

Verification of New/Current Employment

Case Name: _____ Date: _____

HEAplus Application ID: _____ AZTECS Case Number: _____

The person whose name and signature appears below, or on the attached copy of the signature page of the DES/FAA Application, has requested your cooperation in releasing the following information. Please complete the form and fax it to: 602-257-7031 or 1-844-680-9840. For questions, call 1-833-397-3155.

Authorization to Release Information/Autorización para dar información

I authorize the release of any information requested below concerning myself and my household members to the Arizona Department of Economic Security.

Autorizo la divulgación de cualquier información solicitada a continuación sobre mí y los miembros de mi hogar al Departamento de Seguridad Económica de Arizona.

Employed Household Member's Name (Last, First, M.I.) /
Nombre del Miembro del hogar empleado (Apellido, nombre, segundo inicial):

Employee's Social Security Number / *Número de Seguro Social del empleado:* _____

Employed Household Member's Signature / *Firma del Miembro del hogar empleado:* _____ Date / *Fecha:* _____

Signed release attached. A photocopy or fax of a client's or employee's signature shall be treated as an original signature.
New/current employers please complete all questions in Sections A, B and C.

A. New/Current Employer

Date Hired: _____ Anticipated Date of First Check: _____

Rate of Pay: \$ _____ Per: _____ Anticipated Gross Income \$ _____

Number of Hours Worked Per Week (*If hours per week vary, indicate the range possible*): From _____ To _____

Number of Hours Worked Per Day (*If hours vary, indicate the range possible*): From _____ To _____

Days of Week Worked (*check all that apply*):

- Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Does the employee receive any tips/bonus/commission/shift pay? Yes No Type: _____

If yes, what is the range of possible amounts that the employee can receive? From _____ To _____

Frequency of pay: _____ Is this pay normal? Yes No

Are wages received under the Workforce Investment Act (WIA) Program? Yes No

Is the employee reimbursed for (*check one*): Travel Lodging Uniforms

How often? _____ Amount \$ _____

Case Name: _____

Case Number: _____

Employed Household Member's Name: _____

Employee's Social Security Number: _____

A. New/Current Employer (Continued)

Employee is paid: Daily Weekly Bi-weekly Twice monthly Monthly
 Other _____

Is pay direct deposited? Yes No

If yes, Name of bank: _____

Day of week or date(s) pay period starts: _____ ends: _____

Overtime Rate \$ _____ Overtime Hours Per Week: _____ Will overtime continue? Yes No

Contract? Yes No

(If yes, attach copy and provide the gross earnings for each month(s) and year(s) indicated on Section C on page 3.)

Per Job (Rate) \$ _____ Hourly (Rate) \$ _____ Other _____

Child support withholding? Yes No Amount \$ _____ How often? _____

Expected changes in income? Yes No

When? _____ Increase Decrease Why? _____

Worker's Compensation (*claim pending, or claim being paid*)? Yes No

Carrier's Name: _____

Is the employee on a leave of absence? Yes No

When does the leave of absence begin? _____

When is the leave of absence expected to end? _____

Is the leave of absence paid or unpaid? Paid Unpaid

Is the employee receiving short term disability? Yes No How often? _____ Amount \$ _____

Is the employee receiving long term disability? Yes No How often? _____ Amount \$ _____

Does your company offer health insurance? Yes No

(If yes, continue to Section B.)

B. Health Insurance Information

Does the employee currently have (or has had) health insurance with your company? Yes No

If yes, complete information below. If no, did employee decline health insurance? Yes No

Name of Insurance Company: _____

Address (*No., Street*): _____

City: _____ State: _____ ZIP Code: _____

Policy Number: _____ Policy Date: From _____ To _____

List Insured Dependents:

Relationship to Employee:

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

1. mail:

Food and Nutrition Service, USDA
1320 Braddock Place, Room 334
Alexandria, VA 22314; or

2. fax:

(833) 256-1665 or (202) 690-7442; or

3. email:

FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.

To request this document in alternative format or for further information about this policy, contact your local office; TTY/TDD Services: 7-1-1.