OFFICE USE ONLY:
Date/Time Application/Redetermination Received:
Local Department of Social Services:
FIPS:
Case #:
Category of Care:

CHILD CARE SUBSIDY SERVICE APPLICATION AND REDETERMINATION FORM

Correspondence ID: _____

RIGHTS OF APPLICANTS FOR CHILD CARE SUBSIDY SERVICES

Anyone may apply for child care services. You must apply in the city or county in which you live. You do not have to have lived in the county or city for any specific length of time. The child(ren) for whom the child care service application is submitted must be a citizen of the United States or have legal alien status. You must provide proof of their citizenship or legal alien status.

You have the right to equal treatment regardless of race, color, religion, sex, national origin or handicap.

You have the right to receive and complete a Child Care Service Application on the day you request child care services. If you need help filling out the application, someone will assist you.

The process of determining eligibility for child care subsidy must be explained to you. You will be asked to verify certain information.

The local department of social services (local department) will decide on your application within 30 days. If this is impossible, you must be told why. The local department must send you a written Notice of Action if you are not eligible or if there is a delay.

If you are determined eligible, you have a right for child care services to begin within 30 days after the local department gets your signed and completed application unless the local department has a Fee Subsidy Waiting List for child care services. If your name is placed on this waiting list, the child care worker will explain the reason why and the waiting list process. The local department must send written notification explaining their decision to add you to the waiting list. You may request that your name be removed from the waiting list at any time.

You have the right to mandated child care services for which you meet eligibility requirements, for which there is funding and for which a legally operating provider is available. Your right to other services depends on meeting eligibility requirements and on whether or not the local department offers the service. This application is for child care assistance only.

You have a right to see the information in your child care record.

The local department may not release information about you without your written consent except for purposes directly connected with the administration of social service programs or by court order.

Information about the Virginia Department of Social Services (VDSS) and the Child Care Subsidy Program (child care services) may be found at: *www.dss.virginia.gov* or *www.childcareva.com*.

CHILD CARE SUBSIDY SERVICE APPLICATION AND REDETERMINATION FORM

Correspondence ID: _____

Please provide the following information about yourself. (Please Print)

Last Name		First Name		Middle Initial	
Physical Street Address					
City/State/Zip					
Mailing Address (if different)					
City/State/Zip					
Social Security # (optional)		Telephone (Home)			
Telephone (cell)		Telephone (Other)			

A. I am applying for child care assistance because: (Check all that apply)

- ☐ I am employed full-time
- ☐ I am employed part-time
- ☐ I am in education or training
- ☐ I participate in VIEW or SNAPET

B. I am over the age of 18, or a legally emancipated minor.

- ☐ No
- ☐ Yes

C. I would also like information on the following: (Check all that apply)

- ☐ TANF
- ☐ SNAP
- ☐ Heating/Cooling
- ☐ Food
- ☐ Medicaid
- ☐ Child Support
- ☐ Education (GED)
- ☐ Housing
- ☐ Domestic Violence
- ☐ Money Management
- ☐ Child Development
- ☐ Parenting
- ☐ Earned Income Tax Credit
- ☐ Family Planning
- ☐ Head Start/Preschool
- ☐ Drug or Substance Abuse Counseling
- ☐ Medical/Mental Health
- ☐ English as a Second Language Courses
- ☐ Community Resources
- ☐ Other:

D. ☐ YES ☐ NO Have you selected a child care provider? If yes, please provide the following information:

Name _____
Phone Number _____
Address _____
City/State/Zip _____
Type of Provider: ☐ Center ☐ Child Care Provider

E. ☐ YES ☐ NO Are you currently receiving, or have you received within the past twelve months, any benefits listed below from either this Department or another locality?

	TANF	MEDICAID	SNAP	CHILD CARE
Receiving Now	☐	☐	☐	☐
Received within the past 12 months	☐	☐	☐	☐
Never Received	☐	☐	☐	☐
Locality				

CHILD CARE SUBSIDY SERVICE APPLICATION AND REDETERMINATION FORM

Correspondence ID: _____

F. LIST ALL HOUSEHOLD MEMBERS

NAME (LAST/FIRST/MI) (List Applicant First)	**DATE OF BIRTH** **MM/DD/YYYY**	**RELATION-SHIP TO APPLICANT**	**SOCIAL SECURITY NUMBER (OPTIONAL)**	**SEX (M/F)**	**RACE ***	**HISPANIC Y/N**	**SCHOOL ATTENDING**	**GRADE LEVEL**	**IN HEAD START Y/N**	**NEEDS CHILD CARE Y/N**

* Race:
1=White
2= African-American
3 = Asian
4 = American Indian/Alaskan Native
5 = Other

What is the primary language spoken in your household?

☐ English ☐ Vietnamese ☐ Laotian ☐ Somali ☐ French ☐ Other (specify):
☐ Spanish ☐ Farsi ☐ Chinese ☐ Kurdish ☐ German
☐ Cambodian ☐ Haitian-Creole ☐ Korean ☐ Arabic ☐ Japanese

CHILD CARE SUBSIDY SERVICE APPLICATION AND REDETERMINATION FORM

Correspondence ID: _____

G. ENTER THE AMOUNT OF ALL INCOME RECEIVED BY YOU OR ANY OTHER HOUSEHOLD MEMBER.

NAME (LAST/FIRST/MI) (List Applicant First)	EMPLOYED (INCLUDES MILITARY) (Y/N)	SELF EMPLOYED (Y/N)	GROSS EARNINGS PER PAY PERIOD	PAY FREQUENCY *	SOCIAL SECURITY	PENSIONS	INTEREST/ DIVIDENDS	RENTAL INCOME	ALIMONY	CHILD SUPPORT	UNEMPLOYMENT	FARM INCOME	OTHER

* PAY FREQUENCY:

1 = Weekly
2 = Bi-Weekly (Every Two Weeks)
3 = Twice Monthly
4= Monthly

CHILD CARE SUBSIDY SERVICE APPLICATION AND REDETERMINATION FORM

Correspondence ID: _____

H. Employment Information *(complete for everyone in the household)*

Name: _____

Employer: _____

Employer Address: _____

Employer Phone Number: _____ Total hours worked weekly: _____ Travel Time: _____

Employment Start Date: _____

Work Schedule:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours (Example: 8-5)							

Name: _____

Employer: _____

Employer Address: _____

Employer Phone Number: _____ Total hours worked weekly: _____ Travel Time: _____

Employment Start Date: _____

Work Schedule:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours (Example: 8-5)							

Name: _____

Employer: _____

Employer Address: _____

Employer Phone Number: _____ Total hours worked weekly: _____ Travel Time: _____

Employment Start Date: _____

Work Schedule:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours (Example: 8-5)							

Name: _____

Employer: _____

Employer Address: _____

Employer Phone Number: _____ Total hours worked weekly: _____ Travel Time: _____

Employment Start Date: _____

Work Schedule:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours (Example: 8-5)							

CHILD CARE SUBSIDY SERVICE APPLICATION AND REDETERMINATION FORM

Correspondence ID: _____

I. Education/Training Information *(complete for everyone in the household)*

Name: _____

School/Training Program: _____

School Address: _____

_____

School Phone: _____ Total hours: _____Travel time: _____

Class Schedule:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours (Example: 8-5)							

Name: _____

School/Training Program: _____

School Address: _____

_____

School Phone: _____ Total hours: _____Travel time: _____

Class Schedule:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours (Example: 8-5)							

Name: _____

School/Training Program: _____

School Address: _____

_____

School Phone: _____ Total hours: _____Travel time: _____

Class Schedule:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours (Example: 8-5)							

Name: _____

School/Training Program: _____

School Address: _____

_____

School Phone: _____ Total hours: _____Travel time: _____

Class Schedule:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours (Example: 8-5)							

CHILD CARE SUBSIDY SERVICE APPLICATION AND REDETERMINATION FORM

Correspondence ID: _____

J. ☐ YES ☐ NO ☐ UNKNOWN Do any children have special needs/disability or medical issues? If yes, please explain. You must provide verification of any special needs or medical issues.

NAME _____ NEED: _____
NAME _____ NEED: _____
NAME _____ NEED: _____

K. ☐ YES ☐ NO ☐ UNKNOWN Have children received all immunizations required according to their age? If no or unknown, please explain. You may need to provide proof of these immunizations.

NAME _____ REASON: _____
NAME _____ REASON: _____
NAME _____ REASON: _____

L. ☐ YES ☐ NO ☐ UNKNOWN Are all children U.S. citizens or do they have legal alien status? If no, please explain.

NAME _____ EXPLAIN: _____
NAME _____ EXPLAIN: _____
NAME _____ EXPLAIN: _____

M. ☐ YES ☐ NO Are you or any other adult member in your household currently serving in the military or a member of either a National Guard unit or Military Reserve unit?

NAME _____ EXPLAIN: _____
NAME _____ EXPLAIN: _____
NAME _____ EXPLAIN: _____

N. ☐ YES ☐ NO Do you or anyone who lives with you have assets/resources that exceed $1 million in value? Countable assets/resources may include, but are not limited to: cash on hand, money in a checking or savings account, stocks or bonds, trust funds, pension plans, or retirement accounts.

Comments:

CHILD CARE SUBSIDY SERVICE APPLICATION AND REDETERMINATION FORM

Correspondence ID: _____

ACKNOWLEDGEMENT OF APPLICANT'S RESPONSIBILITIES

Please initial the following items and sign below:

_____ **My signature authorizes the release to the local department of social services all information necessary to determine and review my eligibility for child care services. I authorize the release of any employment, medical, or child care information obtained from any source to the state or local department that may review this application for child care assistance.**

_____ **This authorization is valid during the eligibility period of my case. I understand that this time limit does not apply to investigations regarding possible fraud.**

_____ **I understand that it will be necessary to release certain information to my child care provider.**

_____ **I understand that receipt of fee child care is limited to 72 months.**

_____ **I understand that the Virginia Department of Social Services (VDSS) has limited funding available for the purchase of Child Care Subsidy Services. The funding for Child Care Subsidy Services changes from year to year. I further understand that the availability of funding for child care services cannot be guaranteed. I understand that, if this funding ends or runs out, I will receive at least 10 days written advance notice of this action, and my name may be placed on the local department's waiting list at my request.**

_____ **I understand that to qualify for these funds I must have a current need for child care services; I must be working or participating in an approved educational or training program; and my total household gross monthly income must not exceed the maximum monthly household income determined by VDSS.**

_____ **I must give complete and accurate information needed for determining initial and on-going eligibility for child care services. The local department may have to ask for such things as pay stubs or permission to contact agencies or individuals to get proof of my income. If I give incorrect information, I could be prosecuted for perjury, larceny, or welfare fraud, and may no longer be eligible for child care assistance. I must repay any money paid on my behalf to which I was not entitled.**

_____ **I must notify the local department within 10 days of any changes that could affect my eligibility for child care services.**

_____ **My rights and responsibilities have been explained, and I have received a written copy of this application.**

_____ **I understand my appeal rights (see Appeal Instructions).**

Applicant Signature		Date
Representative or Witness (if signed by mark)		Date
Child Care Worker Signature	Phone	Date

RESPONSIBILITIES OF CHILD CARE SERVICE WORKERS

Child Care workers are responsible for assisting applicants for and recipients of child care services to find quality child care. Workers help the family locate child care and arrange for child care subsidy payments to the legally operating child care provider of the parent's choice. Workers assist the family to find any other services needed and available in the locality.

APPEAL INSTRUCTIONS

If you are not satisfied with a local department's decision about your case, you have the right to ask for an appeal by means of a conference or a hearing. You may request a hearing instead of or after the conference. A conference is administered by the local department and should be arranged by your Child Care Worker. This request must be made **within 30 days** after receiving written notice of the local agency's decision. If you request a conference **within 10 days** from the effective date of the notice, your service or service payment will continue until a decision is made.

If you are not satisfied with the outcome of the conference, you may request a hearing. A hearing is an evaluation by staff from the office of the Director of the Division of Appeals and Fair Hearings at the Virginia Department of Social Services. A request for a hearing on your appeal must be made **within 30 days** after receiving written notice of the local agency's decision. If you ask for a hearing **within 10 days** of the effective date of the notice, your service or service payment will continue until a decision is made.

You may appeal to the local department or write directly to:

Director, Division of Appeals and Fair Hearings
Virginia Department of Social Services 801 East
Main Street Richmond, Virginia 23219-2901

If you feel you were discriminated against at any time, you may file a complaint within 180 days of the alleged discriminatory act with the local department, the Commissioner of the Virginia Department of Social Services, or the Region III Office of Civil Rights at:

Office of Civil Rights, Region III U.S. Department of
Health and Human Services 150 South
Independence Mall West, Suite 372 Public Ledger
Building Philadelphia, PA 19106

More information about this process may be found at *www,dss.Virginia.aov/about/civil rights/*.

Worker's Initials Date

CHILD CARE SUBSIDY SERVICE APPLICATION AND REDETERMINATION FORM

Correspondence ID: _____

Child Care Parent Responsibilities

Immunizations

All children receiving services under the Child Care and Development Fund (CCDF) must be age-appropriately immunized, according to the current "Recommended Childhood Immunization Schedule, United States**."** You may be required to provide your child care worker with documentation of immunization, a physician's statement that required immunizations would be detrimental to the child's health, or a statement of religious exemption (on the CRE-1 form, "Certification of Religious Exemption").

Fraud

Fraud is larceny. Fraud involving more than $200 is a felony. The *Code of Virginia* (§63.2-522) deems any person who obtains assistance or benefits by means of a willful false statement or who knowingly fails to notify of changes in circumstances that could affect eligibility for assistance as guilt of larceny. Upon conviction, the *Code of Virginia* authorizes punishment according to state law.

Reporting Changes

You must report all required changes to the local department of social services within 10 days after they occur. You are required to report the following changes:

1. Your gross (before taxes) monthly family wages or other family income if the total amount exceeds: $ _____.
2. Your family no longer has income.
3. A change in education/training activity, including class days/hours and curriculum
4. A change in employment.
5. A change in the number of household members
6. A child receiving child care services reaches his/her 13th birthday
7. A change of address
8. A change of provider
9. A change in the number of hours child(ren) need child care
10. If your ECC card is lost or stolen

Child Support

You must contact your Division of Child Support Enforcement (DCSE) District Office within 10 days of approval of your child care services to schedule an appointment to complete a DCSE application for services, unless good cause has been established. The DCSE District Office contact information will be provided to you by your Child Care Worker.

Recording Attendance

You must record your child's attendance using either the VaECC Swipe Card system, or the Interactive Voice Response system (IVR), by phone. If you do not use your swipe card or IVR, you may be responsible for paying for the unrecorded attendance, and your case may be closed.

Repayment

In addition to any criminal punishment as set forth in the *Code of Virginia*, anyone who causes the Department of Social Services to make an improper vendor payment by withholding any of the above changes will be required to repay the amount of the improper payment. Repayment will be in either a lump sum or according to a written repayment plan between the responsible person and the local Department of Social Services.

By my signature below, I declare that I fully understand and agree to the above reporting requirements. If I give false, incorrect or incomplete information or do not report changes on time, I may be breaking the law and could be prosecuted for perjury, larceny or welfare fraud. I further understand that I must remove my child from child care if I stop going to the activity or work for which I am approved.

_____ _____
Applicant Date

_____ _____
Worker Date

FAIRFAX COUNTY CHILD CARE ASSISTANCE & REFERRAL

OUT OF HOUSEHOLD PARENT INFORMATION

Child 1:

Child's Name: _____

Out of Household Parent's Name: _____ Date of Birth: _____

Out of Household Parent's Address: _____

Out of Household Parent's Phone:_____ Shared Custody: ____ Yes ____ No

Child 2:

Child's Name: _____

Out of Household Parent's Name: _____ Date of Birth: _____

Out of Household Parent's Address: _____

Out of Household Parent's Phone:_____ Shared Custody: ____ Yes ____ No

Child 3:

Child's Name: _____

Out of Household Parent's Name: _____ Date of Birth: _____

Out of Household Parent's Address: _____

Out of Household Parent's Phone:_____ Shared Custody: ____ Yes ____ No

Child 4:

Child's Name: _____

Out of Household Parent's Name: _____ Date of Birth: _____

Out of Household Parent's Address: _____

Out of Household Parent's Phone:_____ Shared Custody: ____ Yes ____ No

Client Name: _____Worker's Initials _____ Date_____

DEPARTMENT OF FAMILY SERVICES
OFFICE FOR CHILDREN
CHILD CARE ASSISTANCE AND REFERRAL

Parent Responsibility Notice

Dear Parents,

Please read this notice carefully. It has information about your responsibilities as a parent in the Child Care Assistance and Referral (CCAR) Program. All parents are required to report changes and follow the policies and procedures in this CCAR Parent Responsibility Notice as well as the Parent Responsibility Letter signed during the initial eligibility and/or annual redetermination process. Failure to comply with requirements in the letter or the notice may result in a repayment to CCAR for the cost of child care and/ or a termination of child care services.

Reporting Requirements

The Parent Responsibility Letter lists changes that must be reported within 10 days of when they occur. You also need to let CCAR know within 10 days about the changes listed below. CCAR staff may ask you to verify changes by submitting additional information. It is important that you submit the requested verification(s) to your worker by the specified deadline.

- A change in phone number
- A change in marital status (This includes cohabitation.)
- A change to your family size, including pregnancy or birth of a child
- A change in work hours
- Receipt of or change in child support payments
- Disability leave due to an illness, pregnancy, etc.
- Withdrawal of your child from child care

Payment Policies

Parent co-payments are determined by the family's gross income and the number of people in the family unit. You are responsible for paying the entire assessed co-payment at the **beginning of each month** to your provider or center unless other arrangements have been made. In addition, you are responsible for charges that are not authorized as part of your eligibility which may include rates above the daily maximum reimbursable cost for care, registration and program activity fees.

Should you have questions about this information, please contact a member from your Child Care Team. The names of the people in your Child Care Team are listed below.

Parent/Guardian Signature_____ Date: _____

Eligibility Specialist _____ Phone: _____

Child Care Specialist _____ Phone: _____

Effective Date: February 8, 2016

County/City: Fairfax County (059) STE 800
12011 government center parkway
fairfax, VA 22035
Phone: (703) 449-8484

Commonwealth of Virginia
DEPARTMENT OF SOCIAL SERVICES

Date:
Case Manager: _____
Case Number: _____
Correspondence #: _____

Client Name:
Address:

Child Care Service Plan

Effective Begin Date:_____

Goals:

Self Sufficiency: ☐ Safety and Well-being of Children: ☐ _____ Other: ☐

Other (explain):

Objectives:

Maintain on-going employment: ☐
Education/Training: ☐
Protection/Prevention for children: ☐
Other: ☐

Other (explain):

Where do you see yourself 6 months from now:

Where do you see yourself 2 years from now:

Where do you see yourself 5 years from now:

Task:

What do you need to do to meet your employment goals:

Case #:

What is your backup plan for child care:

Local Department Responsibility:

Authorize Child Care Services ☐
Referral to Community Resources: ☐
Quality Child Care information: ☐
Other Supportive Services: ☐
Consumer Education: ☐
Other (explain): ☐

Parent Responsibility:

Report changes in 10 Days: ☐
Comply with Local DSS Request: ☐
Education/Training: ☐
Other: ☐
Maintain Employment: ☐
Satisfactory Progress: ☐
Pay required vendor Fees: ☐

Other (explain):

Type of Transportation:

Personal Vehicle: ☐ Public Transportation: ☐ Other: ☐

Other (explain):

Family Needs and other in-state benefits/services:

List Other Family Needs:

List Other State Benefits/Services received:

Does the family receive child support: Yes No
Explain:

Client Signature: _____ Date: _____

Worker Signature: _____ Date: _____

Case#: _____

Child Care Assistance and Referral Program
Verification of Contribution (Child Support)

******This form must be completed in full to show the type and the amount of support your family is receiving from the absent parent. Support can be given in many ways, for example food, shelter, money and personal care items. Failure to complete this form entirely may result in delay of child care services. Thank you! ******

Client Name: _____

Have you filed with the Division of Child Support Enforcement (DCSE)? Yes ☐ No ☐
Case Number _____

Absent parent name:	Child name:	How often:	Amount:
			$
			$
			$
			$
			$
			$

*****In addition to the amount above are you receiving any of the following from the absent parent? Please do not include any SNAP/Food Stamps or TANF you might receive*****

Food: Yes ☐ No ☐ Estimated monthly amount $ _____

Daily Needs: (Personal products, such as formula, diapers, clothing, etc.) Yes ☐ No ☐
Estimated monthly amount $ _____

Other financial support: (Such as alimony, car insurance, car payment or utilities being paid):
Do you receive the support as cash? Yes ☐ No ☐
Total monthly amount received $_____

Does the absent parent pay for your rent/mortgage as part of your support? Yes ☐ No ☐
Total monthly amount $_____

Are you paying Child Support on behalf of someone who does not live with you? Yes ☐ No ☐
Total monthly amount paid $_____

If anything changes with your child support, you must report it to us within 10 days.

I certify that that to the best of my knowledge, the above information is true and correct. I agree that you may contact me if further verification is necessary.

Signature: _____ Date: _____

Phone Number: _____

Fax Number: 703-324-3917 Attention: _____ TEAM: _____

COMPLETE THIS FORM ONLY IF YOU DO NOT RECEIVE PAYSTUBS

County of Fairfax, Virginia

To protect and enrich the quality of life for the people, neighborhoods and diverse communities of Fairfax County

EMPLOYMENT VERIFICATION

FAIRFAX COUNTY PROVIDES CHILD CARE ASSISTANCE TO LOW AND MODERATE-INCOME FAMILIES. TO BE ELIGIBLE FOR THIS PROGRAM, WORKING PARENTS MUST DOCUMENT HOURS OF WORK AND INCOME. PLEASE COMPLETE ALL INFORMATION REQUESTED BELOW.

Section I: Employee to complete

Employee's Name: _____ SSN: ***(optional)***

Employee's Address: _____
(street) (city) (zip)

Employee's Home Telephone: _____

I authorize my employer to release information regarding my employment, salary and schedule.

_____ _____
Employee's Signature Date

Section II: Employer to complete

1. _____ works for me _____ hours per week at an hourly rate of _____.

2. This employee is paid: _____ weekly _____ biweekly (26 times/year)
_____ monthly _____ semi-monthly (24 times/year)

3. The employee **does** _____ / **does not** _____ receive paystubs. If the employee does receive paystubs according to company policy, the next one will be issued: _____.

4. Does this employee's work schedule vary from week to week? Yes _____ No _____

5. Complete employee's schedule:

Date	Hours Scheduled	
Mon	from:	to:
Tues	from:	to:
Wed	from:	to:
Thur	from:	to:
Fri	from:	to:
Sat	from:	to:
Sun	from:	to:

Employee's Start Date: _____

Employer's Name(please print): _____

Employer's Signature _____

Company or Organization: _____

Address: _____

_____

Employer's Telephone: _____

Date: _____

Office for Children/Child Care Assistance and Referral
Department of Family Services
12011 Government Center Parkway, 8th Floor
Fairfax, Virginia 22035
703-449-8484, TTY 711, Fax 703-324-3917
www.fairfaxcounty.gov/ofc

COMPLETE ESTE FORMULARIO SOLAMENTE SI NO RECIBE COLILLAS DE PAGO O CHEQUES

VERIFICACIÓN DE EMPLEO

EL CONDADO DE FAIRFAX PROVEE AYUDA CON EL CUIDADO DE NIÑOS A FAMILIAS DE BAJOS INGRESOS O' DE INGRESOS MODERADOS. PARA SER ELEGIBLE, AQUELLOS PADRES QUE TRABAJAN DEBERÁN PROVEER SUS HORAS DE TRABAJO E INGRESOS. POR FAVOR, COMPLETE TODA LA INFORMACIÓN QUE SE LE SOLICITA A CONTINUACIÓN.

Sección I. Completar por el empleado

Nombre del empleado: _____ Seguro Social(opcional): _____

Dirección del empleado:_____
(calle) (ciudad) (código postal)

Numero de teléfono del empleado: _____

Autorizo a mi empleador a proveer información con respecto a mi empleo, salario y horario de trabajo.

_____ _____
Firma del empleado *Fecha*

Sección II: Completar por el Empleador/Jefe o Supervisor:

1. _____ trabaja para mí _____ horas por semana, y cobra un salario de _____por hora.

2. Este empleado cobra su salario:_____semanal _____bisemanal/cada dos semanas (26 veces/año)
_____mensual _____quincenal/dos veces al mes (24 veces/año)

3. El empleado_____**recibe**_____**no recibe** colillas de pago. Si el empleado recibe colillas de pago, conforme a las política de la empresa, el siguiente cheque será emitido: _____.

4. El horario laboral de este empleado, ¿varía de una semana a otra? Sí_____ No _____

5. Complete el horario de trabajo del empleado:

Fecha	**Horario de trabajo**
Lunes	De: a:
Martes	De: a:
Miércoles	De: a:
Jueves	De: a:
Viernes	De: a:
Sábado	De: a:
Domingo	De: a:

Primer día de trabajo del empleado: _____

Empresa u organización: _____

Dirección: _____

_____

Teléfono del empleador/Jefe o Supervisor:
_____

Nombre del Jefe o Supervisor: _____
(Por favor, imprima el nombre)

Firma del Jefe o Supervisor: _____

Fecha: _____