EARLY LEARNING
COALITION OF HILLSBOROUGH COUNTY

Verification of Employment

School Readiness Program

(Rev. 9.22.17)

Form must be completed by the employer. The information will be used to determine eligibility for services for the employee below.

Date: _____

Dear Employer:

In order to determine the eligibility of _____ for financial assistance with the Early Learning Coalition of Hillsborough County School Readiness Programs, please assist us by completing this form and returning it to your employee as soon as possible. The employee has been given fourteen (14) calendar days to return this form to our office.

Current employer, fill out Sections I, II, and III.

SECTION I: EMPLOYEE INFORMATION

Name of Employee: _____Last Four of Social Security #: _____

Date Current Employment Began: _____ Date First Pay Expected: _____

Rate of Pay: _____ Per: _____ Does the Employee Receive Tips: ☐ Yes ☐ No

(If yes, show tips in Section II)

How Many Hours Per Week Does the Employee Work? _____

What Shift Does the Employee Work? _____ Time: _____

Does the Employee Work Weekends? ☐ Yes ☐ No Days Scheduled Off: _____

Is Employment: ☐ Permanent ☐ Temporary ☐ Seasonal from: _____ to _____

What Day of the Week Does the Employee Get Paid? _____

SECTION II: PAYROLL RECORD

In the table below, list the requested information for the most recent six (6) weeks:

Pay Date	Gross Earnings	Net Pay	Number of Hours Worked	*Amount of tips *(if not known, state amount customary for job performed.)*	Bonuses / Commissions	Child Support Deductions

If number of hours or rate of pay varies in the above pay periods, please explain: _____

_____

_____

SECTION III: CURRENT EMPLOYER INFORMATION

The information written on this form is true and accurate to the best of my knowledge. I am aware that if I have given false information intentionally, I may be subject to prosecution for fraud.

Name of Business: _____

Business Address: _____ Phone Number: _____

_____ _____ _____

Signature of Person Completing Form | Title | Date

Former employer, complete section IV only.

SECTION IV: LOSS/BREAK OF INCOME OR EMPLOYMENT

Name of Employee: _____ Last Four of Social Security #: _____

Date Employment Ended: _____ Reason: _____

Loss/Break of Income of Employment Termination is: ☐ Permanent ☐ Unpaid Leave ☐ Temporary

If unpaid leave or temporary, when will the employee return back to work? _____

The information written on this form is true and accurate to the best of my knowledge. I am aware that if I have given false information intentionally, I may be subject to prosecution for fraud.

Name of Business: _____

Business Address: _____ Phone Number: _____

_____ _____ _____

Signature of Person Completing Form | Title | Date

OFFICE USE ONLY:
Loss/Break of Employment Verified By: _____ **Date Received:**_____

Phone: _____ **Verified with:** _____ **Position:** _____

Verification Attempts (1): **Date:** _____ **Time:**_____ **CSS:**_____

Verification Attempts (2): **Date:** _____ **Time:**_____ **CSS:**_____