TEXAS
Health and Human Services

Date

Need help? Call 2-1-1 or 877-541-7905.
Fax: 877-447-2839
Mail: Texas Health and Human Services Commission P O BOX 149027 Austin, Texas 78714-9027
If you are deaf, hard of hearing, or speech impaired, call 7-1-1 or 800-735-2989. All numbers are free to call.

Name and Address

Case Name	Case No.

This form is for your employer. They need to fill out the form and return it by _____. You must agree to let them give facts about you.

Fill Out and Sign This Agreement

I, _____ *(print your name)* allow HHSC to give my Social Security number (SSN) to the employer listed on this form.

My SSN can be used to get facts about my employment. I also allow the employer listed on this form to give facts asked on this form to HHSC.

_____ _____

Signature **Date**

Employer – Your Help Is Needed

Employee or Former Employee	Social Security No.

We need proof that the following person is or was your employee.

Some employers might get tax refunds or tax credits for hiring people who get certain state benefits.

To learn more, go to TexasWorkforce.org/wotc or email the Texas Workforce Commission at wotc@twc.state.tx.us.

Employer please follow these steps.

This person lives in a home in which someone is applying for state benefits. We need to know the amount of money this person makes or made from this job.

1. Please fill out the “Proof of Employment” form on the next page.
2. If a question doesn't apply, mark it with "N/A."
3. Return the form:

   To send this back to us, you can either:
   (a) give it to the employee listed above,
   (b) mail it in the pre-paid envelope, or (c) fax it to 877-447-2839.

Employment Verification

Proof of employment to be filled out by the employer.

Company or Employer	Address *(Street, City, State, ZIP code)*

Employee Name *(as shown on your records)*	Employee Address *(Street, City, State, ZIP Code – as shown on your records)*

Is (or was) this person employed by you? ◯ Yes ◯ No

If yes, what type of job? ◯ Full Time ◯ Part Time ◯ Permanent ◯ Temporary

If no: Stop here – sign and date the bottom of this form and return it.
If yes: Answer all the questions below. If a question doesn't apply, write "N/A".

Rate of Pay ◯ Per Hour ◯ Per Day ◯ Per Week ◯ Per Month ◯ Per Job	How Often Paid?	Average Hours Per Pay Period

Commissions Tips Bonuses	Overtime Pay	FICA or FIT Withheld	Profit Sharing or Pension Plan
◯ Yes ◯ No	◯ Frequently ◯ Rarely ◯ Never	◯ Yes ◯ No	◯ Yes ◯ No If yes, current value?

Health insurance available?	If yes, employee is:	Name of Insurance Company
◯ Yes ◯ No	◯ Not Enrolled ◯ Enrolled with Family Member ◯ Enrolled for Self Only	

Date Hired	Date First Check Received	Average Hours Per Week	If Employee is or was on Leave Without Pay: Start Date: End Date:

Do you expect any changes to the above information within the next few months? ◯ Yes ◯ No

If yes, explain: _____

On the chart below, list all wages received by this employee during the month(s) of: _____

Date Pay Period Ended	Date Employee Received Paycheck	Actual Hours	Gross Pay	Other Pay* *(tips, commissions, bonuses)*	EITC Advance	Total Pretax Contributions

* Please explain (in comments section below) when and how often tips, commissions, or bonuses are received.

Comments

If this person is no longer in your employ.

Date Separated	Reason for Separation	Date Final Check Received	Gross Amount of Final Check

Employer – Read, Sign and Date

I confirm that this information is true and correct to the best of my knowledge:

Employer Signature	**Date**	**Title**	**Area Code and Phone No.**