GOVERNMENT OF GUAM

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES

DIPATTAMENTON SALUT PUPBLEKO YAN SETBISION SUSIAT

EMPLOYMENT VERIFICATION

Date:_____

To:_____

_____

_____

Dear Sir/Madam:

Federal regulations require all wages and salaries for Mr./Ms. _____, SSN_____, be verified in order for us to determine this person's/family's eligibility for the SNAP, Cash, and/or Medical Assistance programs. Please complete the attached employment verification form as accurately and completely as possible.

Your cooperation in providing the information by _____ will be greatly appreciated. Below is the applicant's/client's consent to release of information.

Should you have any questions, please contact our office at_____, or send email to _____ .

Sincerely,

_____

Eligibility Specialist

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize to release the requested information on my employment status and income to the Division of Public Welfare, Department of Public Health and Social Services.

_____ _____

Employee Name (Please Print) Employee Signature/Date

Attachment

BES Updated 8/5/19

TO BE COMPLETED BY EMPLOYER:

NAME OF EMPLOYEE: _____

DATE HIRED: _____ JOB TITLE: _____

EMPLOYEE'S HOME ADDRESS (in your records): _____

NAME OF EMPLOYER/COMPANY: _____

EMPLOYER ADDRESS: _____

Please check the appropriate box(es) and complete the following as accurately and completely as possible. If the employee is no longer employed, go on to the next page.

[ ] **NEWLY HIRED:** Date first paycheck will be issued: _____
Number of hours worked per pay period (estimated or scheduled): _____ Hourly Rate: $ _____

[ ] **INCREASE OR DECREASE IN PAY:** Effective Date: _____ New Hourly/Monthly Rate: $ _____

How often paid? [ ] Daily [ ] Weekly [ ] Monthly
[ ] Bi-Weekly/every 2 weeks [ ] Twice a Month

IS EMPLOYEE PAID

[ ] **OVERTIME?** What is the average number of overtime hours per pay period that can be reasonably anticipated in the next three months? _____ hours

[ ] **COMMISSION?** When: _____ Amount: $_____ Monthly;
PROFIT SHARING? If YES, When and how often will employee receive this? _____
How much (Gross)? $ _____

[ ] **NIGHT DIFFERENTIAL?** $ _____ Monthly;

[ ] **VACATION PAY OR BONUS?** When: _____
How much (Gross)? $ _____

[ ] **OTHER PAY?** _____ Gross Amount: $ _____

[ ] **NO OTHER PAY.**

Is the Overtime, Night Differential, Holiday Pay, and Other Pay regular or frequent enough to be anticipated by the employee and/or by the employer? [ ] NO [ ] YES

EXPLAIN

_____

_____

ON THE CHART BELOW, PLEASE PROVIDE INFORMATION ABOUT HE ACTUAL GROSS INCOME/PAY RECEIVED FOR THE MONTH OF: _____

Please show the date(s) the check(s) were actually received by the employee or indicate in comment section if checks were mailed.

Pay Period Ending	Date Received	Hours	Gross	Overtime/Night Differential	Commission, Tips, or Other Pay

COMMENTS: _____

_____

IF EMPLOYEE IS NO LONGER EMPLOYED, Please complete the following:

Date of termination: _____

Date last check was received: _____ Amount $ _____

REASON FOR TERMINATION: _____

_____

_____

[ ] Voluntary [ ] Involuntary

_____ _____

NAME (Please Print) Signature/Date

_____ _____

TITLE (Please Print) Telephone Number