income</li></ol>			
to return to work?			
<ul> <li>4. Date employee received final check: Gross amount: \$</li> <li>(Please list last 4 weeks in Section III.)</li> <li>5. Will employee receive any vacation pay, retirement refund, or other?  Yes  No</li> <li>If yes, what type? Date received: Amount: \$</li> </ul>			
5. Will employee receive any vacation pay, retirement refund, or other?	4.	Date employee received final check:	
If yes, what type? Date received: Amount: \$	5		mer?
	٥.		
o. To employee digible for any type of benefits from your company, such as extended insulance coverage, workers	6		
compensation or other?  \( \text{Yes} \) No If ves	0.		out at exterior insulation coverage, workers
A. Name of insurance company:		compensation or other?     Yes     No   If ves:	
B. Reason for benefits:		compensation, or other?  Yes No If yes:  A. Name of insurance company:	

Case Name			Case Number/Cat/Seq.					
Section	n III – RECORD (	OF PAY RECEN	/FD					
	amounts and da			which were	paid for	the last four w	reeks in the s	pace 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 perio	od, plea	se state why.				
Section	ı IV – EMPLOYE	R INFORMATIO	ON					
	nave written or							if I give
false int	formation on p	urpose, I may	be su	ubject to pr	osecu	tion for frau	d.	
Signature of	Signature of Employer					mployer's Title		
Name of Bu	siness				<u>_</u>	elephone Number		
						,		
Address						Pate Completed		

CF-ES 2620, PDF 05/2010 Page 2 of 2