



Joe Patton, Director
951 Commerce Parkway
Lima, Ohio 45804

EMPLOYMENT VERIFICATION REQUEST

Employee Name:	Case Number:	SSN: XXX-XX-
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EMPLOYER TO COMPLETE

Dates of Employment

Corporate Name:	Name of Employment Site:
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Job Position/Title:	First Day Worked:	Date First Pay Received:
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Shift Schedule: 1 st ☐ 2 nd ☐ 3 rd ☐	Employee Tax Filing Status:
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List interruption or leave period during employment From Date: _____ To Date: _____	Income Received During Leave of Absence: Yes ☐ No ☐ If Yes, Amount Received: _____	If Yes, Type of Income Received: ☐ Vacation Pay ☐ Sick Pay ☐ Short Term Disability ☐ Long Term Disability
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If Employment Has Ended, Also Complete This Section

Last Day Worked:	Date Last Pay Received:	Type of Separation:
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Strike Start Date:	Strike End Date:	☐ Laid Off ☐ Illness or Injury
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Effective Lock Out Date:	Eligible for Post-employment Benefits:	☐ No Call or Show ☐ Discharged
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		☐ Resignation (specify): _____
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		☐ Other (specify): _____
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Rate/Hours/Pay Frequency

Current Hourly Rate:	Overtime Hourly Rate:	Day of Week Paid:	Pay Period Frequency: ☐ Week ☐ Twice Monthly ☐ Biweekly ☐ Other (Specify):	Overtime is: ☐ Not expected to be worked in the future ☐ Worked routinely monthly
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Number of set hours to work per Week: _____; OR Number of hours will vary from _____ to _____ per Week
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Wages

Date Paid	Hours	Hourly Rate	Gross Pay <u>Without</u> Tips, Bonus or Commission	Tips	Bonus or Commission

Health Insurance

Is the employee enrolled in health insurance? ☐ Yes ☐ No	Begin Date/End Date:	Policy Number:	Group Number:
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Name/Address of Insurance Company:	List Covered Members:
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Life Insurance

Is the employee enrolled in Life Insurance? ☐ Yes ☐ No	Begin Date/End Date:	Policy Number:	Group Number:
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Name/Address of Insurance Company:	List of Beneficiaries:
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Additional Information Needed For Time Period Below (See Reverse only if Time Period is Noted Below)

Time Period Requested – From Date: _____ To Date: _____

Employer Signature

Employer Representative Signature:	Title:	Phone:	Fax:	Date:
Employee's Address at Time of Employment:		Employee's Phone Number:		

If indicated on the front side, please complete the following information for the time period indicated on the front of this form. If it is more convenient or you need more space, you may substitute copies of the employee's payroll records.

Date Pay Received	Gross Pay <u>Without</u> Tips, Bonus or Commission	Tips	Bonus or Commission	Garnishment	Child Support Deduction

Applicant/Recipient Authorization for Release of Information

Customer Name	Case Number	Last 4 of SSN
CDJFS Representative (Full Name Required)	Third Party Verifier Not Updated:	Date Requested

Name and Address of Employer Asked to Supply Information	Name and Address of Employer Asked to Supply Information
JFS will forward EV by: MAIL: EMAIL: FAX:	JFS will forward EV by: MAIL: EMAIL: FAX:
Name and Address of Employer Asked to Supply Information	Name and Address of Employer Asked to Supply Information
JFS will forward EV by: MAIL: EMAIL: FAX:	JFS will forward EV by: MAIL: EMAIL: FAX:

I agree that the person named above may release to the **ALLEN County Department of Job and Family Services** the following information: Employment verification as requested on the reverse side of this form.
This information will be used to determine eligibility for public assistance and/or food stamps.
I am aware of my responsibility to report completely and fully all facts, which bear upon my eligibility for all public assistance and/or food stamps. 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.

Completion of this form is voluntary, but necessary to determine eligibility for assistance.

Signature of Applicant/Recipient	Date:
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