



Verification of Loss of Employment

INSTRUCTIONS: To be completed entirely, signed, and dated by your former employer. **ONLY use BLUE or BLACK INK. Please print legibly- NO WHITE OUT ALLOWED.** If a mistake is made, please cross it out and initial next to the correction. To determine the eligibility of the individual listed for child care services, please assist by answering the questions below. Information must be verified by Coalition Eligibility staff.

DATE: _____

NAME OF EMPLOYEE: _____

LAST FOUR DIGITS OF SOCIAL: _____

SUPERVISOR NAME: _____

BUSINESS NAME: _____

BUSINESS ADDRESS: _____

BUSINESS PHONE NUMBER: _____

Date Employment Ended: _____

Date Of Final Check: _____

Employee Was (Circle One): Laid Off
Terminated
Temporary Work Ended
Other (Please Explain): _____

This information is true and correct to the best of my knowledge. I know that if I purposely give false information, I may be subject to prosecution.

Employer Signature

Employer Title

*Please upload the completed form to your online account in the portal under "additional documents" at:
<https://familyservices.floridaearlylearning.com/Account/LogOn>. Please note this form is a requirement for each time the client has separated from employment. Information must be verified by Coalition Eligibility staff.