

**ARIZONA DEPARTMENT  
OF ECONOMIC SECURITY**  
**Family Assistance Administration**  
**VERIFICATION OF  
TERMINATED EMPLOYMENT**

**Date:** \_\_\_\_\_

**Case Number/HEA Plus APP ID:**

**Case Name (*Last, First, M.I.*):**

**For questions, call 1-833-397-3155  
Fax completed form to  
602-257-7031 or 1-844-680-9840**

**See pages 13-15 for USDA/EOE/ADA  
disclosures**

**Case Name:** \_\_\_\_\_

**Case Number:** \_\_\_\_\_

**Employed Household Member's Name:**

**Employee's Social Security Number:**

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**The person whose name and signature appears below, or on the attached copy of the signature page of the DES/FAA Application, has requested your cooperation in providing the following information. Please complete and return this form via fax at the number above, within 10 days from the date above.**

**Case Name:** \_\_\_\_\_

**Case Number:** \_\_\_\_\_

**Employed Household Member's Name:**

\_\_\_\_\_  
**Employee's Social Security Number:**

**AUTHORIZATION TO RELEASE  
INFORMATION / AUTORIZACIÓN  
PARA DAR INFORMACIÓN**

**I hereby authorize release of any and all information requested below concerning myself and my household members to the Arizona Department of Economic Security. *Por la presente autorizo y doy mi consentimiento para que se entregue al Arizona Department of Economic Security toda y cualquier información que se pide a continuación acerca de mí o de los miembros de mi hogar.***

**Case Name:** \_\_\_\_\_

**Case Number:** \_\_\_\_\_

**Employed Household Member's Name  
(Last, First, M.I.) / *Nombre del  
Miembro empleado del hogar  
(Apellido, nombre, segundo inicial):***

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**Employee's Social Security Number /  
*Número Seguro Social del empleado:***

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**Employed Household Member's  
Signature / *Firma del Miembro  
empleado del hogar:***

**Date / *Fecha:*** \_\_\_\_\_

**Signed release attached. A  
photocopy or fax of a client's or  
employee's signature shall be  
treated as an original signature.**

**Former employers please complete all  
questions in Sections A, B and C.**

**Case Name:** \_\_\_\_\_

**Case Number:** \_\_\_\_\_

**Employed Household Member's Name:**

\_\_\_\_\_

**Employee's Social Security Number:**

\_\_\_\_\_

## **A. FORMER EMPLOYER**

**Date hired:** \_\_\_\_\_

**Date first check was issued:**

\_\_\_\_\_

**Gross amount of first check:**

**\$** \_\_\_\_\_

**Employee Termination:**

**Last day worked:** \_\_\_\_\_

**Date final check was/will be issued:**

\_\_\_\_\_

**Gross amount of final wages:**

**\$** \_\_\_\_\_

**Case Name:** \_\_\_\_\_

**Case Number:** \_\_\_\_\_

**Employed Household Member's Name:**

\_\_\_\_\_  
**Employee's Social Security Number:**

\_\_\_\_\_

**Reason for Termination:** \_\_\_\_\_

**Laid off          Fired**

**Quit (*Specify reason*):**

\_\_\_\_\_

**Retired (*Monthly benefit*)**

**\$** \_\_\_\_\_

**Other:** \_\_\_\_\_

**Case Name:** \_\_\_\_\_

**Case Number:** \_\_\_\_\_

**Employed Household Member's Name:**  
 \_\_\_\_\_

**Employee's Social Security Number:** \_\_\_\_\_

**Paychecks Received From:** \_\_\_\_\_

**to Final Pay:** \_\_\_\_\_

<b>MONTH /YEAR</b>	<b>PAY PERIOD ENDING</b>	<b>DATE ACTUALLY PAID</b>	<b>GROSS EARNINGS</b>	<b>HOURS</b>	<b>TIPS</b>
			\$		\$
			\$		\$
			\$		\$
			\$		\$

**Case Name:** \_\_\_\_\_

**Case Number:** \_\_\_\_\_

**Employed Household Member's Name:**  
 \_\_\_\_\_

**Employee's Social Security Number:** \_\_\_\_\_

<b>MONTH /YEAR</b>	<b>PAY PERIOD ENDING</b>	<b>DATE ACTUALLY PAID</b>	<b>GROSS EARNINGS</b>	<b>HOURS</b>	<b>TIPS</b>
			\$		\$
			\$		\$
			\$		\$
			\$		\$



**Case Name:** \_\_\_\_\_

**Case Number:** \_\_\_\_\_

**Employed Household Member's Name:**  
 \_\_\_\_\_

**Employee's Social Security Number:** \_\_\_\_\_

<b>If paid in installments, Date? The Gross Amount?</b>		<b>If included in the Final Wages, what type? The Gross Amount?</b>	
<b>Date</b>	<b>Amount</b>	<b>Type</b>	<b>Amount</b>

**Case Name:** \_\_\_\_\_

**Case Number:** \_\_\_\_\_

**Employed Household Member's Name:**

**Employee's Social Security Number:**



**Was the employee covered by health insurance through your company?**

**Yes      No**

**Have benefits stopped?      Yes      No**

**Date:** \_\_\_\_\_

**C. COMPANY INFORMATION**

**Print Name of Person Completing**

**Form:** \_\_\_\_\_

**Signature of Person Completing Form:**



**Title:** \_\_\_\_\_

**Case Name:** \_\_\_\_\_

**Case Number:** \_\_\_\_\_

**Employed Household Member's Name:**

**Employee's Social Security Number:**

\_\_\_\_\_

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**Name of Company:** \_\_\_\_\_

\_\_\_\_\_

**Company Address:**

\_\_\_\_\_

\_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Fax Number:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.**

**Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.**

**To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:**

**1. mail:**

**Food and Nutrition Service, USDA  
1320 Braddock Place, Room 334  
Alexandria, VA 22314; or**

- 1. fax:**  
**(833) 256-1665 or (202) 690-7442;**  
**or**
- 2. email:**  
**[FNSCIVILRIGHTSCOMPLAINTS@usda.gov](mailto:FNSCIVILRIGHTSCOMPLAINTS@usda.gov)**

**This institution is an equal opportunity provider.**

**To request this document in alternative format or for further information about this policy, contact your local office; TTY/TDD Services: 7-1-1. • Disponible en español en línea o en la oficina local.**