



# 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)

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	TUE	WED	THURS	FRI	SAT	SUN
<b>FROM</b>	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM
<b>TO</b>	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> 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:  
 Child Care Resource Service Ccap  
 905 S Goodwin 314 Bevier Hall  
 Urbana, IL 61801

