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

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. *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 /
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: _____ 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

See page 4 for USDA/EOE/ADA disclosures

Case Name: _____ Case Number: _____

Employed Household Member's Name: Employee's Social Security Number:

_____ _____

A. NEW/CURRENT EMPLOYER *(Continued)*

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 3.)

☐ Per Job (Rate) $ _____ ☐ Hourly (Rate) $ _____ ☐ Other _____

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

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:**

_____ _____

_____ _____

_____ _____

_____ _____

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
			$		$
			$		$
			$		$
			$		$
			$		$
			$		$
			$		$
			$		$
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			$		$
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			$		$
			$		$
			$		$
			$		$
			$		$
			$		$
			$		$

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 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.