



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? <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when: why:
------------------------	---	--

Pay frequency: Daily Weekly Every two weeks Two times a month Monthly

Is this job Work Study? <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> No <input type="checkbox"/> Yes; if yes, how often and how much?	_____
Commissions	<input type="checkbox"/> No <input type="checkbox"/> Yes; if yes, how often and how much?	_____
Bonuses	<input type="checkbox"/> No <input type="checkbox"/> Yes; if yes, how often and how much?	_____
Overtime	<input type="checkbox"/> No <input type="checkbox"/> Yes; if yes, how often and how much?	_____
Reimbursements	<input type="checkbox"/> No <input type="checkbox"/> 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:

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