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|  | **Employment****Verification** | Date:      |
| Client ID Number      |

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| **Section 1: To be filled out by the client/employee.** |
| **I authorize my employer to release information to the Department of Children, Youth, and Families.** |
| EMPLOYEE’S SIGNATURE | SOCIAL SECURITY NUMBER (OPTIONAL) | DATE |
| **Section 2: To be filled out by the employer.** |
| EMPLOYEE’S NAME | EMPLOYER’S NAME |
| EMPLOYEE’S JOB TITLE | EMPLOYER’S ADDRESS |
| Is this a new job? [ ]  No [ ]  Yes | DATE EMPLOYEE STARTED WORK | DATE FIRST CHECK WAS RECEIVED       |
| AVERAGE HOURS PER WEEK       | RATE OF PAY OR SALARY (HOURLY, DAILY OR PIECE RATE)       | Has job ended? [ ]  No [ ]  YesIf yes, when: why:  |
| Pay frequency: [ ]  Daily [ ]  Weekly [ ]  Every two weeks [ ]  Two times a month [ ]  Monthly  |
| Is this job Work Study? [ ]  Yes [ ]  No | IF YES, PROVIDE VERIFICATION OF TOTAL FINANCIAL AID AWARD       | WHEN WILL YOUR POSITION END?       |
| Actual gross income (or attach payroll printout) for last three months: |
| MONTH: **$** | MONTH: **$** | MONTH: **$** |
| Tips [ ]  No [ ]  Yes; if yes, how often and how much?  Commissions [ ]  No [ ]  Yes; if yes, how often and how much?  Bonuses [ ]  No [ ]  Yes; if yes, how often and how much?  Overtime [ ]  No [ ]  Yes; if yes, how often and how much?  Reimbursements [ ]  No [ ]  Yes; if yes, how often and how much?  Work schedule (include exact times when possible): |
| MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY |
|  |
| EMPLOYER/REPRESENTATIVE’S SIGNATURE | DATE |
| EMPLOYER/REPRESENTATIVE’S PRINTED NAME AND TITLE | PHONE NUMBER |

This form may be returned to:

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| --- | --- |
| Fax: Fax 1-877-309-9747  | Child Care Subsidy Contact CenterDepartment of Children, Youth, and FamiliesP.O. Box 11346Tacoma WA 98411-9903 |