

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.

See pages 9-10 for USDA/EOE/ADA disclosures

Employed Household Member's Name:

Employee's Social Security Number:

***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. 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 del hogar empleado (Apellido, nombre, segundo inicial):*

Employed Household Member's Name:

Employee's Social Security Number:

Employee's Social Security Number / Número 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: \$ _____

Employed Household Member's Name:

Employee's Social Security Number:

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: _____

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*)

Employed Household Member's Name:

Employee's Social Security Number: _____

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: _____

Employed Household Member's Name:

Employee's Social Security Number:

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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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. •
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