



EMPLOYMENT INFORMATION REQUEST

To:	Date:
Address:	Client Name:
City, State, ZIP:	Social Security Number:
Case Number:	Caseworker:

By my signature, I grant permission to the employer to release this information to the HCDJFS.

<hr/> <p><u>CLIENT SIGNATURE</u></p>

<p><i>Employers:</i> Please complete the information below and return it via fax or mail within five days. Your cooperation is greatly appreciated.</p>
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Date employment began _____ Date employment ended _____

Avg # of hours to be worked per week: _____ Frequency of pay: _____ Weekly _____ Biweekly _____ Other _____

Reason for leaving employment: _____

Date of first pay _____ Date of last pay _____ Rate of pay \$ _____

Health Insurance/Medical Coverage? (Y/N) _____ Provider: _____

Please indicate the 6 most recent pays below:

Pay period ending	# of hours worked	Date pay received	Gross pay amount
1.			
2.			
3.			
4.			
5.			
6.			

If we have further questions about the information, who may we contact?

Name : _____ Title: _____

Phone Number: _____ Fax number: _____