Southwest Ohio County Departments of Job & Family Services

Clermont County DJFS
Office of Adult, Child and Family Stability
2400 Clermont Center Dr., Batavia, Ohio 45103
Phone: 513-732-7111
Fax: 513-732-7216, 513-732-7195
Website: www.acfs.clermontcountyohio.gov

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

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

Rate/Hours/Pay Frequency

Current Hourly Rate:	Day of Week Paid:	Pay Period Frequency:	Overtime is:
		☐ Weekly ☐ Twice Monthly ☐ Biweekly ☐ Other (Specify) _____	☐ 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: