Early Learning Coalition of Florida's Heartland, Inc.

Verfication of Employment / Loss of Income Form

Employer,

Complete this form in its entirety and return to our office **before:** _____

If you have questions or need clarification, please contact Family Services at **cs@elcfh.org** or by phone:

☐ Charlotte Office - 941-255-1650 ☐ Highlands Office - 863-314-9213

To be completed by employer ONLY

Employee: _____ Employer: _____

Address: _____ Address: _____

City, Zip: _____ City, Zip: _____

Social Security No: _____ Telephone: _____

Hire Date: _____ Job Title: _____ Type of work: _____

Is this a seasonal or temporary position: *Yes* ☐ *No* ☐ *If yes, date position begins:* _____ *Ends:* _____

Hours per week: _____ *Rate of pay: $* _____

Frequency of pay: ☐ *day* ☐ *week* ☐ *bi-weekly* ☐ *twice a month* ☐ *monthly* ☐ *Other* _____

Payment Method: ☐ *Cash* ☐ *Check* ☐ *Direct deposit* ☐ *Electronic transfer (Zelle, Cashapp Etc.)*

Work Week Schedule

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Start time							
End time							

Record of Pay Received for Last 4 Weeks

Pay date	Hours worked	Gross earning	Tips	Net pay

If hours or rate of pay has varied in the above, Please state why. _____

Loss of Employment:

* Last day of employement: _____

* Reason for employment loss: _____

Is the loss Permanent or temporary _____ If temporary, date of expected return: _____

The information I have provided is true and complete to the best of my knowledge. I am aware that if I provide false information I may be subject to presecution for FRAUD.

Signature of employer or company designee _____ Printed name of person completing the form _____ Date of signature _____

Fax number _____ Print Email address _____

Updated: 12/08/2025