

## DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES DIVISION OF CHILDREN'S WELLNESS BUREAU OF CHILD CARE SERVICES (BCCS) Child Care Assistance Program



## **EMPLOYMENT VERIFICATION FORM**

This form is to be completed by the employer of the applicant for the child care assistance program. This form is an authorization to release the information concerning the verification of employment and income in order to establish eligibility for the child care assistance program with the Bureau of Child Care Services (BCCS). Please feel free to contact BCCS if you may have any questions or inquiries regarding the eligibility requirements. Your cooperation and prompt return of this information is greatly appreciated.

Section B — Employee Information  Employee Name: Still Employed:	Section A – Employer Information							
Employee Name:	Name of Business:					<mark>Phone:</mark>		
Employee Name: Still Employed: _ Yes No., Last Date of Employment:	Business Address:							
Employee Name: Still Employed: _ Yes No., Last Date of Employment:								
Date of Hire: Still Employed: Yes No, Last Date of Employment:  Employment Status: Full-Time Part-Time Other:  Pay Frequency: Weekly Bi-weekly Semi-monthly Monthly  This employee is paid by: Cash Personal Check Payroll Check Other:  Hourly Pay Rate: Ayg. Ayg. of hours worked per week:  Boes this employee work overtime (OT)? Yes No IF YES, OT hourly rate: Ayg. of OT per week:  Is this employee on Leave of Absence? No. IF YES, What type of leave? Payroll Ghow Pay Leave start date:  Scheduled return date:  Additional Information:  WORK SCHEDULE: If your schedule varies, please provide an example  SUN MON TUES WED THURS FRI SAT  A.M. A.M. A.M. A.M. A.M. A.M. A.M. A.M	Section B - Employee Information							
Employment Status:   Full-Time    Part-Time    Other:    Pay Frequency:    Weekly    Bi-weekly    Semi-monthly    Monthly    This employee is paid by:    Cash    Personal Check    Payroll Check    Other:    Hourly Pay Rate: \$	Employee Name: Job Title:							
Pay Frequency:   Weekly   Bi-weekly   Semi-monthly   Monthly   This employee is paid by:   Cash   Personal Check   Payroll Check   Other:     Hourly Pay Rate: \$	Date of Hire: Still Employed:  \[ \sum Yes \subseteq No, Last Date of Employment:							
This employee is paid by:   Cash   Personal Check   Other:   Hourly Pay Rate: \$	Employment Status: ☐ Full-Time ☐ Part-Time ☐ Other:							
Hourly Pay Rate: \$ Avg. # of hours worked per week:  Does this employee work overtime (OT)?	Pay Frequency: □Weekly □Bi-weekly □Semi-monthly □Monthly							
Hourly Pay Rate: \$ Avg. # of hours worked per week:  Does this employee work overtime (OT)?	This employee is paid by: □Cash □Personal Check □Payroll Check □Other:							
Is this employee on Leave of Absence?   Yes   No.   IF YES, what type of leave?   Paid   W/O Pay								
Leave start date: Scheduled return date:  Additional Information:								
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WORK SCHEDULE: If your schedule varies, please provide an example  SUN MON TUES WED THURS FRI SAT  A.M. A.M. A.M. A.M. A.M. A.M. A.M. A.M								
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P.M. P.M. P.M. P.M. P.M. P.M. P.M. P.M.	P.M.	P.M.	P.M.	P.M.	P.M.	P.M.	P.M.	
understand that this information may be verified by the Guam Department of Public Health & Social Services (DPHSS) Bureau of Child Care ervices (BCCS). Any fraudulent, false or misleading information provided may result in criminal charges and hinder the eligibility determination. certify that the information provided is true and correct to the best of my knowledge.  Section C – Employer Authorization  Authorized by (print name):  Position/Title:  Signature:  Date:  Section D – Applicant Authorization  I authorize release of the above information to DPHSS – BCCS.								
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Authorized by (print name):  Position/Title:  Signature:  Date:  Section D - Applicant Authorization  I authorize release of the above information to DPHSS - BCCS.	I certify that the information provided is true and correct to the best of my knowledge.							
Authorized by (print name):  Position/Title: Signature: Date:  Section D - Applicant Authorization  I authorize release of the above information to DPHSS - BCCS.	Section C – Employer	· Authorization						
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authorize release of the above information to DPHSS – BCCS.								
Applicant (print name):    Signature:   Date:		above information to	DPHSS – BCCS.		Circutture			
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