STATE OF NEVADA

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

DIVISION OF WELFARE AND SUPPORTIVE SERVICES

☐ **TANF** ☐ **MEDICAID** ☐ **SNAP**

Date: _____

Case Name: _____

SSN: _____

Case Manager Signature: _____

**AUTHORIZATION:** I authorize you to release to the Division of Welfare and Supportive Services the requested information.

_____

Client Signature Date

**ATTENTION: Payroll Department**

## EARNINGS VERIFICATION

Please provide the information for each of the items checked below and return to the above address. Your cooperation will help insure integrity and maintain accountability in the administration of public funds in Nevada. The information provided us will be used only in conjunction with the official duties of this department and will be considered confidential.
If our identifying information (name, Social Security number or address) does not agree with your records, please indicate the change.

RE: _____ _____

Name Social Security Number

Employee's Address: _____

☐ 1. Date work began: _____ Number of hours employee is scheduled to work per week: _____

☐ 2. Hourly rate of pay $ _____ ☐ Average hours worked per week: _____ ☐ Date of first paycheck: _____

3. How often are paychecks issued: ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly
When are regularly scheduled paydays? _____

☐ 4. Will "tips" be received? ☐ YES ☐ No If YES: Estimated amount: $ _____ per _____

☐ 5. Is this employment Contractual? ☐ YES ☐ No If YES: Contracted wage amount: $ _____ per _____
Maximum Earnings provided in contract: $ _____ Number of months covered by this contract: _____

☐ 6. Are/Were wages funded in whole or in part by Workforce Incentive (formerly JTPA?) Programs? ☐ YES ☐ NO
If YES, through: ☐ Work experience OR ☐ On-the-job training

☐ 7. Please list below all monies (earnings, sick pay, vacation pay, disability, etc.) PAID or ANTICIPATED TO BE PAID (regardless of when earned to the employee in the month of):

| PAY PERIOD ENDING | HOURS WORKED PER PAY | ACTUAL DATES PAID | GROSS WAGES PAID (Include special allowances such as meals, uniforms, etc., and show a break-out of such amounts) | FICA | FITW |
|---|---|---|---|---|---|
| | | | | | |
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| | | | | | |

☐ 8. Do you anticipate any change in the number of hours, rate of pay or paydays next month: ☐ YES ☐ NO
If YES, please explain the change. _____

☐ 9. Is Medical Insurance available to the employee? ☐ YES ☐ NO If YES, is the employee enrolled? ☐ YES ☐ NO
If YES, provide the policy # _____ Effective Date: _____ End Date: _____
Names of dependents covered: _____

☐ 10 If this person is **NOT** working for you at this time, complete the following information:

| | **DATE** | | |
|---|---|---|---|
| Quit | _____ | | |
| Fired | _____ | Reason for leaving: | _____ |
| Leave of absence | _____ | Expected date of return: | _____ |
| Applied Workers Comp. | _____ | Date of final check: | _____ Gross amount: $ _____ |

_____

Signature of Employer Title Telephone Number Date

**DISTRIBUTION:** WHITE - Employer; CANARY - Suspense