



AVCP, Inc.
 TANF Program
 Pouch 219
 Bethel, AK 99559
 1-800-478-3157
 Fax: (907) 543-7488

Case Number: _____

Eligibility Tech.: _____

WORK STATEMENT:

EMPLOYEE: _____ **SSN:** _____

I hereby authorize the release of employment information to be used solely in the administration of the TANF Program.

*EMPLOYEE SIGNATURE: _____ DATE: _____

EMPLOYER: PLEASE COMPLETE THE FOLLOWING. YOUR COOPERATION IS APPRECIATED.

*EMPLOYER: _____ JOB LOCATION: _____
 *EMPLOYER ADDRESS: _____ PAYROLL PHONE #: _____
 *DATE STARTED: _____ JOB TITLE: _____
 * (Please circle one) F/T P/T PERM TEMP SEASONAL ON-CALL WORK STUDY
 *PAY RATE: _____ HOURS PER DAY: _____ DAYS PER WEEK: _____
 *DATE 1ST PAYCHECK ISSUED: _____ GROSS AMOUNT: _____
 *PAY PERIOD END DATE: _____ PAY DAYS: _____

***PLEASE PROVIDE THE FOLLOWING INFORMATION FOR THE LAST FIVE (5) PAY PERIODS:**

*PERIOD ENDED	DATE PAY RECEIVED	# HOURS WORKED	<u>GROSS</u> ISSUED	OTHER COMP.
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

WHAT OTHER COMPENSATIONS ARE AVAILABLE? i.e., tips, bonuses, commissions, room and board, meals, Trade of any kind, draws, income tax credits. PLEASE EXPLAIN.

MEDICAL INSURANCE COMPANY: _____ TYPE OF COVERAGE: _____
 *JOB ENDED: _____ LAST DAY WORKED: _____
 *REASON JOB ENDED: FIRED _____ QUIT: _____ LAID OFF: _____ OTHER: _____
 *DATE FINAL CHECK AVAILABLE: _____ GROSS AMOUNT: _____
 **DATE FINAL CHECK RECEIVED: _____

WILL THIS EMPLOYEE RECEIVE ANY OTHER MONIES RELATED TO THIS JOB ENDING? _____

*EMPLOYER OR PAYROLL REP. SIGNATURE: _____

*EMPLOYER OR PAYROLL REP. PRINTED NAME: _____

*TITLE: _____ DATE: _____