

ARIZONA DEPARTMENT OF ECONOMIC SECURITY  
 Family Assistance Administration  
**VERIFICATION OF TERMINATED EMPLOYMENT**

Date: _____ Case Number / HEA Plus App ID: _____ Case Name (Last, First, M.I.): _____ <p style="text-align: center;">For questions, call 1-833-397-3155                  Fax completed form to 602-257-7031 or 1-844-680-9840</p>
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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 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.

**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: \_\_\_\_\_

Case Name: \_\_\_\_\_

Case Number: \_\_\_\_\_

Employed Household Member's Name: \_\_\_\_\_

Employee's Social Security Number: \_\_\_\_\_

**Paychecks Received From: \_\_\_\_\_ to Final Pay: \_\_\_\_\_**

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

**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: \_\_\_\_\_

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