DEPARTMENT OF SOCIAL SERVICES
DIVISION OF ECONOMIC ASSISTANCE

PHONE:
FAX:
WEB: dss.sd.gov

November 1, 2022

RE: Wage Information For: ____

I AUTHORIZE THE RELEASE OF THIS INFORMATION TO THE DEPARTMENT OF SOCIAL SERVICES.

See Attached Release of Information

Dear

The individual named above has authorized the release of information to the Department of Social Services (DSS). Please complete the reverse side of this form and return it in the enclosed stamped, self-addressed envelope or by faxing it to our office if there is a number listed above.

Through coordinated efforts of the DSS and Department of Labor and Regulation (DLR) local offices, our programs have increased responsibility in:

- Helping adults who can work become employed and/or stay employed; and
- Accurately reflecting income received by individuals on our programs to reduce the risk of a financial sanction against the State of South Dakota.

Thank you for taking the time to complete all the information on this form. Your help is very much appreciated. Please feel free to contact me if you have questions.

Sincerely,

Economic Assistance Benefits Specialist

DSS-EA-324 10/19

Case Number____________ Section: __1__

WAGE VERIFICATION

To Be Completed by Employer – Return To: ____Fax #: ___________________

EMPLOYEE NAME	SOCIAL SECURITY NUMBER - -

1. Employment Information

First Day	Date: ___/___/___	**First Paycheck (if new)**	Date: ___/___/___	Expected Hrs. in 1st Pay Period (if new):
Rate of Pay	$____________	☐ Per Hour ☐ Per Day ☐ Per Week ☐ Per Month ☐ Per Job		Average Hours Per Week:_________________
Pay Period:	☐ Weekly ☐ Bi-Weekly ☐ Twice a Month ☐ Monthly ☐ Other: ___________			
Last Day (if ended)	Date: ___/___/___	**Last Paycheck (if ended)**	Date: ___/___/___	Gross Amt of Last Paycheck:
Reason Ended (if no longer employed)	☐ Quit ☐ Laid Off ☐ Fired ☐ Did Not Return ☐Medical Leave ☐ Temporary Work ☐ Maternity Leave ☐Other ______________			
Anticipated Wage Increases or Decreases?		Please Explain:		

Other Employment Information

Workforce Innovation and Opportunity Act (WIOA): ☐Yes- On the job Training ☐ Yes-Work Experience ☐ No

Work study, graduate assistantship or stipend: ☐ Yes ☐ No | Will employment last at least 120 days? ☐ Yes ☐ No

2. Income Received

List all earnings employee received in the following timeframe: _______________________ to __________________________
Include anticipated earnings if payments outside regular wages are expected. Please report earnings received in the fields below or submit payroll records. Payroll records may include copies of paystubs, computer printouts, etc.

Date Received by Employee	Hours Worked	Gross Earnings	Tips	Child Support Deducted	Net Earnings	Payment Type*
___/___/___						
___/___/___						
___/___/___						
___/___/___						
___/___/___						

*Payment types include but are not limited to: regular wages, overtime, bonuses, leave pay, and retirement or vacation payout

3. Health Insurance Information

Does employee have medical insurance through your company?	☐ Yes ☐ No
Is medical insurance available through your company?	☐ Yes ☐ No

If employee has employer-sponsored medical insurance, please provide the following:	Name of Insurance Company:	
Coverage Start Date:	Policy Number:	Group Number:

Coverage Includes:
☐ Employee ☐ Dependents (Please list) ____

The above information was provided by:

____ ____________________

Signature and Title of the Individual Completing this Form Date

_______________________________________ ________________ _____________

Please print your name and the name of the business Business Telephone Fax Number