DCIS # _____

*DELAWARE HEALTH AND SOCIAL SERVICES*

DIVISION OF SOCIAL SERVICES

# VERIFICATION OF EMPLOYMENT

To: _____
_____
_____
_____

Date: _____
Case Head: _____
Case Number: _____
Employee Name: _____
Date of Birth: _____

Dear Employer:
Our Division is trying to make a determination of eligibility for the above named individual. Please complete the information checked below, so we can make our eligibility determination. The individual has signed the authorization to give information below. Please return to our DSS address below. The Division appreciates your cooperation. If there are any questions, please call me.

Sincerely,

_____
Social Worker, Division of Social Services
Phone #: _____ Fax #:_____

DSS Office Address:

_____
_____
_____

☐ **A. NEW EMPLOYMENT**

Employee Position: _____ Date Employment Started: _____
Date First Pay: _____ Hours Per Pay Period: _____ Hourly Wage: _____
Does the employee receive tips? ☐ Yes ☐ No What is the average amount of tips per pay? _____
How Often Paid: (Please Check) ☐ Weekly ☐ Every Two Weeks ☐ Twice a Month ☐ Monthly

☐ **B. CURRENT EMPLOYMENT**- Please provide all wage information From:_____ _____ To: _____

| DATE PAY PERIOD ENDED | DATE PAY RECEIVED | AMOUNT OF GROSS PAY | HOURS WORKED |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

☐ **C. OTHER BENEFITS**

Please Check ☐ Sick/FMLA ☐ Workman's Compensation ☐ Lost Wages ☐ Disability ☐ Vacation
Amount of Benefits Receiving: _____
Employer Provides Health Insurance ☐ Yes ☐ No Employee Paid Premium Per Pay Period: _____

☐ **D. TERMINATED EMPLOYMENT**

Date Employment Ended: _____ Is Re-employment Likely?_____
Reason No Longer Employed:

_____

☐ **Company Signature/Title** **Date** **Phone #** **Fax #**

**I hereby give permission for release of the above information.**

_____
Applicant/Representative Signature Date