

### Verification of New/Current 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 releasing the following information. Please complete the form and fax it to: 602-257-7031 or 1-844-680-9840. For questions, call 1-833-397-3155.

**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.*

Employed Household Member's Name (Last, First, M.I.) /  
*Nombre del Miembro del hogar empleado (Apellido, nombre, segundo inicial):*

Employee's Social Security Number / *Número de Seguro Social del empleado:* \_\_\_\_\_

If you are completing this form electronically, typing your signature will constitute a valid signature.

Employed Household Member's Signature / \_\_\_\_\_ Date /  
*Firma del Miembro del hogar empleado: \_\_\_\_\_ 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

Is the employee reimbursed for (check one): Travel Lodging Uniforms

How often? \_\_\_\_\_ Amount \$ \_\_\_\_\_

Case Name: \_\_\_\_\_

Case Number: \_\_\_\_\_

Employed Household Member's Name: \_\_\_\_\_

Employee's Social Security Number: \_\_\_\_\_

**A. New/Current Employer (Continued)**

Employee is paid: Daily Weekly Bi-weekly Twice monthly Monthly  
Other \_\_\_\_\_

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:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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Persons with disabilities who require alternative means of communication for program information (e.g., braille, large print, audiotape, American Sign Language) should contact the responsible State or local Agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 ( voice and TTY). Additionally, Program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, [AD-3027](#) , found online at How to File a Program Discrimination Complaint and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. Mail:

USDA Food and Nutrition Service, 1320 Braddock Place, Room 334  
Alexandria, VA 22314; or

2. Email:

[FNSCIVILRIGHTSCOMPLAINTS@usda.gov](mailto:FNSCIVILRIGHTSCOMPLAINTS@usda.gov).

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To request this document in alternative format or for further information about this policy, contact your local office; TTY/TDD Services: 7-1-1.