WAGE VERIFICATION FORM

I hereby authorize my employer to release the following information to the Illinois Department of Human Services.

_____ _____

CLIENT SIGNATURE **DATE**

JOB INFORMATION (to be filled out by employer only).

Company Name:_____

Street Address/Mailing Address:_____

City, State:_____**Zip:**_____

Phone number:_____**Ext.**_____

Employee Name:_____

Social Security Number:_____ **Start date:**_____

Gross Salary:_____ **Hourly Rate:**_____

Total hours Worked per wk:

Pay Period: Weekly_____ **Bi-weekly**_____ **Twice @ month**_____ **Monthly**_____

If irregular or varied hours are worked, please give average hours:

Per week_____ or per month_____ and **GIVE A SAMPLE SCHEDULE BELOW**.(***DO NOT WRITE VARIES)***

Hours worked: From: To:	MON	TUES	WEDS	THURS	FRI	SAT	SUN

If employee is returning to work from leave or, if this is verification for a new schedule, please

give effective date:_____**.**

Additional Comments:_____

_____

_____ _____ _____

EMPLOYER SIGNATURE **TITLE** **SS# or FEIN#**

_____ _____

EMPLOYER NAME PRINTED **DATE**

PLEASE FAX COMPLETED FORM TO:
(815)758-5652

4-C CHILD CARE SUBSIDY PROGRAM
***ATTN: EXT.*_____**

IF YOU HAVE ANY QUESTIONS PLEASE CALL (815)758-8149/(800)848-8727