PAFS-700
03/22

COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Community Based Services
Division of Family Support

Date: _____
Case Number: _____

Name: _____
Address: _____
_____
_____

Return to:
P.O. Box 2104
Frankfort, KY 40602
Fax: (502) 573-2007

Verification of Employment and Wages

Employer Name : _____

Please provide the following information from your records for _____
(Employee Name) (SSN)

1. Employee Name and/or SSN (**if different**) _____
2. Is this person currently employed by you? ☐ Yes ☐ No
3. Date of most recent hiring_____ Date first paid _____
4. How often do you pay wages? ☐ weekly, ☐ every two weeks, ☐ twice a month, ☐ monthly, ☐ other _____

   Hourly Pay Rate_____Overtime Rate_____Anticipated Hours per Week_____Day of Week Paid _____
   Shift Premium _____
5. Is the employee's hourly pay rate scheduled to change? ☐ Yes ☐ No If yes, the pay rate will change to_____beginning on

   _____ and will be reflected in the check the employee will receive on_____.
6. If the hours listed above have changed or will change, give the normal work hours and date of change:
   Hrs/week_____ Date_____
7. Did the employee voluntarily reduce work hours? ☐Yes ☐ No If yes, reason_____.
8. Is the employee's share of taxes deducted from gross wages? ☐Yes ☐ No
9. Are wages paid through any of the following? ☐ Title V, Older Americans Act ☐ WIOA ☐ WIOA on-the-job training
10. List the wages that have been paid during the months of _____through _____.

Date Received	Hours	Gross Wages	*Tips	Taxes Withheld	Date Received	Hours	Gross Wages	*Tips	Taxes Withheld
1.					6.				
2.					7.				
3.					8.				
4.					9.				
5.					10.				

***Report separately if not included in gross wages.**

11. Has this employee ever filed a Worker's Compensation Claim? ☐ Yes ☐ No Date_____

12. Is this employee participating in a company retirement plan? ☐ Yes ☐ No Type of Plan_____ Balance of Fund_____

Is there a penalty for early withdrawal? ☐ Yes ☐ No If yes, what is the amount of the penalty?_____

13. Is this employee temporarily on leave? ☐ Yes ☐ No If yes, date last worked? _____

Date last paid or expected to be paid _____ Gross amount last paid _____ Expected date of return _____

Termination Status: ☐ Fired ☐ Quit ☐ Other_____**Termination Date**_____

Reason_____

Date final check received or expected_____Gross Amount_____(Include final pay and vacation/sick pay)

Employer/Business Name_____

Please list name, address and telephone number of the company through which payroll is issued, **if different.**

Name_____Phone_____

Address_____City_____State_____Zip_____

Warning: Any person who aids another person to obtain assistance (or benefits) fraudulently is subject to penalties provided by state and federal law, including fines, imprisonment, or both.

I certify that the information contained in this form is true and correct to the best of my knowledge.

Signature of Individual Completing Form _____ Title_____

Date_____ Print Name_____ Phone_____

Address_____

City_____ State_____ Zip_____

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: https://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
Stop 9430
1400 Independence Avenue, SW
Room 212-A Whitten Building
Washington, DC 20250

(2) fax: (202) 690-7442; or
(3) email: program.intake@usda.gov.

This Institution is an equal opportunity provider.

You may also file your complaint with the Cabinet for Health and Family Services, Office of Human Resource Management, EEO Compliance Branch, 275 East Main Street., 5C-D, Frankfort, KY 40621 or call (502) 564-7770 EXT. 4107.

If you have other complaints about your SNAP case, you can call the Ombudsman's Office at (800) 372-2973 or (800) 627-4702 (TTY).