ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Family Assistance Administration

↥ **Local Office Return Address** ↧
(Use the DES-166 envelope)

VERIFICATION OF TERMINATED EMPLOYMENT

Date: _____ Case Number / HEA Plus App ID: _____

Case Name *(Last, First, M.I.)*: _____

For questions, call 1-833-397-3155
Fax completed form to 602-257-7031 or 1-844-680-9840

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 and return this form via fax to the number written above.

AUTHORIZATION TO RELEASE INFORMATION/*AUTORIZACIÓN PARA DAR INFORMACIÓN*

I hereby authorize release of any and all information requested below concerning myself and my household members to the Arizona Department of Economic Security. *Por la presente autorizo y doy mi consentimiento para que se entregue al Arizona Department of Economic Security toda y cualquier información que se pide a continuación acerca de mí o de los miembros de mi hogar.*

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

_____

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

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

☐ Signed release attached. A photocopy or fax of a client's or employee's signature shall be treated as an original signature.

Former employers please complete all questions in Sections A, B and C.

A. FORMER EMPLOYER

Date hired: _____ Date first check was issued: _____ Gross amount of first check: $ _____

Employee Termination:

Last day worked: _____ Date final check was/will be issued: _____ Gross amount of final wages: $ _____

Reason for Termination:

☐ Laid off ☐ Fired ☐ Quit *(Specify reason)*: _____

☐ Retired *(Monthly benefit)* $ _____ ☐ Other: _____

See page 2 for USDA/EOE/ADA/LEP/GINA disclosures

Case Name: _____ Case Number: _____

Employed Household Member's Name: Employee's Social Security Number:

_____ _____

Paychecks Received From: **to Final Pay:**

MONTH / YEAR	PAY PERIOD ENDING	DATE ACTUALLY PAID	GROSS EARNINGS	HOURS	TIPS
			$		$
			$		$
			$		$
			$		$
			$		$
			$		$
			$		$
			$		$

B. BENEFITS RECEIVED

Benefits received: ☐ Sick Leave ☐ Vacation Leave ☐ Disability ☐ Severance

How were these Benefits paid? ☐ Included in final wages ☐ Received in one payment
☐ Paid in installments *(Include future payments)*

If paid in installments, Date? The Gross Amount?		If included in the Final Wages, what type? The Gross Amount?	
Date	Amount	Type	Amount

Was the employee covered by health insurance through your company? ☐ Yes ☐ No

Have benefits stopped? ☐ Yes ☐ No Date: _____

C. COMPANY INFORMATION

Print Name of Person Completing Form: _____

Signature of Person Completing Form: _____

Title: _____ Name of Company: _____

Company Address: _____

Phone Number: _____ Fax Number: _____ Date: _____