**DEPARTMENT OF CHILDREN AND FAMILIES**

Division of Early Care and Education

**Employer Confirmation of Earnings and Hours for Provider**

**Use of form:** This form must be completed by the employer. Wisconsin Statutes s. 49.001(9) and s. 49.143(5)(a) authorize the local agency to request this information from any person that it determines appropriate and necessary for the administration of the program. Please provide this information within 7 days after receiving this request. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

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| --- | --- |
| **Employer Information** | **Employee Information** |
| Name – Employer      | Name – Employee      |
| Address – Street      | Address – Street      |
| City / State / Zip Code      | City / State/ Zip Code      |
| FEIN      |  |
| In order to properly determine eligibility for Wisconsin Shares benefits, it is necessary to obtain and verify employment information about the employee named above. Please furnish the information requested below. |
| Date – Employment Started      | Date – Last Day of Employment      |
| Number of Hours Worked Per Week      | Hourly Pay Rate$      |
| **Work Shift** |
| The Department of Children and Families is requesting timecards, including the actual punch-in and punch-out times, for       from       to      . Please include timecard documentation with this completed form. Contact the State of Wisconsin representative below with any questions or concerns.**Indicate the standard work schedule below.** |
| Time | Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
| Start Time |       |       |       |       |       |       |       |
| End Time |       |       |       |       |       |       |       |
| Answer the following questions by checking the appropriate boxes. |
| [ ]  Yes [ ]  No Did the employee have any paid approved time off during the time frame of      ? |
|  If “Yes”, what is the time frame of paid approved time off?       |
| [ ]  Yes [ ]  No Did you expect the employee to return to work after the approved time off? |
| Indicate what type: [ ]  Sick leave [ ]  Disability [ ]  Worker’s Compensation [ ]  Vacation / personal |
|  |
| **PRINT NAME** – Representative Completing Form |  | Title |  | Telephone Number |  |
|  |
| **SIGNATURE** – Representative Completing Form |  | Date Signed |  |
| Please complete and return this form within seven (7) days to |       |  |
|  | Name |  |
|  |        |  |
|  | Title |  |
| Address – State Agency      |
| Telephone Number – State Agency      | Fax Number – State Agency      | E-mail Address – State Agency      |
| Additional Information      |