**DELAWARE HEALTH AND SOCIAL SERVICES**
**DIVISION OF SOCIAL SERVICES**

Case #: _____

# VERIFICATION OF EMPLOYMENT

To: _____ Date: _____

_____ Employee Name: _____

_____ Employee Date of Birth: _____

**I hereby give permission to release my employment information requested below.**

_____

Employee/Authorized Representative Signature Date

Dear Employer:

The above named individual has agreed to allow the Division of Social Services (DSS) to contact you to verify employment. Please complete the information checked below, sign, and mail or fax this form to the DSS office. If there are any questions, please contact me.

Sincerely,

DSS Worker Name: _____ DSS Address: _____

DSS Phone #: _____ DSS Fax #: _____ _____

## ☐ NEW EMPLOYMENT

Employee position: _____ Date employment began: _____

Date of first pay: _____ Hours per pay period: _____ Hourly wage: $_____

Does the employee receive tips? ☐ Yes ☐ No What is the average amount of tips per pay period? $_____

How often is the employee paid? ☐ Weekly ☐ Bi-weekly ☐ Twice a month ☐ Monthly

## ☐ CURRENT EMPLOYMENT – Please provide all wage information from _____ to _____.

| Date Pay Period Ended | Date Pay Received | Amount of Gross Pay | Hours Worked |
|---|---|---|---|
| | | $ | |
| | | $ | |
| | | $ | |
| | | $ | |
| | | $ | |

## ☐ OTHER BENEFITS

Does the employee receive any of these benefits?

☐ Vacation Leave ☐ Sick Leave/FMLA ☐ Disability ☐Worker's Compensation ☐ Lost Wages

Gross amount of benefits received: $_____ How often paid: _____

Employer provides health insurance? ☐ Yes ☐ No Employee paid premium per pay period: $_____

## ☐ TERMINATED EMPLOYMENT

Date employment ended: _____ Is re-employment likely? ☐ Yes ☐ No

Reason employment was terminated: _____

_____

**Employer Signature:** _____ **Title:** _____ **Date:** _____

**Printed Name:** _____ **Phone #:** _____ **Fax #:** _____