VERIFICATION OF EMPLOYMENT/LOSS OF INCOME

_________________________________ Date: ____________________

____

In order to determine the eligibility of ______________________________________ for public assistance, please assist us by answering the questions below and returning this form to us as soon as possible.

____
Client's name

____
Client's date of birth

Office Address/Fax Number:
Sarasota County Health Department
2200 Ringling Blvd
Sarasota, FL 34237
Fax: 941-526-1531

Please complete each section which is applicable or has been marked on Page 1 AND Page 2 of this form.

☒ **Section I – GENERAL INFORMATION**

1. Name of Employee:____ *Social Security Number:_____________________
   Address:____
2. Job Title:____ Type of Work Performed:____________________________
3. Number of Hours Worked Per Week:________________ Number of Days Worked Per Week:_______________
4. A. How often is/was the employee paid? ☐ Day ☐Week ☐ Bi-Weekly ☐ Monthly
   B. Rate of pay: $___________ per ___________ . Other ______________________________Hr./Day/Wk./etc. (Explain)
5. Date current employment began:__________________ Date previously employed:____________________________
6. Does/did employee receive tips? ☐Yes ☐ No (**If yes, please show tips in Section III.)**
7. Is/was employment seasonal? Yes No If yes, season begins:_______________ ends:____________________________
8. Is/was the employee covered by health insurance? ☐Yes ☐ No
   If yes, name of insurance company:____
9. Number of dependents covered:________________
10. Does/did the employee participate in any type of payroll savings plan or profit sharing? ☐ Yes ☐No
    If yes, what is the balance? $____________________
11. Does the person perform their job duties: ☐in their home ☐in your home ☐N/A

☒ **Section II –VERIFICATION OF LOSS OF INCOME AND/OR UNPAID LEAVE**

1. Date employment ended/Last day before unpaid leave:___________________________________
2. Reason for termination/unpaid leave:____
3. Is the loss of income Permanent or Temporary (ex. maternity leave)? If temporary, when do you expect the employee to return to work? ____
4. Date employee received final check:_______________________ Gross amount: $_____________________
   (**Please list last 4 weeks in Section III.)**
5. Will employee receive any vacation pay, retirement refund, or other? ☐ Yes ☐ No
   If yes, what type? _____________________ Date received:___________________ Amount: $________________
6. Is employee eligible for any type of benefits from your company, such as extended insurance coverage, workers' compensation, or other? Yes No If yes:
   A. Name of insurance company:____
   B. Reason for benefits:____

Client's Name: ___________________________________ Client's Date of birth: ___________________________

☒ **Section III – RECORD OF PAY RECEIVED IN THE LAST FOUR WEEKS**

List the gross amounts and dates of checks or cash, which were paid for the last four weeks in the space below.

Pay Period Ending	Date Pay Received	GROSS Earnings	No. of Regular Hours Worked	Rate of Pay	No. of Overtime Hours	Rate of Pay for Overtime	Tips $$

If the hours or rate of pay has varied in the above period, please state why:

Does this client have direct deposit? ☐ **Yes** ☐**No**

☒ **Section IV – EMPLOYER INFORMATION**

What I have written on this form is true to the best of my knowledge. I know that if I give false information on purpose, I may be subject to prosecution for fraud.

____ _____________________________

Signature of Employer Employer's Title

____ _____________________________

Printed Name of Employer Telephone Number

____ _____________________________

Name of Business Date Completed

____

Address

***We are requesting you provide the social security number (SSN), but you are not required to provide us the SSN under the law. However, if you give us the SSN we can determine eligibility for assistance or services faster and more accurately. Social security numbers are used by the agency for income and eligibility verification and other purposes related to administration of our programs.**