



TRAVIS COUNTY HEALTH AND HUMAN SERVICES  
Family Support Services Division

**Employer Verification of Income**

Client:

Date:

Address:

Application #:

Case Worker:

**Completed by  
Employee**

I, \_\_\_\_\_, Date of Birth: \_\_\_\_\_  
(Employee Name) (Employee's Date of Birth)

hereby authorize \_\_\_\_\_  
(Employer Name)

to release my employment information to the Travis County Health and Human Services Department

Employee's signature: \_\_\_\_\_ Date: \_\_\_\_\_

The above individual has applied for assistance through our agency. In order for us to determine eligibility, we are required to verify the following information. Your cooperation in providing this information is appreciated.

Employee's hire date: \_\_\_\_\_ Last date of employment: \_\_\_\_\_

Employee is paid: Weekly Bi-weekly Semi-monthly Monthly Irregular or Commission

Please indicate all gross income from \_\_\_\_\_, 20\_\_ thru \_\_\_\_\_, 20\_\_ below:

<u>PAY DATE</u>	<u>GROSS PAY</u>	<u>PAY DATE</u>	<u>GROSS PAY</u>
1.		4.	
2.		5.	
3.		6.	

\_\_\_\_\_  
Signature of Employer

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Employer

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

**COMPLETED BY EMPLOYER**