ES-3108

State of Kansas

Department for Children and Families

Economic & Employment Services

05-18

Office Name:

Office Address:

Case Name:

Case Number:

**Request for Employment Information**

**(To be completed by Employer Only)**

Employment information is needed for       .

We need this information to determine if you are eligible for food assistance, cash, child care benefits or for work programs.

Please verify gross earnings from

with pay stubs or a signed statement from your employer showing pay dates and gross wages.

You need to report any child or dependent care expenses. These expenses can be considered when determining your benefit amounts.

Have your employer complete and sign this form. You need to sign and return the completed form to the DCF office by       . If you do not provide this information, your benefits may be changed, denied or closed.

**The following section to be completed by your employer:**

Employer Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is the above named person currently employed: Yes \_\_\_\_\_\_ No \_\_\_\_\_\_

2. If not employed: Fired\_\_\_ Quit \_\_\_ Layoff \_\_\_ Other \_\_\_

Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Date of employment: From \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. First check received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last check received:\_\_\_\_\_\_\_\_\_

5. Pay schedule: Weekly\_\_\_ Bi-weekly\_\_\_ Monthly\_\_\_ Twice/Mo\_\_\_ Other\_\_

6. Number of hours worked per week: \_\_\_\_\_\_\_\_ Hourly pay rate: \_\_\_\_\_\_\_\_

7. Work Schedule (hours and days routinely worked) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Day pay period ends:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Day check received:\_\_\_\_\_\_\_\_\_\_\_\_

9. Most recent 30 day's gross pay amounts. List each paycheck.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Pay Period End Date | Date Paid | Number of hours per pay period | Hourly Pay Rate | Gross Amount |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

10. Tips or Commissions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. Medical Insurance available: Yes\_\_\_ No\_\_\_. If yes, name and address of insurance co.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy/plan#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Start/End Dates: \_\_\_\_\_\_\_\_\_\_

Coverage Type: Single\_\_ Family\_\_ Medical\_\_ Hospital\_\_ Dental\_\_

Name of Employer/Employer's Representative providing this information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Employer/Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have questions call:

at       between the hours of 8 am and 5 pm Monday through Friday.