

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Family Assistance Administration

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

VERIFICATION OF NEW/CURRENT 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 / Date /
 Firma del Miembro empleado del hogar: _____ 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: _____ 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

Case Name: _____

Case Number: _____

Employed Household Member's Name: _____

Employee's Social Security Number: _____

A. NEW/CURRENT EMPLOYER (Continued)

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: 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 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 3.)

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.)

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:

