Employment Verification Letter

County Name: _____

Client Name: _____ *Case #:* _____

Client SSN: _____

To Be Completed By Your Employer (The following information is necessary to determine eligibility for Child Care Assistance):

Name of the business: _____

Business Address: _____

First day of Employment: _____ First date of Check: _____

Expected Weekly Work Schedule:

Sun	Mon	Tue	Wed	Thur	Fri	Sat	Total Hrs per week

Please fill in above weekly schedule – If flex schedules please mark any regular days off (OFF) – Fill in other days with the range of hours the person may work.

Rate of Pay: $_____ Monthly Gross Wages: $_____ Taxes Withheld: ☐ Yes ☐ No

Additional income (overtime/commissions/bonuses/tips*) ☐ Yes (If yes complete the following) ☐ No

How Much: _____ How Often: _____

*If tips, what percentage is reported: _____

The above person has indicated that s/he is employed with your business. Please complete the following information.

_____ _____
Printed Name Title

_____
Phone Number

_____ _____
Signature Date