

EMPLOYMENT VERIFICATION

(This form should be completed by the employer only)

		Date Received by Local Agency
Agency Name COLUMBIA COUNTY DEPT OF HEALTH & HUMAN SERVICES		Agency Phone (608) 742-9227
Agency Address (number, street, city, state) 2652 Murphy Rd Mail to: P.O. BOX 136, PORTAGE, WI 53901		FAX # 608-742-9700
Worker Name	Worker Number	Date Sent

Please Complete All Requested Information Checked Below

Employer Information		Employee Information
Name		Name
Address (street, city, state, ZIP code)		Address (street, city, state, ZIP code)
<input type="checkbox"/> Wisconsin ID Number	<input type="checkbox"/> Federal ID Number	Social Security Number

<input type="checkbox"/> Dates of employment From: _____ To: _____	<input type="checkbox"/> Date of first check	<input type="checkbox"/> Day of week paid	<input type="checkbox"/> Frequency of pay:	<input type="checkbox"/> Weekly
			<input type="checkbox"/> Bi-weekly	<input type="checkbox"/> Semi-monthly
				<input type="checkbox"/> Monthly
<input type="checkbox"/> Number of hours per week it is anticipated the employee will work			<input type="checkbox"/> Is this considered	<input type="checkbox"/> Rate per hour
			<input type="checkbox"/> Full time <input type="checkbox"/> Part time	\$ _____

Enter Information For Pay Received In The Months Indicated (including reported tips)

<input type="checkbox"/> Month of: _____					<input type="checkbox"/> Month of: _____					<input type="checkbox"/> Month of: _____				
Date Paid	Rate of Pay	Number of hours worked Reg OT		Gross Amount	Date Paid	Rate of Pay	Number of Hours Worked Reg OT		Gross Amount	Date Paid	Rate of Pay	Number of Hours Worked Reg OT		Gross Amount

Will the employee be receiving any of the following? (check all that apply)

Tips	<input type="checkbox"/> No <input type="checkbox"/> Yes	Amount \$ _____	Frequency _____
Overtime	<input type="checkbox"/> No <input type="checkbox"/> Yes	Amount \$ _____	Frequency _____
Sick benefits	<input type="checkbox"/> No <input type="checkbox"/> Yes	Amount \$ _____	Frequency _____
Shift Differential	<input type="checkbox"/> No <input type="checkbox"/> Yes	Amount \$ _____	Frequency _____
Bonuses/Commissions	<input type="checkbox"/> No <input type="checkbox"/> Yes	Amount \$ _____	Frequency _____
Other _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	Amount \$ _____	Frequency _____

<input type="checkbox"/> Does employer offer any type of medical insurance coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, when would it be available to this employee? _____/_____/_____	Does the employer pay at least 80% of the health insurance premium? <input type="checkbox"/> No <input type="checkbox"/> Yes	Is the employee currently covered? <input type="checkbox"/> No <input type="checkbox"/> Yes
Name and address of insurance company:		List dependents covered and effective date of coverage for each.	

<input type="checkbox"/> Has employee been terminated? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, type of termination <input type="checkbox"/> Quit <input type="checkbox"/> Layoff <input type="checkbox"/>	Effective date of termination (mm/ddd/yy)
<input type="checkbox"/> Date of final check	<input type="checkbox"/> Gross amount of final check	<input type="checkbox"/> Is the employee on strike? <input type="checkbox"/> Yes <input type="checkbox"/> No

<input type="checkbox"/> _____ Signature of person completing the form	_____ (_____) _____ Title	_____ _____ Phone	_____ _____ Date
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