



JVS/BSF CHILD CARE ASSISTANCE
 430 FIRST AVE. NORTH
 SUITE 620
 MINNEAPOLIS, MN 55401
 phone 612-692-8920
 fax 612-692-8921
 e-mail jvs@jvsmn.org
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Financial-Work Verification

WORK VERIFICATION

Case Name: _____ Case Number: _____
 BSF Case Manager: _____ Date: _____

EMPLOYEE'S AUTHORIZATION TO RELEASE INFORMATION:

I hereby grant permission to _____
 (Employer Name)
 to release the information requested below to JVS. This information may be shared among various departments with Hennepin County and with contracted Employment Service Providers as it relates to my total eligibility for aid from JVS. This authorization expires one year from my signature date.

Employee Signature	Birth Date	Social Security Number	Date
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TO BE COMPLETED BY EMPLOYER: The following information is required to determine eligibility for programs offered by Hennepin County and/or its contracted service providers. PLEASE PROVIDE ALL INFORMATION REQUESTED. Thank you for your help.

If this person never worked at your company, **STOP HERE. CHECK THE BOX, sign and date on the backside.**

1. Employment start date: _____ to _____		2. If new employee, date of first check: _____ Gross Amount \$ _____					
3. GROSS salary per pay period: \$ _____		4. Date of next check: _____ Gross Amount \$ _____					
5. Day of week check is received: <input type="checkbox"/> Sunday <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday		6. Pay frequency: <input type="checkbox"/> Weekly <input type="checkbox"/> Biweekly <input type="checkbox"/> Twice/Month <input type="checkbox"/> Monthly <input type="checkbox"/> Daily <input type="checkbox"/> Other					
7. Hourly pay rate: \$ _____ per hour Effective: ____/____/____		8. Occupation / title:					
9. Approximate date of next raise: Effective: ____/____/____		Hourly rate of next raise: \$ _____ per hour					
10. Does employee work overtime? <input type="checkbox"/> Yes <input type="checkbox"/> No	Overtime rate: \$ _____ OR Average hours: _____ per <input type="checkbox"/> Pay Period <input type="checkbox"/> Week <input type="checkbox"/> Month YTD Total: \$ _____						
11. Check if employee receives: <input type="checkbox"/> Tips <input type="checkbox"/> Commissions <input type="checkbox"/> Bonuses		Average tips / commissions / bonuses per pay period: \$ _____ per _____ YTD Total: \$ _____					
12. Are any company-paid flexible benefits available to be taken in cash? OR Are any "in-kind" (non-cash) benefits received (e.g., a housing allowance or an apartment)? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please list the amount here and explain: \$ _____ per _____ Explain:					
13. LIST BELOW ACTUAL HOURS WORKED EACH DAY. (Please fill in the chart below.)							
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Start Time							
End Time							
14. Number of hours worked per week:		PLEASE NOTE: If the schedule varies, please attach copies of the work schedule for the past two months or explain on another sheet of paper.					

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JVS is a division of Jewish Family and Children's Service of Minneapolis

Affiliate of IAJSV, Accredited by CARF, the Rehabilitation Accreditation Commission

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15. Earliest date health/dental benefits are available? Effective: ____/____/____	Check persons coverage is available for: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents	
16. Employee cost per pay period: Employee \$_____ Spouse \$_____ Dependents \$_____	Monthly amount employee pays toward health/dental premiums: \$_____/month	
17. Insurance company name:	Group number:	Coverage effective date:
18. Health benefits contact person:	Phone number:	
19. Is employee paying court-ordered child support? <input type="checkbox"/> Yes <input type="checkbox"/> No	Amount per pay period: \$_____ per _____	

IF BOX IS CHECKED, please fill in wage income below (or attach a printout) from the start date of employment through the present.

Date Check Received	Gross Wages	Tips	FICA & Medicare	Federal Tax	State Tax	Other Deductions
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I certify that this information is true and correct to the best of my knowledge and that I have the authority to make such verifications on behalf of this organization/company.

Signature of Representative: _____ Printed Name: _____

Title: _____ Phone: () _____ Date: _____

Company Name: _____ Address: _____
