VERIFICATION OF INCOME/LOSS OF INCOME

Return to: Early Learning Coalition of Florida's Gateway, Inc.
(ELCFG)
1104 SW Main Blvd
Lake City, FL 32025
Phone 386-752-9770
Fax # 386-752-9786

I, _____ _____, SSN#_____-_____-_____ give my authorization to release my employee information to Early Learning Coalition of Florida's Gateway (ELC-FG) in order to determine my eligibility for child care assistance. Please assist me by answering the questions below and returning this for to ELC-FG before_____.

_____
Parent Signature

PLEASE HAVE EMPLOYER COMPLETE EACH SECTION WHICH HAS BEEN MARKED ON THE FRONT AND BACK OF THIS FORM

☐ **Section I – GENERAL INFORMATION**

1. Name of Employee_____SSN#_____
2. Address of Employee_____
3. Job Title_____ Type of Work Performed_____
4. Number of Hours worked per week_____ Number of Days Worked Per Week_____
   a. How often paid☐ Daily ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Semi-Monthly
   b. Rate of pay $_____per _____(hr/day/wk) Other_____
5. Does parent receive over time? ? ☐ YES ☐ NO If yes how many hours approx. _____
6. Number of dependents claimed_____
7. Date Current employment began_____ Date previously employed_____
8. Does/did employee receive tips? ☐ YES ☐ NO *If yes, show tips in section II.*
9. Is/was employment seasonal? ☐ YES ☐ NO *If yes, season begins* _____*ends* _____
10. Is/was the employee covered by health insurance? ☐ YES ☐ NO
    Name of Insurance Company _____
11. Number of dependents covered _____
12. Does/did the employee participate in any type of payroll savings plan or profit sharing? ☐ YES ☐ NO
    If Yes, what is the balance $_____
13. Is health insurance available to the employee? ☐ YES ☐ NO

☐ **Section II – RECORD OF PAY RECEIVED**

1. List the gross amount and dates of checks or cash which were or will be paid during the months of: _Six weeks of income__ in the space below.

Pay Period Ends	Date Pay Received	Gross Earnings	# of hours worked	Tips	Earned Income Credit	Net Pay

Verification of Income continued:

_____ _____

☐ **Section III – EMPLOYER INFORMATION**

What I have written on this form to the best of my knowledge. I know that if I give false information on the VOI we have now, if any, I may be subject to prosecution for fraud.

_____ _____

Printed Employer Name **Signature of Employer**

_____ _____

Employer Title **Name of Business**

_____ _____

Address **City, State & Zip** **Employer Phone Number**

_____

Date Completed

☐ **Section IV – LOSS OF INCOME**

1. Date employment ended: _____
2. Reason for termination: _____
3. Is the loss of income Permanent Temporary? If temporary, when do you expect the employee to return to work?
   _____
4. Date employee received final check: _____
5. Will employee receive any vacation pay, retirement refund, or other Yes No
6. Is employee eligible for any type of benefits from your company, such as extended insurance coverage, workers' compensation, or other? Yes No If yes:_____
   A. Name of insurance company: _____
   B. Reason for benefits:_____

For Early Learning Coalition of Florida's Gateway use only. Verified on _____by _____

Comments:

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