State of Illinois
Department of Human Services - Bureau of Child Care and Development

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**
FROM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM
TO	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ 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