

ONLINE

DPHHS-HCS/CC-011
(Rev. 4/04)

STATE OF MONTANA
Department of Public Health and Human Services
Human and Community Services Division

RELEASE OF INFORMATION/REQUEST FOR VERIFICATION

Directions: Applicant completes Release of Information portion, then delivers the form to employer and school for completion. The applicant, employer, or school may return the completed form to the CCR&R agency.

PERMISSION TO RELEASE INFORMATION

I, _____, grant permission to
(Applicant)

_____ to release
(Place of Employment, School or Training Institution)

the information requested on this form to the Child Care Resource and Referral (CCR&R) Agency, listed to the right.

Applicant's Signature: _____

SSN: _____ Date: _____

Return to CCR&R by _____

The Nurturing Center
146 Third Avenue West
Kalispell, MT 59901

406-756-1414

800-204-0644

REQUEST FOR TRAINING VERIFICATION

School Official: The information requested is needed to determine eligibility for a child care scholarship. Thank you for your cooperation.

This individual is enrolled: Part-time at: _____,
 Full-time (Name of School)

and is training for _____
(Occupation)

This verifies that _____, is making: satisfactory progress in
(Name of Student) unsatisfactory

their training program and is in: good school standing. Anticipated graduation date? _____
 poor

Current Semester Dates: Begin: _____ to End: _____

Does this individual currently hold a bachelor's degree? Yes No If yes, graduation date? _____

Current Bachelor's Degree: _____

Please list class and lab time and effective dates, or attach an official copy of the student's class schedule:

	MON	TUE	WED	THU	FRI	SAT	SUN
Start Time	_____	_____	_____	_____	_____	_____	_____
End Time	_____	_____	_____	_____	_____	_____	_____
Effective from	_____ to _____						

(School Official Signature)

(Print Name)

(Telephone)

(Date)

- over -

WORK VERIFICATION for _____

(Applicant)

Employer: The information requested is needed to determine eligibility for a child care scholarship. Thank you for your cooperation.

1. What date did / does employment start? _____
(Month) (Day) (Year)

2. What is this employee's GROSS salary, wages and commissions? \$ _____/month & \$ _____/hr.

3. Does this employee have any company-paid flexible child care benefits that could be taken in cash?

Yes No If yes, please list amount \$ _____ per month. Explain:

4. Does this employee receive tips or bonuses? Yes No If yes, please approximate \$ _____ per month.

5. Does this employee ever work overtime? Yes No If yes, what is the monthly rate? \$ _____.

6. Does this employee receive "in-kind" (non-cash) or cash benefits as part of their pay? For example, a housing allowance, apartment or food? Yes No If yes, please list amount \$ _____ per month.

Explain: _____

7. Please complete the following work schedule and indicate effective dates:

	MON	TUE	WED	THU	FRI	SAT	SUN
Start Time	_____	_____	_____	_____	_____	_____	_____
End Time	_____	_____	_____	_____	_____	_____	_____

Work schedule effective from _____ to _____.

1st payday is: ____/____/____, then weekly, every two weeks, monthly, or twice-a-month

Average number of work hours per week: _____ If work schedule varies, please explain:

Applicant: Please attach wage stubs to this form. Self-employed individuals must attach documentation of their income (e.g., taxes, income statements).

PLEASE READ AND SIGN: I certify that this information is true and correct to the best of my knowledge. I have the authority to make such verification on behalf of this company.

Employer's Signature: _____ Print Name: _____

Title: _____ Telephone: _____

Place of Employment: _____ Date: _____