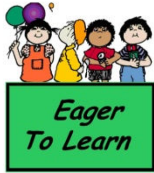

Early Learning Coalition of Polk County

www.elcpolk.org

Verification of Employment
Loss of Income

Date: _________________

I, ___________________________ give permission for my employer to release the following information to Early Learning Coalition of Polk County for the purpose of determining my eligibility for childcare assistance.

____
Parent signature

Section I – General Information
Name of employee: ___________________________ SSN: ______________

Address: ____

Job title: ________________________ Type of work performed:__________________

Number of hours/week: ___________ Number of days/week _____________________

How often is/was employee paid: ____ day ____ week ____ bi-weekly ____ monthly

Rate of pay: $_______ per _______ (hr/day/wk/etc.) Other_______________________

Date current employment began: __________ Date previously employed __________

Does/did employee receive tips? ___ yes ___ no (if yes, please show tips in Section III)

Section II – Loss of Income
Date employment ended: _______________ Reason for termination ______________

Is the loss of income _______ Permanent or _______temporary? If temporary, when do you expect the employee to return to work? ________________________________

Date employee received final check: ______________ Gross amount _____________
(Please list last 6 weeks of pay in Section III.)

Will employee receive any vacation pay, retirement refund, or other? ____ Yes ____ No
If yes, what type? __________ Date received __________ Amount _______

Is employee eligible for any type of benefits from your company, such as ext. insurance coverage, worker's compensation , or other? _____ Yes _____ No

Section III – Record of Pay Received

List the gross amount and dates of checks or cash which were paid for the last 6 weeks in the space below.

Pay Period Ending	Date Pay Received	Gross Earnings	No. of reg. hours worked	Rate of pay	No. of OT hours	Rate of pay for OT	Tips	Earned Income Credit

If hours or rate of pay has varied in the above period, please state why. ____________

____

____

____

Section IV – Employer Information

I certify that the information given in this form is true and correct to the best of my knowledge. I also acknowledge that the purposeful giving of false information is a prosecutable offense.

______________________________ ______________________________
Signature of Employer Employer's Title

______________________________ ______________________________
Name of Business Telephone Number

______________________________ ______________________________
Address Date Completed

Return completed form to: Early Learning Coalition of Polk County
Attention: ______________________