

Employer Name:
 Employer Address:

Please sign this form and have your employer complete the information. Return or fax the completed form to the address or fax number above.

I hereby authorize this employer to release information about my employment to DHHS.

Client/Employee Signature: _____ SSN: _____ Date: _____

This form to be completed and signed by the EMPLOYER

Date Employment began		Date of First Paycheck	
Hourly Pay Rate		Estimated Hours Scheduled per Week	
How often is pay received?	Circle One: Weekly / Every Two Weeks / Twice a Month / Monthly / Other: _____		
Is any other pay received? (tips, incentive, bonus, etc.)	Please explain: Estimated monthly amount: Is this included on the paystub?		
Has pay rate/hours changed in the past 30 days?	Please explain:		
Which benefits are available?	Circle any that apply: Sick Leave / Vacation Leave / Insurance / Other: _____		

WAGE INFO - Date from: _____ to: _____ (Complete for the 4 most recent pay periods)							
Pay Period Ending	Date Paid	Gross Pay	Number of Regular Hours	Number of Overtime Hours	Amounts of Tips Included in Gross Pay? Y/N	Overtime Pay Included in Gross Pay? Y/N	Other (specify)

Complete for TERMINATED employment

Employment Ended Due To:		Circle One: Quit / Discharge / Mutual Agreement / Other: _____ Explanation if needed:			
Last Day Worked		Date of Final Paycheck		Gross Earnings for last MONTH pay received	
Amount of severance or lump sum, if paid:		Amount		Date Paid	

EMPLOYER must sign and include contact information below for the form to be accepted.

Employer Signature/Title:	Date:
Print name:	Phone Number: Fax Number:

The Department of Health and Human Services is committed to affirmative action/equal employment opportunity and does not discriminate in delivering benefits or services.

Economic Assistance Toll Free: (800)383-4278 Lincoln: (402)323-3900 Omaha: (402)525-1258	Go online: ACCESSNebraska.ne.gov
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