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