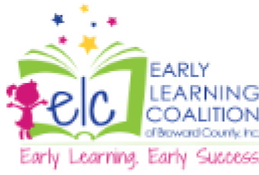

Verification of Loss of Income/Employment

Date: ___________________

NAME OF EMPLOYEE: ______________________________

Last Four Digits of Social: ______________________________

Place of Employment: ______________________________

Supervisor's Name: ______________________________

Business Address: ______________________________

Business Phone: ______________________________

Business Fax: ______________________________

Date Employment Ended
or Date Hours Were Cut: ______________________________

Date of final check: ______________________________

Employee was (circle one):

Laid Off
Terminated
Temporary Work Ended
Hours Cut from_________per week to ___________
Other (please explain):

____

This information is true and correct to the best of my knowledge. I know that if I purposely give false information, I may be subject to prosecution.

____
Signature of Person Completing Form

____
Title of Person Completing Form

____
Name of Business

____
Phone

***Please upload the completed form to your online account in the portal under "additional documents" at: family.elcbroward.org.**
Please note this form is a requirement for each time the client has separated from employment.