BEST BEGINNINGS CHILD CARE SCHOLARSHIP
ATTACHMENT D
WORK VERIFICATION

DIRECTIONS FOR APPLICANT / EMPLOYEE

1. Complete Section 1
   o Applicant / Employee – Permission to Release Information

2. Have your current employer complete sections 2 and 3
   o Employment and Wage Information and Employer Certification

3. Return completed form via fax to your Child Care Resource and Referral Agency

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<th>Region 1</th>
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<tr>
<td>The Nurturing Center</td>
<td>Child Care Resources</td>
<td>Butte 4 C's</td>
<td>Child Care Connections</td>
<td>Family Connections MT Great Falls</td>
<td>Family Connections MT Havre</td>
<td>HRDC District 7</td>
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<tr>
<td>Fax: (406) 756-1410</td>
<td>Fax: (406) 549-1189</td>
<td>Fax: (406) 723-6982</td>
<td>Fax: (406) 587-1682</td>
<td>Fax: (406) 453-8976</td>
<td>Fax: (406) 265-1312</td>
<td>Fax: (406) 869-2585</td>
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1. APPLICANT / EMPLOYEE – PERMISSION TO RELEASE INFORMATION

I, _______________________________, grant permission to _______________________________ for the release of the information requested on this form to the Child Care Resource and Referral Agency, listed above, to determine my family's eligibility for the Best Beginnings Child Care Scholarship.

Applicant’s Signature: ________________________________________ Date: ____________________

DIRECTIONS FOR EMPLOYER

The individual listed above has applied for a Best Beginnings Child Care Scholarship. The Best Beginnings Child Care Scholarship helps qualifying Montana families pay for their child care costs, while participating in qualifying activities, such as work and school. The applicants’ signature above authorizes the release of the information requested on the back of this form. By completing this form, you are providing information, about the identified individual, that will be used to determine their eligibility for child care assistance. Thank you for your cooperation.

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<th>Hoh Name</th>
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<tbody>
<tr>
<td>Begin Date</td>
<td>End Date</td>
<td>Reason</td>
<td>Determination Date</td>
<td>Determined By</td>
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ATTACHMENT D: Work Verification: DPHHS-HCS/CC-159 (rev 08/15)
2. **APPLICANT / EMPLOYEE SCHEDULE**

The following work schedule is effective from: __________________ to: __________________

<table>
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<tr>
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<th>SUNDAY</th>
<th>MONDAY</th>
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☐ This schedule remains the same for the entire month  ☐ This schedule varies from week to week

If work schedule varies, please explain:

3. **EMPLOYMENT AND WAGE INFORMATION**

<table>
<thead>
<tr>
<th>Employee Name:</th>
<th>Employer Name:</th>
<th>Work Address:</th>
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</thead>
<tbody>
<tr>
<td>Work Start Date:</td>
<td>Work End Date:</td>
<td>Date of First Paycheck:</td>
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Is this a Salaried or Hourly Employee?
□ Salaried ($________ per ________)  □ Hourly ($________ per hour)

How Often is This Employee Paid?
□ Daily □ Weekly □ Every Two Weeks □ Twice a Month □ Monthly □ Other _________

Average number of work hours per week: _________ hours per week

What is this employee’s gross salary, wages, and commissions? $__________ per month

Does this employee receive tips or bonuses?
□ Yes  ☐ No  $__________ per month

Does this employee ever work overtime?
□ Yes  ☐ No  $__________ per month

Does this employee receive “in-kind” (non-cash) or cash benefits as part of their pay? For example, housing allowance, apartment or food?
□ Yes  ☐ No  $__________ per month

Explain:

Does this employee have any company-paid flexible child care benefits that could be taken in cash? If yes, please approximate dollar amount per month
□ Yes  ☐ No  $__________ per month

Explain:

4. **EMPLOYER CERTIFICATION (to be signed by employer)**

PLEASE READ AND SIGN:

I certify that the above information is true and correct to the best of my knowledge and that I have the authority to make such verification on behalf of this company.

Employer / Supervisor Name (please print)  Title  Phone Number

Employer / Supervisor Signature  Date