

WAGE AND INSURANCE VERIFICATION

DCSS 0230 (01/18/15)

CSE Case Number: _____

Participant Name: _____

Employer Name: _____

EMPLOYEE/CASE PARTICIPANT IDENTIFICATION AND CONTACT INFORMATION *(If you have different information, write new information in the blank spaces.)*

- A. Name: _____
- B. Social Security Number: _____
- C. Date of Birth: _____
- D. Address: _____

- E. Phone Number: _____

EMPLOYEE WORK STATUS *(Check all applicable boxes and fill in requested information.)*

- Never employed *(If never employed, no need to complete form further. Just sign the certification on page 3 and return entire form.)*
- Currently employed: Part-time Full-time Seasonal
 Usual season start date: _____ Usual season end date: _____
- No longer employed: Last date employed: _____
 Reason for termination of employment: _____
 New employer name and address: _____

Is there an Income Withholding Order for support on file in your business for this employee? Yes No

What income tax filing status does employee report? Single Head of Household Married

How many dependents does employee claim for income tax withholding purposes? _____

EMPLOYEE EARNINGS

Next Pay Date *(Month, Day, Year)* Pay Frequency *(Check one)* Weekly Bi-Weekly Semi-Monthly Monthly

Hourly Rate *(If applicable)* \$ _____ Number of Hours _____

Monthly Deduction For Mandatory Retirement \$ _____ For Mandatory Union Dues \$ _____

Union Name _____ Union Local Number _____

Period of Employment From *(Month, Day, Year)* _____ To *(Month, Day, Year)* _____

Please complete employee's earnings for the past 12 months or attach a copy of payroll earnings for those months. If the employee has worked less than 12 months, provide the information for the number of months employee did have earnings.

- Check if copy of payroll earnings is attached.
- Check if employee has worked less than 12 months.

Month / Year	Gross	Month / Year	Gross	Month / Year	Gross
January _____	\$ _____	July _____	\$ _____	January _____	\$ _____
February _____	\$ _____	August _____	\$ _____	February _____	\$ _____
March _____	\$ _____	September _____	\$ _____	March _____	\$ _____
April _____	\$ _____	October _____	\$ _____	April _____	\$ _____
May _____	\$ _____	November _____	\$ _____	May _____	\$ _____
June _____	\$ _____	December _____	\$ _____	June _____	\$ _____

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HEALTH INSURANCE INFORMATION *(Note to the preparer: If more than one plan is available to the employee, please list the lowest cost insurance plan available for the employee, even if it is different than the plan the employee is presently enrolled in.)*

Check all applicable boxes:

- No health insurance is available to: Employee Employee's dependents
- Health insurance is available at **no cost** for: Employee Employee's dependents
- Cost to the employee of **lowest cost** available health insurance **for employee only**:
 Cost reported is for period: Annual Monthly Two Weeks Weekly Other
 Medical: \$ _____ Dental: \$ _____ Vision: \$ _____ Other: \$ _____
- Cost to the employee of **lowest cost** available health insurance **for each of employee's insured dependents**:
 Cost reported is for period: Annual Monthly Two Weeks Weekly Other
 Medical: \$ _____ Dental: \$ _____ Vision: \$ _____ Other: \$ _____
- Total** cost to the employee of **lowest cost** available health insurance **for employee and all of employee's insured dependents**:
 Cost reported is for period: Annual Monthly Two Weeks Weekly Other
 Medical: \$ _____ Dental: \$ _____ Vision: \$ _____ Other: \$ _____

DEPENDENT INFORMATION *(List names of all of employee's insured dependents. Add a sheet of paper if more space needed.)*

POLICY INFORMATION

	MEDICAL	DENTAL	VISION	OTHER
Insurance Co. Name:	_____	_____	_____	_____
Mailing Address:	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Phone Number:	_____	_____	_____	_____
Policy Number.:	_____	_____	_____	_____
Effective Date:	_____	_____	_____	_____
Expiration Date:	_____	_____	_____	_____

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CERTIFICATION OF RECORD

I have personally completed this form, or printed and attached records containing **all** of the employee's earnings and benefits information requested in this form, from the payroll records in my custody and control. I am personally aware such records are kept in the regular course of business and that entries therein are made at or about the time of the condition or event. I have compared the records with the above Wage and Insurance Verification (DCSS 0230) and know the information I am supplying to be accurate.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Print Name	Signature	Executed on (<i>Date</i>)
Job Title	Address	
Name of Company or Business Organization		
Telephone Number	Fax Number	Email Address