



COLORADO

Department of Human Services

Verification of Employment/Loss of Income Form

Case Number (1Bxxxxx)

Form Instructions:

- Please complete all sections of this form as they apply.
- If known, please include your Case Number on both pages when returning this form to your local office.
- If you are completing this form for a current employee, please skip Section III- Loss of Income.

Section I – General Employment Information

Employee Name

Employer Name

Employee SSN or last 4 digits, if known

Date Employment Began

Pay per hour
(\$15.00/hour)

Average # of hrs/week
(20 hrs per week)

Pay Frequency
(Daily, Weekly, Every two weeks, Monthly)

- Seasonal employment? Yes No
 - If yes, season begins: _____ ends: _____

Section II – Record of Pay Received

Check Details		Regular		Overtime		Additional
Received Date (mm/dd/yyyy)	Gross Total Earnings	# of Hours Worked	Pay per Hour	# of Hours Worked	Pay per Hour	Tips
	\$	hours	\$	hours	\$	\$
	\$	hours	\$	hours	\$	\$
	\$	hours	\$	hours	\$	\$
	\$	hours	\$	hours	\$	\$
	\$	hours	\$	hours	\$	\$
	\$	hours	\$	hours	\$	\$
	\$	hours	\$	hours	\$	\$
	\$	hours	\$	hours	\$	\$

If hours/rate of pay has varied, please explain.
Please note any bonuses or commissions and how often they are received in this section.



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Section III – Loss of Income

Date Employment Ended

Reason for Termination

Final Check: Received Date

Final Check: Gross Total Amount

- Is the loss of income: Permanent or Temporary?
 - If temporary, when do you expect the employee to return to work?

Section IV – Employer Representative Information

<i>What I have written in this form is true to the best of my knowledge.</i>	
<i>Employer Representative Printed Name:</i>	
<i>Employer Representative Signature:</i>	
<i>Employer Representative Position Title:</i>	
<i>Employer Representative Phone Number:</i>	
<i>Date Completed:</i>	