



Verification 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 employment:	_____
* 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