Southwest Ohio
County Departments of
Job & Family Services

County Agency: Hamilton County Job & Family Services
Address: 222 E. Central Parkway, Cincinnati, OH 45202
Phone: (513) 946-1000
Fax: (513) 946-1076
Website: www.hcjfs.org

Employment Verification Request

JFS Worker:	Phone:	Date:	Return by:
Employer Name:			Employee Name:
Employer Address:			Social Security Number:
City:	State:	Zip:	Case Number:

By applying for CDJFS programs, the individual has agreed that the CDJFS may contact other persons or organizations to obtain the necessary proof of eligibility and level of assistance. In addition, Ohio Revised Code 5101.37 authorizes the CDJFS to make investigations that are necessary in the performance of their duties.

Authorization for Release of Information

I agree that the employer named below may release my employment information to Hamilton County Job & Family Services & the Cincinnati Metropolitan Housing Authority.

This information will be used to determine eligibility for: ☐ Cash Assistance; ☐ Food Assistance; ☐ Medical Assistance; ☐ Other, specify: _____.

I am aware of my responsibilities to report completely and fully all facts which bear upon my eligibility for assistance. I realize if the requested information reveals I have improperly reported my situation, the information may be given to the prosecuting attorney for possible civil action or criminal prosecution.

Signature of Applicant/Recipient: _____ **Date:** _____

Employer to Complete

Dates of Employment

Corporate Name:	***If employment has ended, also complete this section.***		
Name of Employment Site:	Last Day Worked:	Date Last Pay Received:	Type of Separation:
First Day Worked:	☐ Laid Off ☐ Illness or Injury ☐ No Call or Show ☐ Other (specify): _____ ☐ Resignation ☐ Eligible for Post-Employment Benefits (specify): ☐ Discharged		
Date First Pay Received:			
List interruption or leave period during employment. From Date: _____ To Date: _____	Strike Start Date:	Strike End Date:	Effective Lockout Date:

Rate/Hours/Pay Frequency

Current Hourly Rate:	Day of Week Paid:	Pay Period Frequency: ☐ Weekly ☐ Twice Monthly ☐ Biweekly ☐ Other (Specify) _____	Overtime is: ☐ Not expected to be worked in the future ☐ Worked routinely monthly

Number of set hours to work per Week: _____; OR Number of hours will vary from _____ to _____ per Week

Wages (Last 6 Pays)

Period Ending	Date Received	Hours	Hourly Rate	Gross Pay *Without* Tips, Bonus or Commission	Tips	Bonus or Commission	Garnishment	Child Support Deduction

Health Insurance

Is the employee or their dependents enrolled in health insurance? ☐ No ☐ Yes	Begin Date:	End Date:	Policy Number:	Group Number:
Name/Address of Insurance Company:	List Covered Members:			

Additional Information Needed For Time Period Below (See Reverse only if Time Period is Noted Below)

Time Period Requested – From Date:	To Date:

Employer Signature

Employer Representative Signature:	Title:	Phone:	FAX:	Date:

Employee Name:	Employee Social Security Number:

If indicated on the front side, complete the following information for the time period indicated on page 1 of this form. If it is more convenient or you need more space, please substitute copies of the employee's payroll records.

Date Pay Received	Gross Pay Without Tips, Bonus or Commission	Tips	Bonus or Commission	Garnishment	Child Support Deduction

Other Information Requested

Requested Information:

Employer Response to Requested Information:

Employer Signature

Employer Representative Signature:	Title:	Date:

Phone:	FAX: