APPLICANT/RECIPIENT AUTHORIZATION FOR RELEASE OF INFORMATION

Name and Address of Employer Asked to Supply Information		
	Customer Name	**Case Number**
	CDJFS Representative (Full Name required)	
	Last 4 of SSN:	**Date Requested**

I agree that the person named above may release to the **ALLEN County Department of Job and Family Services** the following information: Employment verification as requested on the reverse side of this form.
This information will be used to determine eligibility for public assistance and/or food stamps.
I am aware of my responsibility to report completely and fully all facts, which bear upon my eligibility for all public assistance and/or food stamps. I realize if the requested information reveals I have improperly reported my situation, the information may be given to the prosecuting attorney for possible civil action or criminal prosecution.

Completion of this form is voluntary, but necessary to determine eligibility for assistance.

Signature of Applicant/Recipient	Date

Job Family SERVICES Allen County

Joe Patton, Director
951 Commerce Parkway
Lima, Ohio 45804

EMPLOYMENT VERIFICATION

This side is to be completed by

Employee Name: SS#: XXX-XX-

Beginning Date of Employment _____ Ending Date of Employment _____

Job Position / Title _____

Was / Is employed: full-time _____ part-time _____ Hours anticipated / Week _____

Pay Frequency: weekly _____ bi-weekly _____ semi-monthly _____ monthly _____

Does your business have regularly scheduled overtime? _____ If yes, average number of hours per week: _____

Hourly rate? _____ Overtime rate per hour? _____ Length of Probationary Period? _____

If currently employed, is the individual subject to any of the following? (Check those which apply, and the amounts paid or withheld) Earned Income Credit _____ Garnishment of Court-ordered Child Support _____

Other: _____

Is employee enrolled in group medical insurance? Yes_____ No_____ If yes, date of enrollment_____

Individuals covered? _____

Name and address of insurance company _____

Reason Employment Ended_____

PLEASE USE REVERSE SIDE OR ADDITIONAL PAPER IF NECESSARY.

PAY HISTORY (Note: Breakdown by Pay Period is a Must, please include each pay date and gross amount paid)

Date Paid	Gross Amount Paid	Rate	Tips (if not in gross)	Hours Worked	Date Paid	Gross Amount Paid	Rate	Tips (if not in gross)	Hours Worked

To your knowledge, has this person ever received: Workers' Compensation, Unemployment Compensation, tips, voluntary payroll withholdings, medical coverage, additional sick pay or any income other than that listed above?

No _____ Yes _____. If yes, please explain what was received and the amount. _____

Signature and position of person completing this form _____

Name and Address of Company _____

Phone _____ **Date**_____