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

See page 11 for USDA/EOE/ ADA/LEP/GINA 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 or in the enclosed envelope within 10 days from the above date.

Case Name: ______________________________

Case Number: ______________________________

Employed Household Member's Name:

____

Employee's Social Security Number:

____

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.***

Case Name: ______________________________

Case Number: ______________________________

Employed Household Member's Name:

____

Employee's Social Security Number:

____

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*:

____

Employed Household Member's Signature / *Firma del Miembro empleado del hogar*:

____

Date / *Fecha*: ______________________________

Case Name: ____________________

Case Number: ____________________

Employed Household Member's Name:

____

Employee's Social Security Number:

____

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:

$ ____________________

Case Name: ______________________

Case Number: ______________________

Employed Household Member's Name:

____

Employee's Social Security Number:

____

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
			$		$
			$		$
			$		$
			$		$
			$		$

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:

____

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
______________	$ ______________
______________	$ ______________
______________	$ ______________

Case Name: ______________________________

Case Number: ______________________________

Employed Household Member's Name:

____

Employee's Social Security Number:

____

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:

____

Case Name: ______________________________

Case Number: ______________________________

Employed Household Member's Name:

____

Employee's Social Security Number:

____

Title: ______________________________

Name of Company:

____

Company Address:

____

____

Phone Number: ______________________________

Fax Number: ______________________________

Date: ____________________

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