**Employment Verification Letter**

County Name:

Client Name: Case #:

Client SSN:

To Be Completed By Your Employer (The following information is necessary to determine eligibility for Child Care Assistance):

Name of the business:

Business Address:

First day of Employment: First date of Check:

Expected Weekly Work Schedule:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Sun | Mon | Tue | Wed | Thur | Fri | Sat | Total Hrs per week |
|  |  |  |  |  |  |  |  |

Please fill in above weekly schedule – If flex schedules please mark any regular days off (OFF) – Fill in other days with the range of hours the person may work.

Rate of Pay: $

Monthly Gross Wages: $

Taxes Withheld:  Yes  No

Additional income (overtime/commissions/bonuses/tips\*)  Yes (If yes complete the following)  No

How Much: How Often:

\*If tips, what percentage is reported:

The above person has indicated that s/he is employed with your business. Please complete the following information.

Printed Name Title

Phone Number

Signature Date