WAGE AND INSURANCE VERIFICATION

DCSS 0230 (12/15/2024)

CSE Case Number:

Participant Name:

Employer Name:

EMPLOYEE/CASE PARTICIPANT IDENTIFICATION AND CONTACT INFORMATION

(If you have different information, write new information in the blank spaces.)

Name:	Social Security Number:	Date of Birth:

Address:	Phone Number:

REQUIRED INFORMATION

EMPLOYEE WORK STATUS (Check all applicable boxes and fill in requested information.)

☐ **Never employed** (If never employed, no need to complete form further. Just sign the certification on page 3 and return entire form.)

☐ **Currently employed:** ☐ Part-time ☐ Full-time ☐ Seasonal

Usual season start date: _____

☐ **Independent Contractor**

Usual season end date: _____

Occupation:

☐ **No longer employed:** Last date employed: _____

Reason for termination of employment: _____

New employer name:	New employer address:

Has your business received an Income Withholding Order for support for this employee/Independent Contractor? ☐ Yes ☐ No

What income tax filing status does employee report? ☐ Single ☐ Head of Household ☐ Married	How many dependents does employee claim for income tax withholding purposes? _____

EMPLOYEE/INDEPENDENT CONTRACTOR EARNINGS

Next Pay Date (Month, Day, Year):	Pay Frequency (Check one): ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly
Hourly Rate (If applicable): $ _____	Number of Hours: _____
Monthly Deduction For Mandatory Retirement: $ _____	For Mandatory Union Dues: $ _____

Union Name:	Union Local Number:

Period of Employment: From (Month, Day, Year): To (Month, Day, Year):

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Please complete employee's/independent contractor's earnings for the past 12 months or attach a copy of payroll/1099 earnings for those months. If the employee has worked less than 12 months, provide the information for the number of months employee did have earnings.

☐ Check if copy of payroll/1099 earnings is attached.

☐ Check if employee/independent contractor has worked less than 12 months.

Month / Year	Gross	Month / Year	Gross	Month / Year	Gross
January _____	$_____	July _____	$_____	January _____	$_____
February _____	$_____	August _____	$_____	February _____	$_____
March _____	$_____	September _____	$_____	March _____	$_____
April _____	$_____	October _____	$_____	April _____	$_____
May _____	$_____	November _____	$_____	May _____	$_____
June _____	$_____	December _____	$_____	June _____	$_____

HEALTH INSURANCE INFORMATION (Note to the preparer: If more than one plan is available to the employee, **please list the lowest cost insurance plan** available for the employee, even if it is different than the plan the employee is presently enrolled in.)

Check all applicable boxes:

☐ No health insurance is available to: ☐ Employee ☐ Employee's dependents

☐ Health insurance is available at **no cost** for: ☐ Employee ☐ Employee's dependents

☐ **Total** cost to the employee of **lowest cost** available health insurance **for employee and all of employee's insured dependents**:

Cost reported is for period: ☐ Annual ☐ Monthly ☐ Two Weeks ☐ Weekly ☐ Other

☐ Medical: $_____ ☐ Dental: $_____ ☐ Vision: $_____ ☐ Other: $_____

DEPENDENT INFORMATION

(List names of all of employee's insured dependents. Add a sheet of paper if more space needed.)

_____ _____ _____

_____ _____ _____

_____ _____ _____

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Participant Name:
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POLICY INFORMATION

	MEDICAL	DENTAL	VISION
Insurance Co. Name:			
Mailing Address:			
Phone Number:			
Policy Number:			
Effective Date:			
Expiration Date:			

CERTIFICATION OF RECORD

I have personally completed this form, or printed and attached records containing **all** of the employee's earnings and benefits information requested in this form, from the payroll records in my custody and control. I am personally aware such records are kept in the regular course of business and that entries therein are made at or about the time of the condition or event. I have compared the records with the above Wage and Insurance Verification (DCSS 0230) and know the information I am supplying to be accurate.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Print Name	Signature	Executed on (Date)
Job Title	Address	
Name of Company or Business Organization		
Telephone Number	Email Address	
Fax Number	FEIN (Do not provide SSN)	