EMPLOYMENT QUESTIONNAIRE

Case Name:
Case Number:
Worker Name:
Worker Number:
Worker Telephone:
Date:

You must complete, sign and date this form and return it by: ______________________

Since ______________ Is now employed or has changed jobs, we need the following information:

Date job started: ____________ Job Title: ______________________

Employer's name, address and phone number: ______________________

____

Is this seasonal farm work? ☐ Yes ☐ No

Number of hours worked: Per Day: ____________ Per Week: ____________

How often are checks received? (check one)

☐ Weekly What day of the Week? ______________

☐ Every other week What day of the Week? ______________

☐ Twice monthly What dates? ______________

How much are you paid? Per hour $ ________ Per week $ ________ Per month $ ________

Are tips received? ☐ Yes, estimated amount per week $ __________ ☐ No

Date you will receive your first pay check? ______________

Do you pay for dependent care due to your job? ☐ Yes ☐ No

If yes, is provider licensed or exempt? ☐ Licensed ☐ Exempt

Name of Child	Age	Amount Paid	How Often

Are you covered by medical insurance through your employer? ☐ Yes ☐ No

Are you covered by dental insurance through your employer? ☐ Yes ☐ No

If yes, list members of your family who are covered: ______________________

Do you pay the premium? ☐ Yes How much and how often? ______________________

☐ No

______________________________ ______________________________

Signature of Employed Person Date Signed