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

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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  Yes  If 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 Center Department of Children, Youth, and Families P.O. Box 11346 Tacoma WA 98411-9903 |