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

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

Date: _____

Case Number/HEA Plus APP ID:

_____

See pages 13-14 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.**

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 Date of Termination:

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:

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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the Department prohibits 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.