

## South Carolina Department of Social Services REQUEST FOR WAGE INFORMATION

PLEASE RETURN BY: \_\_\_\_\_

<b>From: (County name and address)</b>  <b>County Telephone Number:</b>  <b>County Fax Number:</b>	<b>Employee Name:</b>  <b>Last 4 Digits of Employee's Social Security Number:</b> XXX-XX- _____  <b>Case Name: (If different from Employee Name)</b>  <b>Case Number:</b>  <b>Employer Telephone Number:</b>  <b>Employer Fax Number:</b>
<b>To: (Name of employer)</b>  <b>Address of Employer:</b>	

\_\_\_\_\_  
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.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Items 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:  Mon  Tues  Wed  Thurs  Fri  Sat  Sun
- Other expected earnings not included above (tips, commissions, etc.): \_\_\_\_\_.
- 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 employee 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: \_\_\_\_\_

