

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

**ARIZONA DEPARTMENT
OF ECONOMIC SECURITY
Family Assistance
Administration**

**VERIFICATION OF NEW/
CURRENT EMPLOYMENT**

Date: _____

**Case Number/HEA Plus
APP ID:**

**See pages 27-28 for USDA/EOE/
ADA/LEP/GINA disclosures**

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 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.

Case Name:

Case Number:

**Employed Household
Member's Name:**

**Employee's Social
Security Number:**

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

A. NEW / CURRENT EMPLOYER

Date Hired: _____

**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 _____

**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

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:

**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 _____

**Child support
withholding? Yes No**

Amount \$ _____

How often? _____

**Expected changes in
income? Yes No**

When? _____

**Type: Increase
 Decrease Other –**

Reason: _____

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

Carrier's Name:

**Is the employee on a
leave of absence?**

Yes No

**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 \$ _____

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

***(If yes, continue to
Section B.)***

Case Name:

Case Number:

**Employed Household
Member's Name:**

**Employee's Social
Security Number:**

**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:**

Address (*No., Street*):

City: _____

State: _____

ZIP Code: _____

Policy Number:

Policy Date:

From _____

To _____

**LIST INSURED
DEPENDENTS:**

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
\$		\$
\$		\$
\$		\$
\$		\$

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

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

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

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: _____

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discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. To request this document in alternative format or for further information about this policy, contact your local office; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request.