



WAGE VERIFICATION FORM

4-C: Community Coordinated Child Care 155 N Third Street Suite 300 DeKalb IL (800) 848-8727x225 Fax (815) 758-2227

(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)758-2227

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