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

See pages 27-32 for USDA/ EOE/ADA disclosures

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 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.

Case Name:

Case Number:

Employed Household Member's Name:

Employee's Social Security Number:

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**

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 14.)

☐ **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.)

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
$		$
$		$
$		$
$		$

Print Name of Person Completing Form:

Signature of Person Completing Form:

Title:

Name of Company:

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.