



TEXAS

Health and Human
Services Commission

Name and address

Date

Caseworker

Office Address and Telephone No.

FAX:

Employee/Household Member

Social Security No.

This individual is a member of a household applying for assistance from the Texas Health and Human Services Commission or has income that affects another household's application for assistance. To determine the household's eligibility, it is necessary to verify all earnings. Since this person is (or was) your employee, your help is needed.

HERE'S HOW YOU CAN HELP: Please provide the information requested on the back of this letter. Please ensure that all information is complete and correct, since it will affect someone's eligibility and benefits. If a question does not apply, mark it N/A. After you complete the form, give it to your employee or mail it in the envelope provided—or you may FAX it to the number listed above.

This information is needed by _____, so if you could send it before this date it would be most appreciated.

NOTICE TO EMPLOYERS: You may be eligible for a tax refund and/or tax credit for hiring recipients who receive TANF or food stamp benefits. For more information contact the Texas Workforce Commission, Work Opportunity Tax Credit Unit at 1-800-695-6879.

Thank you for helping. If you have questions, please feel free to call.

Case Name

Case No.

I, _____ give my permission to release the information requested on this form.
Yo, _____ doy mi permiso para que mi empleador dé la información que se pide en esta forma.

Signature/Firma

Date/Fecha

Employment Verification

THANK YOU for taking the time to complete all of the information on this form. Your help is very much appreciated.

Employee Name (as shown on your records)					
Employee Address--Street, City, State, ZIP (as shown on your records)					
Is (or was) this person employed by you? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what type of job?		<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary	
Rate of Pay \$		<input type="checkbox"/> Per Hour <input type="checkbox"/> Per Day <input type="checkbox"/> Per Week <input type="checkbox"/> Per Month <input type="checkbox"/> Per Job		How often paid?	
Commissions/Tips/Bonuses <input type="checkbox"/> Yes* <input type="checkbox"/> No		Overtime Pay <input type="checkbox"/> Frequently <input type="checkbox"/> Rarely <input type="checkbox"/> Never		FICA or FIT withheld <input type="checkbox"/> Yes <input type="checkbox"/> No	
Health Insurance Available? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, employee is: <input type="checkbox"/> Not Enrolled <input type="checkbox"/> Enrolled With Family Members <input type="checkbox"/> Enrolled for Self Only		Profit Sharing/Pension Plan <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, current value \$	
Date Hired		Date First Check Received		Average Hours per Week	
				If Employee is/was on Leave Without Pay: Start Date End Date	
Do you expect any changes to the above information within the next few months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:					

On the chart below, list all wages received by this employee during the month(s) of:					
DATE PAY PERIOD ENDED	DATE EMPLOYEE RECEIVED PAYCHECK	ACTUAL HOURS	GROSS PAY	OTHER PAY* (tips, commissions, bonuses)	EITC ADVANCE

*Please explain (in comments section below) when and how often tips, commissions, or bonuses are received.

IF THIS PERSON IS NO LONGER IN YOUR EMPLOY:

Date Separated	Reason for Separation	Date Final Check Received	Gross Amount of Final Check \$
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Comments: _____

Company or Employer	Address (Street, City, State, ZIP)
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This information is true and correct to the best of my knowledge and belief.

Signature--Person Verifying this Information	Date	Title	Telephone No.
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