ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Family Assistance Administration
VERIFICATION OF NEW/CURRENT EMPLOYMENT

Date: _____

Case Number / HEA Plus APP ID:

Case Name *(Last, First, M.I.)*:

For questions, call: 1-833-397-3155
Fax completed form to
602-257-7031 or 1-844-680-9840

See page 18-20 for USDA/ EOE/ ADA disclosures

Case Name: _____

Case Number: _____

Employed Household Member's Name:

_____

Employee's Social Security Number:

_____

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.

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.

Case Name: _____

Case Number: _____

Employed Household Member's Name:

_____

Employee's Social Security Number:

_____

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 Seguro Social del empleado*****:**

_____

Case Name: _____

Case Number: _____

Employed Household Member's Name:

_____

Employee's Social Security Number:

_____

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.**

New/current employers please complete all questions in Sections A, B and C.

A. NEW / CURRENT EMPLOYER

Date Hired: _____

Case Name: _____

Case Number: _____

Employed Household Member's Name:

_____

Employee's Social Security Number:

_____

Anticipated Date of First Check:

_____

Rate of Pay $ _____

Per: _____

Anticipated Gross Income $ _____

Number of Hours Worked Per Week:
(If hours per week vary, indicate the range possible)

From _____ **To** _____

Number of Hours Worked Per Day:
(If hours vary, indicate the range possible)

From _____ **To** _____

Case Name: _____

Case Number: _____

Employed Household Member's Name:

_____

Employee's Social Security Number:

_____

Days of Week Worked *(check all that apply):*

☐ **Monday** ☐ **Tuesday** ☐ **Wednesday**
☐ **Thursday** ☐ **Friday** ☐ **Saturday**
☐ **Sunday**

Does the employee receive any tips/ bonus/commission/shift pay?
☐ **Yes** ☐ **No**

Type: _____

If yes, what is the range of possible amounts that the employee can

receive? From _____ **To** _____

Frequency of pay: _____

Is this pay normal? ☐ **Yes** ☐ **No**

Case Name: _____

Case Number: _____

Employed Household Member's Name:

_____

Employee's Social Security Number:

_____

Are wages received under the Workforce Investment Act (WIA) Program? ☐ **Yes** ☐ **No**

Employee reimbursed for *(check one)*:
☐ **Travel** ☐ **Lodging** ☐ **Uniforms**

How often? _____

Amount? $ _____

Employee is paid:
☐ **Daily** ☐ **Weekly** ☐ **Bi-weekly**
☐ **Twice monthly** ☐ **Monthly**

Is pay direct deposited? ☐ **Yes** ☐ **No**

If yes, Name of Bank:

_____

Case Name: _____

Case Number: _____

Employed Household Member's Name:

_____

Employee's Social Security Number:

_____

Day of week or date(s) pay period

starts: _____ **ends:** _____

Overtime Rate $ _____

Overtime Hours Per Week: _____

Will overtime continue? ☐ **Yes** ☐ **No**

Contract? ☐ **Yes** ☐ **No**

(If yes, attach copy and provide the gross earnings for each month(s) and year(s) indicated on Section C on page 14.)

☐ **Per Job (Rate) $** _____

☐ **Hourly (Rate) $** _____

☐ **Other** _____

Case Name: _____

Case Number: _____

Employed Household Member's Name:

_____

Employee's Social Security Number:

_____

Child support withholding?
☐ **Yes** ☐ **No**

Amount $ _____

How often? _____

Expected changes in income?

☐ **Yes** ☐ **No** **When?** _____

☐ **Increase** ☐ **Decrease**

Why? _____

Worker's Compensation *(Claim pending, or claim being paid)*?
☐ **Yes** ☐ **No**

Carrier's Name:

_____

Is the employee on a leave of absence? ☐ **Yes** ☐ **No**

Case Name: _____

Case Number: _____

Employed Household Member's Name:

_____

Employee's Social Security Number:

_____

When does the leave of absence begin? _____

When is the leave of absence expected to end? _____

Is the leave of absence paid or unpaid? ☐ **Paid** ☐ **Unpaid**

Is the employee receiving short term disability? ☐ **Yes** ☐ **No**

How often? _____

Amount $ _____

Is the employee receiving long term disability? ☐ **Yes** ☐ **No**

How often? _____

Amount $ _____

Case Name: _____

Case Number: _____

Employed Household Member's Name:

_____

Employee's Social Security Number:

_____

Does your company offer health insurance? ☐ **Yes** ☐ **No**

(If yes, continue to Section B.)

B. HEALTH INSURANCE INFORMATION

Does the employee currently have (or has had) health insurance with your company? ☐ **Yes** ☐ **No**

If yes, complete information below.

If no, did employee decline health insurance? ☐ **Yes** ☐ **No**

Name of Insurance Company:

_____

Case Name: _____

Case Number: _____

Employed Household Member's Name:

_____

Employee's Social Security Number:

_____

Address *(No., Street)*:

_____

City: _____

State: _____ **ZIP Code:** _____

Policy Number: _____

Policy Date:

From _____ **To** _____

LIST INSURED DEPENDENTS:

_____

_____

_____

_____

Case Name: _____

Case Number: _____

Employed Household Member's Name:

_____

Employee's Social Security Number:

_____

RELATIONSHIP TO EMPLOYEE:

_____

_____

_____

_____

Case Name: _____

Case Number: _____

Employed Household Member's Name:

_____

Employee's Social Security Number: _____

C. PAYCHECKS ISSUED

Indicate each paycheck issued to the employee:

From *(Month/Year)* _____ **To *(Month/Year)*** _____

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

Case Name: _____

Case Number: _____

Employed Household Member's Name:

_____

Employee's Social Security Number: _____

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

Case Name: _____

Case Number: _____

Employed Household Member's Name:

_____

Employee's Social Security Number: _____

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

Case Name: _____

Case Number: _____

Employed Household Member's Name:

_____

Employee's Social Security Number:

_____

Print Name of Person Completing Form: _____

Signature of Person Completing Form: _____

Title: _____

Name of Company:

_____

Phone Number: _____

Fax Number: _____

Date: _____

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

To ile a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA o ice, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in su icient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

1. mail:

Food and Nutrition Service, USDA
1320 Braddock Place, Room 334
Alexandria, VA 22314; or

2. fax:
(833) 256-1665 or (202) 690-7442; or

3. email:
FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.

To request this document in alternative format or for further information about this policy, contact your local office; TTY/TDD Services: 7-1-1.