



Verification of Employment Termination



The person below has indicated that s/he is(or was) employed with your business. Please complete the following information and return to employee or directly to Adams County Human Services Child Care Assistance Program at the address at the bottom of the page or via facsimile. The Following information is necessary to determine eligibility for Child Care Assistance. Thank you for your time.

TO BE COMPLETED BY EMPLOYER (former):

Employee Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Name of Business: \_\_\_\_\_

Business Address: \_\_\_\_\_

Last day of employment: \_\_\_\_\_ Last check date: \_\_\_\_\_

EMPLOYEE'S PAY & WORK SCHEDULE:

Last check date: \_\_\_\_\_ Wages: \_\_\_\_\_ hr/mo Taxes withheld:  Yes  No

Pay frequency:  Weekly  Bi-weekly  Semi-monthly  Monthly/other: \_\_\_\_\_

Additional income (overtime/commission/bonuses/tips\*)  No  Yes \*If yes, complete the following:

How much: \_\_\_\_\_ How often: \_\_\_\_\_ \*If tips, what percentage is reported: \_\_\_\_\_

WEEKLY WORK SCHEDULE:

Table with 8 columns: SUN, MON, TUE, WED, THUR, FRI, SAT, TOTAL HRS PER WEEK

Please fill in above weekly schedule. If varied schedule, please mark any regular days off "OFF." Fill in other days to the best of your ability. Include earliest time in/latest time off.

IF VARIED schedule, average hours per week: \_\_\_\_\_ (min #hrs.) \_\_\_\_\_ (max #hrs.)

Earliest time in: \_\_\_\_\_ Latest time out: \_\_\_\_\_

I confirm that the above information is complete and accurate to the best of my knowledge.

Printed name

Title

Phone number

email (optional)

Signature of employer

Date

Adams County Department of Human Services
Colorado Child Care Assistance Program
11860 Pecos St
Westminster, CO 80234

Phone: 720-523-2337
Fax: 720- 523-2201