TO: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IV-D Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The Cabinet for Health and Family Services (CHFS) needs to verify income and employment information for the person named above. **Please return this form by fax or mail to the office listed below with the information requested within 15 business days**. If the Social Security number is not listed above or is incorrect, provide it in the blank below.

CHFS requests the information listed below pursuant to Kentucky Revised Statutes **(KRS) 205.735, 205.730, 403.212 and 405.465(5)**. This will be treated as confidential information by CHFS or any other agency or state that administers the Child Support Program pursuant to **Part D of Title IV of the Social Security Act**.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cabinet for Health and Family Services

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Full Name: | | | | Social Security Number: | | | |
| Home Street Address: City: State: ZIP:  Telephone: | | | | | | | |
| Mail Address: City: State: ZIP:  Telephone: | | | | | | | |
| Work/Retirement Starting Date: | | | Work/Retirement Ending Date: | | | | |
| ( ) Full Time ( ) Part Time ( ) Seasonal ( ) Other | | | | | | | |
| Gross Wage/Income Per Pay Period $ ( ) Weekly ( ) Bi-Weekly ( ) Semi-monthly | | | | | | | |
| ( ) Monthly ( ) Hourly ( ) Daily ( ) Yearly | | | | | Hours Worked Per Month | | |
| ( ) Bonuses $ | ( ) Commissions $ | | | | | ( ) Other $ | |
| Union: | | | | Union Number: | | | |
| Occupation: | | | | Date of Birth: | | | |
| Is group health insurance available for this employee? ( ) Yes ( ) No | | | | | | | |
| Insurance Provider: Telephone:  Street Address: City: State: ZIP: | | | | | | | |
| Name of each child(ren) covered by policy: | | | | | | | |
| What is the cost of health insurance for this employee? $ Per | | | | | | | |
| What is the cost of health insurance to cover child(ren) $ Per | | | | | | | |
| Policy Number | | | Effective Date of Policy: | | | | |
| If no longer employed by you, why did employment end?  ( ) Quit ( ) Laid Off ( ) Fired ( ) Other ( ) Retirement | | | | | | | |
| New Employer’s Name and Address (if known): | | | | | | | |
| Income Withholding Order is to be sent to:  Employer Name Telephone:  Street Address: City: State: ZIP: | | | | | | | |
| Your Signature & Title: | | | | | | | Date: |
| Your Federal and State Tax ID Numbers: | | FEIN | | | | | EIN |