

VERIFICATION OF SELF-EMPLOYMENT

The following information is necessary to determine eligibility for Child Care Assistance.

TO BE COMPLETED BY CCCAP CLIENT:

CCCAP Caseworker Name or Ext.: _____ Date: _____

CCCAP Client Name: _____ Social Security #: _____

===== **TO BE COMPLETED BY EMPLOYER:** =====

Name of Business: _____

Business Address: _____
City/State

First Day of Employment: _____ First Check Date: _____

WEEKLY WORK SCHEDULE: (Please list typical schedule i.e. 9-5)

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 as best you can, include earliest time in/latest time off.

If FLEX schedule: Average hours per week _____ (min # hrs) _____ (max #hrs)

Earliest time in _____ Latest time out _____

Rate of pay: _____ Monthly Gross Wages: _____ Taxes withheld Yes No

How often paid? Weekly Biweekly Twice a month Monthly Other _____

Additional income (overtime/commission/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 and return to employee or directly to AFS at the address or number at the bottom of the page.

I confirm that the above information is complete and accurate:

Printed Name

Title

Signature

Phone Number

Date

**Adams County Department of Human Services
Colorado Child Care Assistance Program
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