



CHILD CARE ASSISTANCE PROGRAM VERIFICATION OF EMPLOYMENT

The following information is necessary to determine eligibility for the Child Care Assistance Program.

Participant Section

Name: _____ Date: _____ CCAP Case #: _____

Employer Section

****TO BE COMPLETED BY EMPLOYER****

The above person has indicated that s/he is employed with your business. Please complete the following information and return to the participant or directly to Denver Human Services by mail, fax, or email.

Business Information

Name of Business: _____

Business Address: _____

Hiring Information

First Day of Employment: _____ First Check Date: _____

Wages

Number of Hours Worked per Week: _____ Rate of Pay: _____

How often paid: _____ Monthly Gross Wages: _____

Taxes Withheld: Yes No

Additional Income (overtime/commission/bonuses/tips): Yes No

If so, how often: _____ How Much: _____

Schedule

Nontraditional hours are weekday nights and evenings between 6 p.m. and 6:30 a.m. and any time on weekends.

Is this employee scheduled to work nontraditional hours: Yes No

If yes, please include a copy of employee's work schedule with this form.

Information of Person Completing this Form:

Print Name

Title

Phone number or Email Address

Signature

Date