

Employment Verification

DSHS MAILING ADDRESS

DSHS, PO BOX 11699, TACOMA WA 98411-9905

DSHS PHONE NUMBER

DSHS FAX NUMBER

888-338-7410

CASE / CLIENT ID NUMBER

DATE

Please use blue or black ink and print or type.

Section 1: To be filled out by the client/employee.

I authorize my employer to release information to the Department of Social and Health Services.

EMPLOYEE'S SIGNATURE

SOCIAL SECURITY NUMBER (OPTIONAL)

DATE

Section 2: To be filled out by the employer.

EMPLOYEE'S NAME

EMPLOYER'S NAME

EMPLOYEE'S JOB TITLE

EMPLOYER'S ADDRESS

Is this a new job? ☐ No ☐ Yes

DATE EMPLOYEE STARTED WORK

DATE FIRST CHECK WAS RECEIVED

AVERAGE HOURS PER WEEK

RATE OF PAY OR SALARY (HOURLY,
DAILY OR PIECE RATE)

Has job ended? ☐ No ☐ Yes
If yes, when: why:

Pay frequency: ☐ Daily ☐ Weekly ☐ Every two weeks ☐ Two times a month ☐ Monthly

IS THIS JOB WORK
STUDY?

☐ Yes ☐ No

WHAT TYPE OF WORK
STUDY?

☐ State ☐ Federal

IF YES, PROVIDE VERIFICATION OF
TOTAL FINANCIAL AID AWARD

WHEN WILL YOUR
POSITION END?

Actual gross income (or attach payroll printout) for last three months:

MONTH:

\$

MONTH:

\$

MONTH:

\$

Actual gross income for current month and anticipated gross income for next two months:

CURRENT MONTH:

\$

MONTH:

\$

MONTH:

\$

Tips ☐ No ☐ Yes; if yes, how often and how much? _____

Commissions ☐ No ☐ Yes; if yes, how often and how much? _____

Bonuses ☐ No ☐ Yes; if yes, how often and how much? _____

Overtime ☐ No ☐ Yes; if yes, how often and how much? _____

Work schedule (include exact times when possible):

MONDAY

TUESDAY

WEDNESDAY

THURSDAY

FRIDAY

SATURDAY

SUNDAY

Is Health Insurance available? ☐ Yes ☐ No

If yes, is employee enrolled in the health plan? ☐ Yes ☐ No

When does the coverage begin?

What is the employee's portion of premiums?

EMPLOYER/REPRESENTATIVE'S SIGNATURE

DATE

EMPLOYER/REPRESENTATIVE'S PRINTED NAME AND TITLE

PHONE NUMBER