↳ **Local Office Return Address** ↴
(Use the DES-166 envelope)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Family Assistance Administration
VERIFICATION OF NEW/ CURRENT EMPLOYMENT

Date: _____

Case Number/HEA Plus APP ID:

_____

See pages 27-28 for USDA/EOE/ ADA/LEP/GINA disclosures

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

For questions, call 1-855-432-7587 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 or in the enclosed envelope within 10 days from the above date.

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 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.**

Case Name:

Case Number:

Employed Household Member's Name:

Employee's Social Security Number:

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:

☐ **Weekly** ☐ **Bi-weekly**

☐ **Twice monthly**

☐ **Monthly**

Is pay direct deposited?

☐ **Yes** ☐ **No**

If yes, Name of Bank:

Day of week or date(s) pay period 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** _____

Child support withholding? ☐ Yes ☐ No

Amount $ _____

How often? _____

Expected changes in income? ☐ Yes ☐ No

When? _____

Type: ☐ Increase ☐ Decrease ☐ Other –

Reason: _____

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.)

Case Name:

Case Number:

Employed Household Member's Name:

Employee's Social Security Number:

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
$		$
$		$
$		$
$		$

MONTH / YEAR	PAY PERIOD ENDING	DATE ACTUALLY PAID

GROSS EARNINGS	HOURS	TIPS
$		$
$		$
$		$
$		$

MONTH / YEAR	PAY PERIOD ENDING	DATE ACTUALLY PAID

GROSS EARNINGS	HOURS	TIPS
$		$
$		$
$		$
$		$

MONTH / YEAR	PAY PERIOD ENDING	DATE ACTUALLY PAID

GROSS EARNINGS	HOURS	TIPS
$		$
$		$
$		$
$		$

MONTH / YEAR	PAY PERIOD ENDING	DATE ACTUALLY PAID

GROSS EARNINGS	HOURS	TIPS
$		$
$		$
$		$
$		$

Case Name:

Case Number:

Employed Household Member's Name:

Employee's Social Security Number:

Print Name of Person Completing Form:

Signature of Person Completing Form:

Title:

Name of Company:

Phone Number:

Fax Number:

Date:

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discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. To request this document in alternative format or for further information about this policy, contact your local office; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request.