PAFS-700 02/16

## COMMONWEALTH OF KENTUCKY Cabinet for Health and Family Services Department for Community Based Services Division of Family Support

Date:		
Case	Number:	

## **VERIFICATION OF EMPLOYMENT AND WAGES**(Continuation Page)

Case Name:		Case Number:										
Emplo	yer Name:											
Employee Name:			Employee SSN:									
Pay Period	Date Received	Hours	Gross Wages	* Tips	Taxes Withheld	Pay Period	Date Received	Hours	Gross Wages	* Tips	Taxes Withheld	
From - To						From - To						
1.						27.						
2.						28.						
3.						29.						
4.						30.						
5.						31.						
6.						32.						
7.						33.						
8.						34.						
9.						35.						
10.						36.						
11.						37.						
12.						38.						
13.						39.						
14.						40.						
15.						41.						
16.						42.						
17.						43.						
18.						44.						
19.						45.						
20.						46.						
21.						47.						
22.						48.						
23.						49.						
24.						50.						
25.						51.						
26.						52.						
* Repo	rt separate	ely if no	t include	ed in gr	ross waç	ges.						
SignedTitle				Date								
Emplo	yer Name											