



### EMPLOYER STATEMENT

I hereby authorize release to the Department of Family Services and authorized LIEAP agent all the information relating to my employment and income.

Employee's Printed Name: \_\_\_\_\_ Last 4 digits of SSN: \_\_\_\_\_

Employee's Address: \_\_\_\_\_

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Under the authority of Wyoming Statute 42-2-109, the State of Wyoming requests income verification in order to verify eligibility for state programs. This form is to be completed by the employer or employer's designee.*

**How often paid:**

- |   |  |
|---|--|
| <input type="checkbox"/> Weekly           | <input type="checkbox"/> Twice a month |
| <input type="checkbox"/> Every other week | <input type="checkbox"/> Monthly       |

Please complete the Pay Information below for the three (3) most recent pay periods or attach copies of the information from your payroll system.

Pay Period Beginning Date	Pay Period Ending Date	Date Paid	Hourly Rate of Pay	Hours Worked	Tips Commissions or Bonus	Total Gross Wages

Date Employment Started \_\_\_\_\_

Date of First Check \_\_\_\_\_

Date Employment Ended \_\_\_\_\_

Date of Final Check \_\_\_\_\_

Printed Name and Title of Employer or Designee	Business Name
Signature of Employer or Designee/Date	Business Phone Number