ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Family Assistance Administration

VERIFICATION OF TERMINATED EMPLOYMENT

Date: _____

Case Number/HEA Plus APP ID:

_____

See pages 16-22 for USDA/EOE/ ADA 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 providing the following information.

Please complete and return this form via fax at the number above, within 10 days from the date 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.

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.**

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:**

_____

Paychecks Received From:

to Final Pay:

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:

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 paid in installments, Date? The Gross Amount?	
Date	**Amount**

If included in the Final Wages, what type? The Gross Amount?	
Type	**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: _____

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

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may contact USDA through the Federal Relay Service at (800) 877-8339.

To file 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 office, 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 sufficient 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. ● Disponible en español en línea o en la oficina local.