

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Family Assistance Administration

↑ **Local Office Return Address** ↓
(Use the DES-166 envelope)

VERIFICATION OF TERMINATED EMPLOYMENT

Date: _____ Case Number / HEA Plus App ID: _____
 Case Name (Last, First, M.I.): _____
 For questions, call 1-855-432-7587
 Fax completed form to 602-257-7031 or 1-844-680-9840

The person whose name and signature appears below, or on the attached copy of the signature page of the DES/FAA Application, has requested your cooperation in releasing the following information. Please complete and return this form via fax to the number written above or in the enclosed envelope **within 10 days** from the above date.

AUTHORIZATION TO RELEASE INFORMATION / AUTORIZACIÓN PARA DAR INFORMACIÓN

I hereby authorize release of any and all information requested below concerning myself and my household members to the Arizona Department of Economic Security. *Por la presente autorizo y doy mi consentimiento para que se entregue al Arizona Department of Economic Security toda y cualquier información que se pide a continuación acerca de mí o de los miembros de mi hogar.*

Employed Household Member's Name (Last, First, M.I.) /
 Nombre del Miembro empleado del hogar (Apellido, nombre, segundo inicial): _____

Employee's Social Security Number / Número de Seguro Social del empleado: _____

Employed Household Member's Signature / Date /
 Firma del Miembro empleado del hogar: _____ Fecha: _____

Signed release attached. A photocopy or fax of a client's or employee's signature shall be treated as an original signature.

Former employers please complete all questions in Sections A, B and C.

A. FORMER EMPLOYER

Date hired: _____ Date first check was issued: _____ Gross amount of first check: \$ _____

Employee Termination:

Last day worked: _____ Date final check was/will be issued: _____ Gross amount of final wages: \$ _____

Reason for Termination:

Laid off Fired Quit (Specify reason): _____

Retired (Monthly benefit) \$ _____ Other: _____

Case Name: _____

Case Number: _____

Employed Household Member's Name: _____

Employee's Social Security Number: _____

Paychecks Received From: _____ to Date of Termination: _____

MONTH / YEAR	PAY PERIOD ENDING	DATE ACTUALLY PAID	GROSS EARNINGS	HOURS	TIPS
			\$		\$
			\$		\$
			\$		\$
			\$		\$
			\$		\$
			\$		\$
			\$		\$
			\$		\$
			\$		\$
			\$		\$

B. BENEFITS RECEIVED

Benefits received: Sick Leave Vacation Leave Disability Severance

How were these Benefits paid? Included in final wages Received in one payment
 Paid in installments (*Include future payments*)

If installments Benefits were paid when? Gross amount?

DATE	GROSS AMOUNT	DATE	GROSS AMOUNT
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____

Was the employee covered by health insurance through your company? Yes No

Have benefits stopped? Yes No Date: _____

C. COMPANY INFORMATION

Print Name of Person Completing Form: _____

Signature of Person Completing Form: _____

Title: _____ Name of Company: _____

Company Address: _____

Phone Number: _____ Fax Number: _____ Date: _____

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