MONTGOMERY COUNTY DEPARTMENT OF JOB AND FAMILY SERVICES
1111 S. Edwin C. Moses Blvd.
Dayton, Ohio 45422
EMPLOYMENT VERIFICATION

Dear Employer:

This is a request for confidential wage and employment information which will be used to determine eligibility for Public Assistance/Food Stamps and supportive services on the person named below. We appreciate your cooperation and have enclosed a self-addressed, stamped envelope for your convenience.

MCDJFS EMPLOYEE: Complete all information in black boxes below and have customer sign the release of information.

Employer's Name:			Employee's Name:
Address:			Social Security Number:
City:	State:	Zip:	AG Name:
MCDJFS Worker's Signature:			AG Number:
Phone:	UNID	Date:	**DATE INFORMATION IS NEEDED:**

RELEASE OF INFORMATION

I authorize the employer above to release information to the Montgomery County Department of Job and Family Services regarding my employment. I am aware of my responsibilities to report, completely and fully, all facts which bear upon my eligibility for public assistance and supportive services. 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.

Applicant's/Customer's Signature	Date

EMPLOYER: **Please complete the information below as it appears in your files. Return to the worker listed above by the date entered in the *"DATE INFORMATION IS NEEDED"* box above.**

Employee's Full Name:				Position:		Currently employed? ~ No; ~ Yes
Address:				Is position permanent? ~ No; ~ Yes	Federal Work Study? ~ No; ~ Yes	No. of dependents claimed:
Date(s) employment began:	Date(s) terminated:	Date last check received:	Type of separation: ~ Discharge ~ Laid off ~ Illness/Injury ~ Quit	Eligible for rehire? ~ No ~ Yes, When?	Reason for quit or discharge:	
Social Security Number:		Rate of Pay: *(hourly)*		Paid: ~ weekly; ~ biweekly; ~ daily; ~ other:		
Date of Birth:	Union member? *(If yes, list name/local.)* ~ No ~ Yes			What day of week paid? *(circle)* S M T W TH F S		
				Does pay include overtime? ~ No; ~ Yes		
				If yes, how long will it continue?		
Does employee receive tips? ~ No; ~ Yes	Do you record tips? ~ No; ~ Yes			Does employee receive EITC? ~ No; ~ Yes	Was a W-2 filed the preceding year? ~ No; ~ Yes	

Is employee scheduled to work a set # of hours per week? ~ Yes - # of hours scheduled per week: ~ No - Average # of hours worked per week:	Are these hours? ~ Actual ~ Proposed	HOURS	S	M	T	W	TH	F	S
		Begin:							
		End:							

Type of current Medical Insurance coverage? Policy No.:	Medical Insurance: ~ Went into effect: (Date) ; Monthly cost to employee: $ ~ Will become effective: (Date) ; Monthly cost to employee: $ ~ Expired/will expire: (Date)
Deadline date for continuation of insurance under COBRA:	

Eligible for severance pay? ~ No; ~ Yes	Date check issued:	Gross amount of check: $	Any deductions? ~ No; ~ Yes; $	
Eligible for sick benefits? ~ No; ~ Yes	Date of first sick benefit check:	Gross amount of check: $	Any deductions? ~ No; ~ Yes; $	Date of last sick benefit check:
Eligible for Unemployment Compensation? ~ No; ~ Yes	Worker's Compensation Claim Filed? ~ No; ~ Yes; Claim #			Date filed:
Year-to-date earnings: *(Year)* $	Total earnings for the last 2 most recent years of employment: *(Year)* $; *(Year)* $			

Signature of Person Supplying Information:	Title:	Employer I.D. #	Phone:	Date:

Please complete the information on the reverse for the period thru .

T Please complete the following information for the time period indicated in the black box at the bottom of the front of this form;
T Or, if more convenient, you may substitute copies of your payroll records.

Pay Period Ending	Date Pay Received	Number of Hours Worked	Rate Per Hour	Gross Earnings & Tips
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Please attach additional pages if necessary.