

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF ECONOMIC ASSISTANCE



RE: Wage Information For

Dear

The individual named above has authorized the release of information to the Department of Social Services (DSS). Please complete the reverse side of this form and return it in the enclosed stamped, self-addressed envelope or by faxing it to our office if there is a number listed above.

Through coordinated efforts of the DSS and Department of Labor local offices, our programs have increased responsibility in:

- ◆ Helping adults who are able to work become employed and/or stay employed; and
- ◆ Accurately reflecting income received by individuals on our programs to reduce the risk of a financial sanction against the State of South Dakota.

Please feel free to contact me if you have questions. Thank you for your anticipated cooperation.

Sincerely,

Economic Assistance Benefits Specialist

WAGE VERIFICATION – Please Return To: _____ **Fax #** _____

I AUTHORIZE THE RELEASE OF THIS INFORMATION TO THE DEPARTMENT OF SOCIAL SERVICES.
 _____ (EMPLOYEE SIGNATURE)

Please complete all sections as indicated for _____
 _____ Employee Name Social Security Number

1. He/she received the following earnings for the time frame _____ through _____
 Please report on this form using fields below or submit payroll records, computer printouts, prints of computer screens, or copies of the pay stubs.

| | | | | | |
|---|----------------|----------------|----------------|----------------|----------------|
| Date RECEIVED by Employee | ____/____/____ | ____/____/____ | ____/____/____ | ____/____/____ | ____/____/____ |
| Hours Worked | _____ hrs | _____ hrs | _____ hrs | _____ hrs | _____ hrs |
| GROSS Earnings | \$ _____ | \$ _____ | \$ _____ | \$ _____ | \$ _____ |
| TIPS – list only if not in gross | \$ _____ | \$ _____ | \$ _____ | \$ _____ | \$ _____ |
| Child Support Deducted | \$ _____ | \$ _____ | \$ _____ | \$ _____ | \$ _____ |
| NET Earnings | \$ _____ | \$ _____ | \$ _____ | \$ _____ | \$ _____ |

2. **Employment began** on ____/____/____ **First pay received or to be received** ____/____/____

Pay checks received on Mon Tues Wed Thurs Fri Sat Sun
Paid Weekly Bi-Weekly Twice a Month Monthly Other _____

He/she **will work approximately** _____ **hours per week** at \$ _____ **per hour.**

- Is this under Workforce Investment Act (WIA)? Yes-On the Job Training Yes-Work Experience No
- Is this graduate assistantship or stipend? Yes No
- Is this job expected to last at least 120 days? Yes No

3. Do you anticipate any increases or decreases in hours or pay? Yes No If yes, please explain:

 Did the employee cause a reduction in hours? Yes No Were increased hours refused? Yes No

4. For employment that has ended: **Last date of employment** was ____/____/____.

Last check was or will be received on ____/____/____ for **Gross Amount** \$ _____.

Reason the job ended:

- Quit Laid off Fired Failed to show up for work
 Medical leave Maternity leave Work was temporary Other _____

- Did employment end due to a layoff or temporary suspension? Yes No If yes, please indicate the date you anticipate calling the employee back to work ____/____/____.
- Will the employee receive any other compensation such as vacation or severance pay, 401K, retirement, etc.? Yes No If yes, \$ _____ **gross** amount and ____/____/____ date available.

5. **Health insurance information:** Name of insurance company: _____

- Insurance not offered or not purchased by employee
 Current coverage start date ____/____/____ policy # _____ Group # _____
 Employee Dependents (please list) _____

Covers (please check): Inpatient Outpatient Prescription Vision Care Dental
 Other _____ Mental Cancer Accident LTC Work Comp

- If employment has ended, did insurance coverage end also? Yes No If yes, please list the individuals covered: _____

The above information was provided by:

Signature and Title of the Individual Completing this Form **Date**

 Please print your name and the name of the business **Business Telephone** **Fax Number**