REQUEST FOR EARNINGS INFORMATION – DIVISION OF FAMILY RESOURCES

State Form 54092 (R3 / 8-24) / DFR 0065
Family and Social Services Administration

NOTICE OF CONFIDENTIALITY

The information obtained on this form is confidential under state and federal regulations, including 470 IAC 1-2-7, 470 IAC 1-3-1, 470 IAC 6-1-1, 405 IAC 1-1-12, 45 CFR 205.50, 7 CFR 272.1(c), and 42 CFR 431.300. This information will not be released except as permitted or required by law or with the consent of the applicant/recipient.

SOCIAL SECURITY NUMBER

***This State agency is requesting disclosure of your Social Security number, under IC 4-1-8-1, in order to perform its statutory function. Disclosure is mandatory and this form will not be processed without it.**

Date *(month, day, year)*

TO:	FROM: FSSA Document Center PO Box 1810 Marion, Indiana 46952 Fax#: (888)436-9199

RE: Request for Earnings Information for .	
Employee Social Security number *(last four digits)** XXX – XX –	
Case name	Case number

To Whom It May Concern:

The information being requested pages 2 and 3 of this form is necessary to determine eligibility for Temporary Assistance For Needy Families (TANF), the Supplemental Nutrition Assistance Program (SNAP), and/or Medical Assistance. Family and Social Services (FSSA) is required by law to verify earned income in the determination of eligibility for assistance. Your cooperation is needed in providing the information which is checked on the reverse side of this form.

Thank you in advance for your prompt attention and cooperation.

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EMPLOYER INFORMATION REGARDING EMPLOYEE	AGENCY INFORMATION REGARDING EMPLOYEE
Employer	Employer
Name of employee	Name of employee
Employee Social Security number *(last four digits)** XXX - XX –	Employee Social Security number *(last four digits)* * XXX – XX –
Address of employee *(street, city, state, and ZIP code)*	

PLEASE COMPLETE ALL THE REQUESTED INFORMATION WHICH IS CHECKED

☐ 1. Dates of employment FROM: TO:	☐ 2. Date of first check (*month, day, year)*	☐ 2a. Day of week paid
☐ 3. Number of hours the employee is anticipated to work each week	3a. Rate per hour $	3b. Frequency of pay ☐ Weekly ☐ Bi-weekly ☐ Semimonthly ☐ Monthly
☐ 4. Has the employee been terminated? ☐ Yes ☐ No	4a. If Yes, type of termination ☐ Quit ☐ Layoff ☐ Fired	4b. Effective date of action *(month, day, year)*

☐ 5. Date of final check *(month, day, year)*	5a. When will employee receive it?	☐ 6. Is the employee on strike? ☐ Yes ☐ No	6b. If Yes, date strike began *(month, day, year)*

☐ 7. Is the employee receiving any of the following? *(check all that apply)*

a. Tips-Reported	☐ Yes ☐ No	Amount $	Frequency
b. Sick benefits	☐ Yes ☐ No	Amount $	Frequency
c. Sub pay	☐ Yes ☐ No	Amount $	Frequency
d. Estimate of tips not reported		Amount $	Frequency

☐ 8. Does the employee belong to a credit union or other savings or retirement plan with a deduction from the gross pay? ☐ Yes ☐ No	8a. If Yes, name and location of the financial institution

☐ 9. Does the employee have medical insurance coverage? ☐ Yes ☐ No	9a. If Yes type of coverage	9b. Name of insurance company	9c. Policy number
9d. Effective date of coverage for the employee *(month, day, year)*	9e. List the dependents covered and the effective date of coverage for each		
9f. Address where claims are sent			
☐ 10. Does the employee have life insurance coverage? ☐ Yes ☐ No	10a. If Yes, type of coverage	10b. Name of insurance company	10c. Policy number
10d. Effective date of coverage for the employee *(month, day, year)*	10e. List the dependents covered and the effective date of coverage for each		
☐ 11. Does the employee have any mandatory deductions, excluding taxes or medical/life insurance? ☐ Yes ☐ No	11a. If Yes, list type(s) of deductions	11b. Amount of deduction $	

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Name of employer	Name of employee	Employee Social Security number *(last four digits)** XXX – XX –

☐ 12. ENTER INFORMATION REQUESTED BELOW FOR EACH PAY RECEIVED IN THE MONTHS INDICATED (Including reported tips from 7a)

Month of:			Month of:			Month of:			Month of:		
Date Paid	Gross Amount	Number of hours worked	Date Paid	Gross Amount	Number of hours worked	Date Paid	Gross Amount	Number of hours worked	Date Paid	Gross Amount	Number of hours worked

Signature of individual completing this form	Date signed *(month, day, year)*
Title of individual completing this form	Telephone number ( )