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 |