



# WAGE VERIFICATION FORM

4-C: Community Coordinated Child Care 155 N Third Street Suite 300 DeKalb IL (800) 848-8727x225 Fax (815) 758-5652

(THIS FORM MAY ONLY BE USED IF CLIENT HAS NOT BEEN EMPLOYED LONG ENOUGH TO HAVE TWO PAY STUBS)

I hereby authorize my employer to release the following information to the Illinois Department of Human Services.

CLIENT SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

PRINTED NAME \_\_\_\_\_

**JOB INFORMATION (to be filled out by employer only)**

Company Name: \_\_\_\_\_

Street Address/Mailing Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip : \_\_\_\_\_

Phone number: \_\_\_\_\_ Ext. \_\_\_\_\_

Employee Name: \_\_\_\_\_

Social Security Number (optional): \_\_\_\_\_ Start date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Gross Salary: \_\_\_\_\_ Hourly Rate: \_\_\_\_\_ Tips: \_\_\_\_\_

Pay Period: Weekly  Bi-weekly  Twice @ month  Monthly

PLEASE CHECK BOX ONLY IF EMPLOYEE IS PAID IN CASH

**GIVE A SAMPLE SCHEDULE OF AVERAGE HOURS BELOW**  
*(PLEASE DO NOT WRITE VARIES)*

Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total hours Worked per week:	
From	a.m. p.m.	a.m. p.m.	a.m. p.m.	a.m. p.m.	a.m. p.m.	a.m. p.m.	a.m. p.m.		
To	a.m. p.m.	a.m. p.m.	a.m. p.m.	a.m. p.m.	a.m. p.m.	a.m. p.m.	a.m. p.m.		

*If employee is returning to work from leave or if this is verification for a new schedule*

*Please indicate effective date: \_\_\_\_/\_\_\_\_/\_\_\_\_.*

Additional Comments:

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

EMPLOYER SIGNATURE \_\_\_\_\_

TITLE \_\_\_\_\_

EMPLOYER NAME PRINTED \_\_\_\_\_

DATE \_\_\_\_\_

COMPLETED FORM MAY BE FAXED TO:  
(815)758-5652

IF YOU HAVE ANY QUESTIONS PLEASE CALL 4-C CHILD CARE ASSISTANCE PROGRAM  
(815) 758-8149 EXT 225 or (800) 848-8727 EXT 225