LUCAS DEPARTMENT COUNTY JOB & FAMILY SERVICES
3210 MONROE STREET P.O. BOX 10007
TOLEDO, OHIO 43699-0007
(419)213-8999
fax (419)213-8820

EMPLOYMENT VERIFICATION STATEMENT

DATE ISSUED ______________ DATE DUE ______________

____
EMPLOYER

____
ADDRESS

____
CITY STATE ZIP CODE

CASE NUMBER ______________
EMPLOYEE NAME ______________
ADDRESS ______________
S.S. NUMBER ______________
ELIGIBILITY WORKER ______________
PHONE NUMBER ______________ FAX ______________

I AGREE THAT THE PERSON/COMPANY NAMED ABOVE MAY RELEASE TO THE LUCAS COUNTY JOB & FAMILY SERVICES ALL INFORMATION REQUESTED ON THIS FORM. THIS INFORMATION WILL REMAIN CONFIDENTIAL AND BE USED TO DETERMINE/REDETERMINE ELIGIBILITY FOR ASSISTANCE.

I AM AWARE OF MY RESPONSIBILITIES TO REPORT COMPLETELY AND FULLY ALL FACTS WHICH BEAR UPON MY ELIGIBILITY FOR ALL PUBLIC ASSISTANCE. 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.

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EMPLOYEE MUST SIGN HERE DATE

EMPLOYMENT VERIFICATION STATEMENT

(This section is to be completed by the Employer.)

DATE EMPLOYMENT BEGAN ______________ CURRENT RATE OF PAY ______________

FULL/PART TIME ______________ HOURS SCHEDULED WEEKLY ______________

HOW PAID (WKLY/BI-WKLY) ______________ DAY OF WEEK PAID ______________

OCCUPATION ______________ TRAINING PROGRAM ______________

DOES EMPLOYEE HAVE HOSPITALIZATION OR OTHER MEDICAL COVERAGE? ______________

NAME OF INSURANCE COMPANY ______________

DATE LAST WORKED ______________ DATE OF FINAL PAY ______________

IS ADDITIONAL SEVERANCE AND/OR VACATION PAY EXPECTED? ______________ AMOUNT ______________

DID YOU TERMINATE/LAYOFF EMPLOYEE? ______________ REASON ______________

____

DID THE EMPLOYEE QUIT? ______________ REASON ______________

____

ELIGIBLE FOR RE-EMPLOYMENT? ______________ WHEN/WHY? ______________

(PLEASE COMPLETE VERIFICATION ON SECOND PAGE)

(This section is to be completed by the Employer.)

EMPLOYEE	S.S. NUMBER	PAGE 2

WORKERS COMPENSATION CLAIM PENDING? ______________ CLAIM NUMBER ________________________

DATE CLAIM FILED ____________________________ SICK BENEFITS ________________

PAYROLL DEDUCTIONS OTHER THAN TAXES? TYPE _______________ AMOUNT _______________

TYPE _______________ AMOUNT _______________ E.I.C. PAYMENTS _______________

GROSS INCOME VERIFICATION

PLEASE PROVIDE PAYROLL INFORMATION FOR EACH PAY PERIOD FOR THE DURATION OF EMPLOYMENT. YOU MAY ATTACH A COMPUTER PRINTOUT OR OTHER VERIFICATION INSTEAD OF COMPLETING THIS PORTION OF THE FORM.

PAY PERIOD ENDING	ACTUAL DATE PAID	NUMBER OF HOURS WORKED	RATE	GROSS PAY	TIPS, IF ANY	CHILD SUPPORT DEDUCTION

WORK SCHEDULE (PLEASE INCLUDE AM/PM)			
MONDAY		TO	
TUESDAY		TO	
WEDNESDAY		TO	
THURSDAY		TO	
FRIDAY		TO	
SATURDAY		TO	
SUNDAY		TO	

THIS INFORMATION MAY BE NECESSARY TO SCHEDULE DAY CARE AND OTHER SERVICES TO SUPPORT THE EMPLOYMENT.

VARIABLE SCHEDULE YES/NO _______________

MAXIMUM HOURS WORKED WEEKLY _______________

EARLIEST START TIME _______________ AM/PM

LATEST END TIME _______________ AM/PM

IS ALL THE EMPLOYEE INFORMATION LISTED ON THIS FORM CORRECT (ADDRESS, SS#, NAME)? IF NOT, PLEASE SHOW INCONSISTENCIES. ____

REMARKS ____

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SIGNATURE OF EMPLOYER/DESIGNEE DATE

TITLE TELEPHONE NUMBER