DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
DIVISION OF CHILDREN'S WELLNESS
BUREAU OF CHILD CARE SERVICES (BCCS)
Child Care Assistance Program

EMPLOYMENT VERIFICATION FORM

This form is to be completed by the employer of the applicant for the child care assistance program. This form is an authorization to release the information concerning the verification of employment and income in order to establish eligibility for the child care assistance program with the Bureau of Child Care Services (BCCS). Please feel free to contact BCCS if you may have any questions or inquiries regarding the eligibility requirements. Your cooperation and prompt return of this information is greatly appreciated.

Section A – Employer Information

Name of Business:	Phone:
Business Address:	

Section B – Employee Information

Employee Name: _____ Job Title: _____

Date of Hire: _____ Still Employed: ☐Yes ☐No, Last Date of Employment: _____

Employment Status: ☐Full-Time ☐Part-Time ☐Other: _____

Pay Frequency: ☐Weekly ☐Bi-weekly ☐Semi-monthly ☐Monthly

This employee is paid by: ☐Cash ☐Personal Check ☐Payroll Check ☐Other: _____

Hourly Pay Rate: $_____ Avg. # of hours worked per week: _____

Does this employee work overtime (OT)? ☐Yes ☐No **IF YES,** OT hourly rate: $_____ Avg.# of OT per week: _____

Is this employee on Leave of Absence? ☐Yes ☐No. **IF YES,** what type of leave? _____ ☐Paid ☐W/O Pay

Leave start date: _____ Scheduled return date: _____

Additional Information: _____

WORK SCHEDULE: If your schedule varies, please provide an example

SUN	MON	TUES	WED	THURS	FRI	SAT
A.M.	A.M.	A.M.	A.M.	A.M.	A.M.	A.M.
P.M.	P.M.	P.M.	P.M.	P.M.	P.M.	P.M.
A.M.	A.M.	A.M.	A.M.	A.M.	A.M.	A.M.
P.M.	P.M.	P.M.	P.M.	P.M.	P.M.	P.M.

I understand that this information may be verified by the Guam Department of Public Health & Social Services (DPHSS) Bureau of Child Care Services (BCCS). Any fraudulent, false or misleading information provided may result in criminal charges and hinder the eligibility determination. I certify that the information provided is true and correct to the best of my knowledge.

Section C – Employer Authorization

Authorized by (print name):	Position/Title:	Signature:	Date:

Section D – Applicant Authorization

I authorize release of the above information to DPHSS – BCCS.

Applicant (print name):	Signature:	Date:

DATE RECEIVED