# Verification of Loss of Income/Employment

Date: ______________________

Name of Employee: ______________________

SSN (last four only): ______________________

Place of Employment: ______________________

Supervisor's Name: ______________________

Business Address: ______________________

______________________

Business Phone: ______________________

Business FAX: ______________________

Date Employment Ended or Date Hours Were Cut: ______________________

Date of Final Check (if applicable): ______________________

Employee was: ________ Laid Off ________ Terminated

________ Temporary Work Ended

________ Hours Cut from ________ per week to ________ .

________ Other (please explain): ______________________

______________________

This information is true and correct to the best of my knowledge. I know that if I purposely give false information, I may be subject to prosecution.

______________________ Signature of Person Completing Form

______________________ Title of Person Completing Form

______________________ Name of Business

______________________ Phone

Please return to Early Learning Coalition of Manatee County

3526 9th Street West, Suite 200, Bradenton, FL 34205 Phone: 941.757.2900 FAX: 941.757.2916