Arizona Department of Economic Security
Family Assistance Administration

Verification of New/Current Employment

Date: ______________ Case Number / HEA Plus App ID: ______________________________

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

For questions, call: 1-833-397-3155
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.

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 /
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: ______________ 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: Daily Weekly Bi-weekly Twice monthly Monthly
Other ______________________________

See page 4 for USDA/EOE/ADA disclosures

Case Name: ______________________________ Case Number: ______________

Employed Household Member's Name: ______________________________ Employee's Social Security Number: ______________

A. New/Current Employer *(Continued)*

Is pay direct deposited? Yes No

If yes, Name of bank: ______________________________

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 3.)

Per Job (Rate) $ __________ Hourly (Rate) $ __________ Other ______________

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

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.)

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
			$		$
			$		$
			$		$
			$		$
			$		$
			$		$
			$		$
			$		$
			$		$
			$		$
			$		$
			$		$
			$		$
			$		$
			$		$
			$		$
			$		$
			$		$
			$		$
			$		$

Print Name of Person Completing Form: ______________________________

Signature of Person Completing Form: ______________________________

Title: ____________________ Name of Company: ______________________________

Phone Number: ____________________ Fax Number: ____________________ Date: ____________________

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

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.