WEST VIRGINIA Department of Health & Human Resources

EMPLOYMENT STATEMENT

This section is to be completed by the employee.

Employee Name: _____ Phone Number: _____

Social Security Number: _____ Date of Birth: _____

I hereby request that my employment information be released to the West Virginia Department of Health and Human Resources. Furthermore, I understand that this information will be kept confidential and will be used for program purposes only.

Signature of Applicant: _____ Date: _____

This section is to be completed for new employment.

Employee's Date of Hire: _____ Employee's Position: _____

Select **ALL** Methods of Paying Employee: ☐ Hourly Rate of Pay: _____

☐ Yearly Salary: _____ ☐ Additional Compensation: _____

If you marked "Additional Compensation," please select **ALL** types of additional compensation and provide the amount that the employee is expected to receive per pay period:

☐ Commission _____ ☐ Tips _____ ☐ Incentive Pay _____

☐ Bonuses _____ ☐ Overtime _____ ☐ Other _____

How often is the Employee Paid: ☐ Weekly ☐ Every Other Week ☐ Twice a Month

☐ Once a Month ☐ Other (please specify):_____

If Paid Twice a Month, on What Numbered Days of the Month is the Employee Paid? _____

Anticipated Number of Hours the Employee is Hired per Week: _____

Date of First Pay: _____ Gross Payment Amount of First Pay: _____

Is Child Support Being Withheld From Pay? _____ Amount Withheld Per Pay: _____

This section is to be completed for loss of employment.

Employee's Date of Hire: _____ Employee's Position: _____

Date of Separation: _____ Reason for Separation: _____

Date of ~~Last~~ Final Pay: _____ Gross Payment Amount of ~~Last~~ Final Pay: _____

This section is to be completed by the employer.

Employer/Company Name: _____

Employer Address: _____

Employer Phone Number: _____

Employer Name/Title: _____

Employer Signature: _____ Date: _____