Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
Employment Verification Form

WIC Staff Completes the Following:

_____ is a member of a household applying for assistance
(Name of applicant or member of applicant's household)
or has income that affects another household's application for assistance. To determine the household's eligibility, we must verify all earnings. Since this person is your employee, your assistance is needed.

Employee Completes the Following:

I authorize the employer listed below to release the information on this form.

_____ _____
Signature of employee (applicant or member of applicant's household) Date

Employer Completes the Following:

Company/Employer_____ Telephone No. _____

Address: _____
(Physical Address) (City) (State) (Zip Code)

1. Is the person named above currently employed with your company? ☐ Yes ☐ No Date Hired: _____
2. Hourly wage (complete only if paid hourly) $_____/hour
3. How often paid? ☐ Daily ☐ Weekly ☐ Every two weeks ☐ Twice monthly ☐ Monthly
4. Is the employee usually paid commission, overtime, or tips? ☐ Yes ☐ No

Section I. In the chart below, record the gross amount of income the person has received **within the last 30 days**.

Date Pay Period Ended	Actual Hours	Gross Pay (prior to deductions)	Other Pay (e.g., tips, overtime, commission)

Section II. In the chart below, please provide an estimate of his/her gross pay for the pay period if the employee **has not** received his/her first paycheck.

Date Pay Period Ended	Actual Hours	Estimated Pay (prior to deductions)	Other Pay (e.g., tips, overtime, commission)

I understand that if I deliberately omit or give false information that this applicant and/or member of applicant's household can be removed from WIC, criminally prosecuted, or both. The above information may be verified by WIC officials.

_____ _____ _____
Signature of person completing employer section of this form Title Date

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992.

Submit your completed form or letter to USDA by:
1. mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410;
2. fax: (202) 690-7442; or
3. email: program.intake@usda.gov.

TEXAS WIC
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Opciones sabias • Familias sanas

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TEXAS Department of State Health Services