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* _____

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

1. If hours or rate of pay varied, please state why: _____

Pay Prd. Ends	Date Pay Recd.	Gross Pay	# Hours Worked	Tips	Net Pay

Parent Name

_____

☐ **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. Is the loss of income Permanent Temporary? If temporary, when do you expect the employee to return to work? _____
3. Date employee received final check: _____
4. Will employee receive any vacation pay, retirement refund, or other Yes No
5. 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:

_____

_____