

EMPLOYMENT VERIFICATION REQUEST

Worker Name:	Phone #:	Date:	Return by:
Employee Name:		Employee SS#:	
Employer Name:			
Employer Address:		City:	State: Zip Code:

RELEASE OF INFORMATION AUTHORIZATION

I authorize the above employer to release my employment information to the above county Department of Job & Family Services. I am aware of my responsibilities to report completely and fully all facts that bear upon my eligibility for cash, medical and food assistance benefits. I realize if the requested information reveals I have improperly reported by situation, the information may be given to the prosecuting attorney for possible civil action or criminal prosecution.

Employee Signature: _____ Date: _____

EMPLOYER TO COMPLETE

DATES OF EMPLOYMENT			
Corporate Name:		Federal Employer ID:	If employment has ended, also complete this section.
Name of Employment Site:		Last Day Worked:	Date Last Pay Received:
First Day Worked:	Date First Pay Received:	Type of Separation: <input type="checkbox"/> Laid Off <input type="checkbox"/> No Call or Show <input type="checkbox"/> Discharged <input type="checkbox"/> Illness or Injury <input type="checkbox"/> Resignation <input type="checkbox"/> Other (specify): _____	Post-Employment Benefits: <input type="checkbox"/> Sick <input type="checkbox"/> Severance <input type="checkbox"/> Unemployment <input type="checkbox"/> Workers Comp <input type="checkbox"/> Amount: _____ <input type="checkbox"/> Frequency: _____ <input type="checkbox"/> First Day Received: _____ <input type="checkbox"/> Last Day Received: _____
List interruption or leave period during employment: From Date: _____ To Date: _____		Strike Start Date:	Strike End Date: Effective Lockout Date:

RATE/HOURS/PAY FREQUENCY		
Current Hourly Rate:	Day of Week Paid: <input type="checkbox"/> Sun. <input type="checkbox"/> Mon. <input type="checkbox"/> Tues. <input type="checkbox"/> Wed. <input type="checkbox"/> Thurs. <input type="checkbox"/> Fri. <input type="checkbox"/> Sat.	Is pay direct deposit? <input type="checkbox"/> Yes <input type="checkbox"/> No
Number of set hours to work per week: _____ OR Number of hours will vary from _____ to _____ per week.		
Pay Period Frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Twice Monthly <input type="checkbox"/> Other (specify) _____		Overtime is: <input type="checkbox"/> Not expected to be worked in the future. <input type="checkbox"/> Worked routinely monthly.



COUNTY COMMISSIONERS
CINDY CARPENTER
DONALD L. DIXON
T.C. ROGERS

BUTLER COUNTY DEPARTMENT OF JOB & FAMILY SERVICES
315 HIGH STREET, 8TH FLOOR, HAMILTON, OHIO 45011
PHONE: 513.887.5600 • FAX: 513.887.4334
E-MAIL: VERIFICATIONS@JFS.OHIO.GOV
VISIT US ON THE WEB: WWW.BUTLERCOUNTYOHO.ORG/WORKPLACE

Employee Name:	Employee SS#:
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WAGES (Last 6 Pays)								
Period Ending	Date Received	Hours	Hourly Rate	Gross Pay Without Tips, Bonus or Commission	Tips	Bonus or Commission	Garnishment	Child Support Deduction

HEALTH INSURANCE				
Is the employee or their dependents enrolled in health insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes	Begin Date:	End Date:	Policy #:	Group #:
Name/Address of Insurance Company:			List Covered Members:	

Additional information is needed for the below time period (see Additional Information Section if time period is noted below).

Time Period Requested: From Date:	To Date:
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ADDITIONAL INFORMATION					
If indicated above, please complete the following information for the requested time period. If it is more convenient or you need more space, you may substitute copies of the employee's payroll records.					
Date Pay Received	Gross Pay Without Tips, Bonus or Commission	Tips	Bonus or Commission	Garnishment	Child Support Deduction

OTHER INFORMATION REQUESTED
Requested Information:
Employer Response to Requested Information:

EMPLOYER SIGNATURE				
Employer Representative Signature:	Title:	Phone #:	Fax #:	Date:



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