State of Illinois
Department of Human Services - Bureau of Child Care and Development

WAGE VERIFICATION

Client Name: _____

Address: _____

I hereby authorize my employer to release the following information to the Illinois Department of Human Services. I understand that this information may be verified by phone. Any fraudulent, false or misleading information given may result in loss of childcare payments and my child care case may be cancelled or denied.

_____
Client Signature

_____ _____
Client Case Number Date

JOB INFORMATION: TO BE COMPLETED BY YOUR EMPLOYER ONLY.

Employee Name: _____ Start Date: _____

Rate of Hourly Pay: _____ Commission: _____ Tips: _____ (Monthly Average)

Hours Worked
Per Pay Period: Weekly: _____ Bi-Weekly: _____ Twice Per Month: _____ Monthly: _____

Is the employee paid cash? ☐ Yes ☐ No Employee Job Title: _____

If on leave: Return Date: _____ Type of Leave: _____

WORK SCHEDULE: If your schedule varies, provide an example of your schedule.

	MON	TUES	WED	THURS	FRI	SAT	SUN
FROM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM
TO	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM

Do these hours vary? _____ If yes, please explain: _____

_____

Employer / Company Name: _____

Employer Address: _____ City: _____

Employer Phone Number: _____

_____ _____
Employer Name Printed Title

_____ _____
Employer Signature Date

THIS FORM MUST BE COMPLETED BY YOUR EMPLOYER AND RETURNED TO THE ADDRESS AT THE RIGHT WITHIN 10 BUSINESS DAYS.

PLEASE RETURN FORM TO:
Eastern Illinois University
Child Care Resource & Referral
600 Lincoln Avenue
Charleston, IL 61920