Arkansas Department of Human Services
Verification of Earnings

TO EMPLOYER:
To determine eligibility and correct benefits for your employee we need the information requested below. **This will enable us to ensure that the public funds are used only for the actual and correct benefits to which a household is entitled.** PLEASE COMPLETE THE ITEMS CIRCLED AS WELL AS THE SIGNATURE SECTION AT THE BOTTOM OF THIS FORM.
If you need this material in a different format such as large print, contact your local DHS county office.

_____ **Address** Department of Human Services
Caseworker

_____ _____
Telephone Number TDD#

_____ _____
Employee **Casehead**

_____ _____
SSN of Employee Case Number

1. The above employee began work _____ and earns $_____ per hour. He/she works an average of _____ hours per week. Date first pay to be received _____.
   Anticipated gross amount of 1st pay $_____.
   Employee is paid: ☐ Weekly ☐ Monthly ☐ Other -- Please indicate how often _____
   ☐ Every 2 weeks ☐ Twice Monthly
2. Please show GROSS EARNINGS (before any deductions) PAID TO this employee as indicated. Please list each pay check separately **including vacation pay and bonuses.**

	Pay Period Ending	**Date Received**	**Hours Worked**	**Gross Wages**	**Tips**	**Housing/Utilities** Paid above wages
☐ REC'D in the Month of January						
☐ For the past _____ consecutive pay periods						

3. **Earnings:** Are any of the earnings funded by JTPA - On The Job Training Program? ☐ Yes or ☐ No

4. **Termination:** If employee no longer is employed by you, what was the date and reason for leaving this job?
   _____
   Date last check will be received _____ and gross amount _____
5. Additional Information/Expected Changes: (such as layoffs, raises, increased or reduced hours, vacation pay, bonuses, and sick pay).
   _____
6. **Insurance:** If employee has insurance through this job, what is the name and address of the insurance carrier?_____
   Claims processing address if different than insurance carrier _____
   Policy Number _____ Effective date of policy _____
   Type of coverage _____ Policy: ☐ individual or ☐ group
   Policyholder and covered individuals _____
   I do hereby certify that the above information is factual and correct to the best of my knowledge.

_____ _____ _____
Employer/Payroll Clerk Signature Date Telephone

_____ _____
Place of Business Address