



Southwest Ohio
County Departments of Job & Family Services

County Agency: Hamilton County Department of Job & Family Services
Address: 222 E. Central Parkway - Cincinnati, OH 45202
Phone: (513) 946-1000
Fax: (513) 946-1076
Website: www.hcjfs.org

Employment Verification Request

Employer Name:		Employee Name:	
Address:		Social Security Number:	
City:	State:	Zip:	Case Number:
JFS Worker:	Phone:	Date:	Return by:

Release of Information Authorization

I authorize the above employer to release my employment information to the above county Department of Job and 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 my situation, the information may be given to the prosecuting attorney for possible civil action or criminal prosecution.

Employee Signature	Date
--------------------	------

Employer to Complete X Sections

Dates of Employment/Separation/Post Employment Benefits

Corporate Name	Name of Employment Site	Federal Employer I.D.
First Day Worked	Date First Pay Received	Last Day Worked
		Date Last Pay Received

List interruption or leave period during employment. From Date: _____ To Date: _____	Strike Start Date	Strike End Date	Effective Lockout Date
---	-------------------	-----------------	------------------------

Type of Separation	Post Employment Benefits	Amount: _____
<input type="checkbox"/> Laid Off	<input type="checkbox"/> Sick	Frequency: _____
<input type="checkbox"/> No Call/No Show	<input type="checkbox"/> Severance	First Day Received: _____
<input type="checkbox"/> Discharged	<input type="checkbox"/> Unemployment	Last Day: _____
<input type="checkbox"/> Illness/Injury	<input type="checkbox"/> Workers Comp.	
<input type="checkbox"/> Resignation		
<input type="checkbox"/> Other (specify) _____		

Rate/Hours/Pay Frequency

Current Hourly Rate:	Number of set hours to work per <u>Week</u> : _____; <i>OR</i>
	Number of hours will vary from _____ to _____ per <u>Week</u>

Day of Week Paid	Pay Period Frequency	Overtime is
<input type="checkbox"/> Sun; <input type="checkbox"/> Mon; <input type="checkbox"/> Tue;	<input type="checkbox"/> Weekly; <input type="checkbox"/> Twice Monthly	<input type="checkbox"/> Not expected to be worked in the future
<input type="checkbox"/> Wed; <input type="checkbox"/> Thu; <input type="checkbox"/> Fri; <input type="checkbox"/> Sat	<input type="checkbox"/> Biweekly; <input type="checkbox"/> Other, Specify _____	<input type="checkbox"/> Worked routinely monthly

Wages (Last 6 Pays)

Period Ending	Date Received	Hours	Hourly Rate	Gross Pay <i>Without</i> 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 Number	Group Number
Name/Address of Insurance Company			List Covered Members	

Additional Information Is Needed For The Below Time Period (See Reverse if Time Period is Indicated Below)

Time Period Requested – From Date:	To Date:
------------------------------------	----------

Employer Signature

Employer Representative Signature	Title	Phone	FAX	Date
-----------------------------------	-------	-------	-----	------

