Reset

South Carolina Department of Social Services

REQUEST FOR WAGE INFORMATION

Please return by: _____

From: (county name and address)

Name of Employee: (first, middle initial, last)

_____

Social Security No.: _____

Case Name: (if different from employee name)

Telephone: _____

_____

To: (name and address of employer)

Case Number: _____

Signature of Authorized Agency Official:

_____

Date: _____

I understand the Department of Social Services considers my income in determining my family's eligibility for assistance. I hereby authorize my employer to release the following information about my wages.

Signature of Employee: _____ **Date:** _____

Items checked are to be completed by employer for dates _____ **through** _____.

☐ Date employment began: _____. If this is a new job, date first check was received: _____.

☐ Employee is paid: ☐ Weekly ☐ Biweekly ☐ Semimonthly ☐ Monthly ☐ Other: _____.

☐ Hours expected to work per pay period after training period ends: _____.

☐ Wages per hour: _____. If not paid hourly, wages expected per pay period: _____.

Is this seasonal employment? ☐ Yes ☐ No Day of week pay is usually received by employee: _____.

☐ Other expected earnings not included above (tips, commissions, etc.): _____.

☐ Number of dependents claimed for federal income tax purposes: _____. Marital status: _____.

☐ Is employee covered by a health insurance program? ☐ Yes ☐ No Insurance company's name: _____.

☐ Does employee have any type of savings plan at work (credit union, Christmas Club, etc.)? ☐ Yes ☐ No

If yes, give type of account and current balance: _____. Direct deposit of wages? ☐ Yes ☐ No

☐ Do you anticipate any changes in hourly rate or work hours? ☐ Yes ☐ No

If yes, please indicate change and expected date of change: _____.

☐ **List wage information below:** Gross pay refers to the total wages earned before any deductions and includes the employee share of social security paid by the employer for the employee.

Date Pay Period Ends	Date Pay Received	Hours Worked	Gross Pay	Tips, Bonus, Commission not included in gross	Any Benefits, Workman's Compensation, Disability, Maternity		Sick, Severance, Vacation Pay		Earned Income Credit	Eligible for UCB
					Type	Amount	Type	Amount		

☐ **If employee is on leave or laid off**, please indicate type of leave: _____. Date of final check: _____

Gross amount of final check: _____ Date employee is expected to return to work: _____

☐ **If employment has terminated**, please indicate reason employment ended: _____.

Date of final check: _____ Gross amount of final check: _____

Signature and Title of Person Providing Information: _____

Telephone: _____ Date Signed: _____

DSS Form 1245 (JUN 97) Edition of SEP 94 is obsolete.

Please provide income information beginning with the month of ________________ and continuing to ________________ .

Date Pay Received	Gross Pay	Date Pay Received	Gross Pay

Signature and Title of Person Providing Information: ____ .

Telephone: ______________________________ Date Signed: ______________________________