Southwest Ohio
County Departments of
Job & Family Services

County Agency: WARREN COUNTY HUMAN SERVICES
Address: 416 S. EAST STREET, LEBANON, OHIO 45036
Phone: (513)695-1420
Fax: (513)695-2702
Website: http://www.co.warren.oh.us/humanservices

EMPLOYMENT VERIFICATION REQUEST

JFS Worker:	Phone:	Date:	Return by:
Employer Name:			Employee Name:
Employer Address:			Social Security Number:
City:	State:	Zip:	Case Number:

By applying for CDJFS programs, the individual has agreed that the CDJFS may contact other persons or organizations to obtain the necessary proof of eligibility and level of assistance. In addition, Ohio Revised Code 5101.37 authorizes the CDJFS to make investigations that are necessary in the performance of their duties.

EMPLOYER TO COMPLETE

Dates of Employment

Corporate Name:

Name of Employment Site:

First Day Worked:

Date First Pay Received:

List interruption or leave period during employment.

From Date: __________ To Date: __________

If employment has ended, also complete this section.

Last Day Worked:	Date Last Pay Received:	Type of Separation:

☐ Laid Off
☐ No Call or Show
☐ Resignation
☐ Discharged
☐ Illness or Injury
☐ Other (specify): ____________________
☐ Eligible for Post-Employment Benefits (specify):
____

Strike Start Date:	Strike End Date:	Effective Lockout Date:

Rate/Hours/Pay Frequency

Current Hourly Rate:	Day of Week Paid:	Pay Period Frequency: ☐ Weekly ☐ Twice Monthly ☐ Biweekly ☐ Other (Specify) ____________	Overtime is: ☐ Not expected to be worked in the future ☐ Worked routinely monthly

Number of set hours to work per Week: ______________________; OR Number of hours will vary from __________ to __________ per Week

Wages (Last 6 Pays)

Period Ending	Date Received	Hours	Hourly Rate	Gross Pay *Without* Tips, Bonus or Commission	Tips	Bonus or Commission	Garnishment	Child Support Deduction

Health Insurance

Is the employee or their dependents enrolled in health insurance? ☐ No ☐ Yes	Begin Date:	End Date:	Policy Number:	Group Number:

Name/Address of Insurance Company:	List Covered Members:

Additional Information Needed For Time Period Below (See Reverse only if Time Period is Noted Below)

Time Period Requested – From Date:	To Date:

Employer Signature

Employer Representative Signature:	Title:	Phone:	FAX:	Date:

Employee Name:	Employee Social Security Number:

If indicated on the front side, please complete the following information for the time period indicated on the front of this form. If it is more convenient or you need more space, you may substitute copies of the employee's payroll records.

Date Pay Received	Gross Pay Without Tips, Bonus or Commission	Tips	Bonus or Commission	Garnishment	Child Support Deduction

Other Information Requested

Requested Information:

Employer Response to Requested Information:

Employer Signature

Employer Representative Signature:	Title:	Date:

Phone:	FAX: