Arizona Department of Economic Security

Family Assistance Administration

Verification of Terminated Employment

Case Name: ______________________________ Date: __________

HEAplus Application ID: ____________________ AZTECS Case 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 providing the following information. Please complete this form and fax it to: (602) 257-7031 or 1 (844) 680-9840. For questions, call 1 (833) 397-3155.

Authorization to Release Information/*Autorización para dar Información*

I authorize the release of any information requested below concerning myself and my household members to the Arizona Department of Economic Security.

Autorizo la divulgación de cualquier información solicitada a continuación sobre mí y los miembros de mi hogar al Departamento de Seguridad Económica de Arizona.

Employed Household Member's Name (Last, First, M.I.) /
Nombre del Miembro del hogar empleado (Apellido, nombre, segundo inicial):

____

Employee's Social Security Number / *Número de Seguro Social del empleado*: ____________________

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

See page 3 for USDA/EOE/ADA disclosures

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?		**If included in the Final Wages, what type? The Gross Amount?**	
Date	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 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.