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 /
Firma del Miembro empleado del hogar: _____ Date /
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: _____

See page 2 for USDA/EOE/ADA/LEP/GINA disclosures

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: _____