STATE OF HAWAII
Department of Human Services

Benefit, Employment and Support Services Division

# EMPLOYMENT RECORD AND PAYROLL CERTIFICATION FORM

TO: _____ DATE:

_____ RE: _____

_____ SSN: XXX-XX-_____ BD: _____

To Whom It May Concern:

Employment and payroll record information on the above-named individual is being requested. Your immediate attention to this matter is appreciated. Please respond by: _____ Thank You.

_____
(Eligibility Worker)

_____ _____ _____
(Telephone Number) (FAX Number) (Unit Address)

I, _____, hereby give my permission for the release of information to the Department of Human Services regarding my employment and earnings.

_____ _____
(Applicant/Recipient's Signature) (Date)

☐ 1. Starting and ending dates of employment: From: _____ To: _____

☐ 2. Nature of employment: _____

☐ 3. Reason for and type of termination from employment: ☐ Quit ☐ Fired ☐ Laid-Off

Other: _____ Last day worked(m/d/yy): _____

☐ 4. Is there any possibility of your re-employing this individual now or anytime in the future?

☐ Yes ☐ No If YES, approximate date: _____

☐ 5. Is this individual entitled to a pension? ☐ Yes ☐ No

If YES, furnish date and amount of each payment (☐ attach separate sheet of pension).

☐ 6. Did this individual receive any sick pay, vacation pay, or severance pay upon termination?

☐ Yes ☐ No If YES, furnish date and amount of each payment (☐ attach separate sheet).

☐ 7. Did this individual receive any cash payments or commissions other than those recorded in wage or salary pay records? ☐Yes ☐No If yes, date & amount of each payment (☐attach separate sheet).

☐ 8. Did this individual receive compensation, gifts, rewards, or premiums in place of financial payments?

☐Yes ☐No If YES, please describe type of compensation & date given (☐ attach separate sheet).

☐ 9. Did this individual apply for and receive any Workmen's Compensation or Temporary Disability Insurance claim payments while employed by you? ☐ Yes ☐ No If YES, furnish dates and amount of each payment or give the name of the insurance carrier or other agency providing benefits:

_____

If NO, state reasons for ineligibility. _____

_____

(Continued on Back)

☐ 10. Is health insurance available? ☐ YES ☐ NO Who is/was covered by any health plan?

| NAME | PlAN & Number | Coverage (Basic, Drug, etc) | Effective Datee | Termination Datee |
|---|---|---|---|---|
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☐ 11. If health insurance is not available, please state reason(s) why the employee is not eligible for service. _____

☐ **12. Please attach copies of payroll records for the period from: _____ to: _____**
or enter the information below. Please indicate if weekly, bi-weekly, semi-monthly, or monthly pay by listing all pay dates. Gross is pay by dates paid, not pay period ending dates. Continue on separate sheet, if necessary.

| Month /Year | Pay Period Ending Date | **Date Paid** | Hours Reg/OT | Hourly Rate | **Gross Pay** | **Tips** | Advance EIC | Commissions | Medical Premium | **Year To Date** |
|---|---|---|---|---|---|---|---|---|---|---|
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Additional Comments:

I, the undersigned, certify that the information provided is a true and correct extract from the employment and payroll record(s), of which I have legal custody:

Employer's Representative: _____ Job Title: _____

Signature: _____ Phone: _____ Date Prepared: _____