

**Arizona Department of  
Economic Security  
Family Assistance Administration  
Verification of  
New/Current Employment**

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

**Case Number / HEA Plus APP ID:**

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**Case Name (*Last, First, M.I.*):**

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**For questions, call: 1-833-397-3155  
Fax completed form to  
602-257-7031 or 1-844-680-9840**

**See page 18-20 for USDA/  
EOE/ADA disclosures**

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

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

**Employed Household Member's Name:**

\_\_\_\_\_

**Employee's Social Security 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 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.**

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

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

**Employed Household Member's Name:**

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

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***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:**

\_\_\_\_\_

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

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

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

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

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

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

**Employed Household Member's Name:**

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

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**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** \_\_\_\_\_

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

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

**Employed Household Member's Name:**

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**Employee's Social Security Number:**

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**Days of Week Worked (*check all that apply*):**

<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>
<b>Thursday</b>	<b>Friday</b>	<b>Saturday</b>
<b>Sunday</b>		

**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:**

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**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**

**Other** \_\_\_\_\_

**Is pay direct deposited?      Yes      No**

**If yes, Name of Bank:**

\_\_\_\_\_

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

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

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

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

**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 14.)***

**Per Job (Rate) \$** \_\_\_\_\_

**Hourly (Rate) \$** \_\_\_\_\_

**Other** \_\_\_\_\_



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

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

**Employed Household Member's Name:**

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

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**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**

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

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

**Employed Household Member's Name:**

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

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**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 \$** \_\_\_\_\_

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

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

**Employed Household Member's Name:**

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**Employee's Social Security Number:**

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**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:**

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

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

**Employed Household Member's Name:**

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

\_\_\_\_\_  
**Address (No., Street):**

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

**State:** \_\_\_\_\_ **ZIP Code:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_

**Policy Date:**

**From** \_\_\_\_\_ **To** \_\_\_\_\_

**List Insured Dependents:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

**Employed Household Member's Name:**

\_\_\_\_\_

**Employee's Social Security Number:**

\_\_\_\_\_

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**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) \_\_\_\_\_**

<b>Month /Year</b>	<b>Pay Period Ending</b>	<b>Date Actually Paid</b>	<b>Gross Earnings</b>	<b>Hours</b>	<b>Tips</b>
			\$		\$
			\$		\$
			\$		\$
			\$		\$







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

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

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**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](mailto:FNSCIVILRIGHTSCOMPLAINTS@usda.gov)****This institution is an equal opportunity provider.**

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**To request this document in alternative format or for further information about this policy, contact your local office; TTY/TDD Services: 7-1-1.**