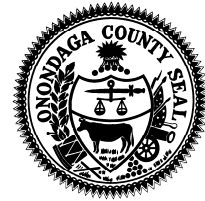


**ONONDAGA COUNTY  
DEPARTMENT OF SOCIAL SERVICES**



**VERIFICATION OF EMPLOYMENT**  
**To Be Completed By Employer**

**Section I**

EMPLOYEE'S NAME : \_\_\_\_\_ S.S. #: \_\_\_\_\_

EMPLOYER'S NAME: \_\_\_\_\_

EMPLOYER'S ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

**Section II Please list last 8 weeks gross income:**

PAY DATE	GROSS PAY	TIPS	COMMISSION

**Abstract of Section 143 of the NY State  
Social Service Law**

Employers are required to furnish to the NYS Department of Social Services information concerning wages, salaries, earnings or other income of any applicant for, or recipient of, public assistance or medical assistance, or any relative legally responsible for the support of such applicant or recipient.

DATE EMPLOYMENT STARTED: \_\_\_\_\_

NUMBER OF HOURS EMPLOYED PER WEEK: \_\_\_\_\_

HOURLY PAY RATE: \_\_\_\_\_

POSITION HELD BY EMPLOYEE LISTED ABOVE: \_\_\_\_\_

IS EMPLOYEE RECEIVING N.Y.S. DISABILITY BENEFITS? \_\_\_\_\_ WORKMEN'S COMPENSATION BENEFITS? \_\_\_\_\_

IF EMPLOYMENT HAS TERMINATED, PLEASE STATE WHEN: \_\_\_\_\_

**Section III (a)** If the employee's hours ***do not vary***, please complete this section.

\*\*\* If hours ***vary*** or employee works rotating days or hours please complete **Section III (b)** on the reverse of this form \*\*\*

<u>DAYS EMPLOYED</u>	<u>EXACT HOURS OF EMPLOYMENT</u>				<b>AGENCY NOTES:</b>
SUNDAY	_____ AM/PM	TO _____	_____ AM/PM		
MONDAY	_____ AM/PM	TO _____	_____ AM/PM		
TUESDAY	_____ AM/PM	TO _____	_____ AM/PM		
WEDNESDAY	_____ AM/PM	TO _____	_____ AM/PM		
THURSDAY	_____ AM/PM	TO _____	_____ AM/PM		
FRIDAY	_____ AM/PM	TO _____	_____ AM/PM		
SATURDAY	_____ AM/PM	TO _____	_____ AM/PM		

**Section IV**

EMPLOYER'S REP NAME (PLEASE PRINT): \_\_\_\_\_

EMPLOYER'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

TELEPHONE NUMBER: (        ) \_\_\_\_\_

**Please Return To:**

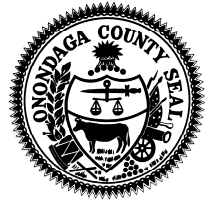
**ONONDAGA COUNTY DEPARTMENT OF SOCIAL SERVICES**  
Day Care Services Unit  
600 South State Street  
Syracuse, New York 13202  
Phone (315) 435-5683 Fax (315) 435-5682

Worker # \_\_\_\_\_

# ONONDAGA COUNTY

## Day Care Services Unit

600 South State Street  
Syracuse, New York 13202



### DAILY WORK SCHEDULE (section III (b)) FOR EMPLOYEES WORKING VARIED DAYS, HOURS and/or WEEKENDS

#### **THIS FORM DOES NOT NEED TO BE COMPLETED FOR EMPLOYEES WORKING A PERMANENT SCHEDULE**

We are requesting the times and dates that the employee has or will be scheduled to work. Depending on the length of their employment, the number of weeks that you can provide may vary. Put an **X** in the dates that the employee did not work. Indicate hours as AM or PM (i.e. 8:30 am – 5:00 pm, or 1:00 pm – 8:00 pm).

For questions regarding this form please call 435-5683. Thank you in advance for your cooperation.

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>