



**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:		<i>If employment has ended, also complete this section.</i>	
Name of Employment Site:		Last Day Worked:	Date Last Pay Received:
First Day Worked:		<input type="checkbox"/> Laid Off <input type="checkbox"/> Illness or Injury <input type="checkbox"/> No Call or Show <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Resignation <input type="checkbox"/> Eligible for Post-Employment Benefits (specify): _____ <input type="checkbox"/> Discharged	
Date First Pay Received:		_____	
List interruption or leave period during employment.		Strike Start Date:	Strike End Date:
From Date: _____ To Date: _____			Effective Lockout Date:

Rate/Hours/Pay Frequency			
Current Hourly Rate:	Day of Week Paid:	Pay Period Frequency:	Overtime is:
		<input type="checkbox"/> Weekly <input type="checkbox"/> Twice Monthly <input type="checkbox"/> Biweekly <input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Not expected to be worked in the future <input type="checkbox"/> 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 <i>Without</i> Tips, Bonus or Commission	Tips	Bonus or Commission	Garnishment	Child Support Deduction

Health Insurance				
Is the employee or their dependents enrolled in health insurance?		Begin Date:	End Date:	Policy Number:
<input type="checkbox"/> No <input type="checkbox"/> Yes				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:

