DSS-EA-324 04/17

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF ECONOMIC ASSISTANCE

DSS
Strong Families - South Dakota's Foundation and Our Future

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 and Regulation (DLR) 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

Case Number_____ Section: __1__

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. Employee received the following earnings for the time frame _____ through _____
Please report on this form using fields below or submit payroll records, computer printouts, 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
How Often Paid: ☐ Weekly ☐ Bi-Weekly ☐ Twice a Month ☐ Monthly ☐ Other_____
Approximately how many hours worked 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

Hired as **Full Time?** ☐ **or Part Time?** ☐ Employee?

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