



State of Utah  
Department of Workforce Services  
**EMPLOYER VERIFICATION STATEMENT**

Heat Agency: \_\_\_\_\_  
Case #: \_\_\_\_\_

<b>HEAT OFFICE</b>	_____ has applied for utility benefits through the Home Energy Assistance Target (HEAT) Program. In order to complete his/her application, it is necessary that wage information for the month and year identified in number 5 below be verified. This information is kept strictly confidential and will be used solely for the purpose of determining eligibility for the HEAT assistance program. Please complete the part(s) relevant to the employee's situation.
	HEAT Contact: _____ HEAT Office: _____
	HEAT Office Phone #: _____ Fax #: _____
	Email Address: _____

<b>CLIENT</b>	CLIENT RELEASE STATEMENT: <i>Must be completed by client.</i> I, _____, verify that the last four digits of my Social Security Number are _____ and I give my permission to release my employment information to the HEAT Program.
	Employee's Signature: /s/ _____ Date: _____

<b>EMPLOYER</b>	EMPLOYER INFORMATION: <i>Must be completed by employer.</i>
	Name/Company: _____
	Phone #: _____
	Street Address: _____
	City, State, Zip: _____
	1. I certify that the above-named person is a (check one): <input type="checkbox"/> Current employee <input type="checkbox"/> Terminated employee (If terminated, last date worked: _____, last paycheck date: _____)
	2. This person works or worked for me (check one): <input type="checkbox"/> Full time <input type="checkbox"/> Part time
	3. This employee is/was paid (check one): <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> 2x/month <input type="checkbox"/> Monthly <input type="checkbox"/> Other: _____
	4. Number of hours or anticipated number of hours per pay period: _____
	<b>5. *** The total GROSS wages for the employee before taxes and other deductions during the month and year of _____ was \$ _____ .***</b>
6. During the month and year above, the following deductions were taken from this employee's wages: Medical \$_____ Dental \$_____ Vision \$_____ Child Support \$_____ Alimony \$_____	
Please include a printout of gross wages for month specified if available.	
Signature: /s/ _____ Date: _____	
Print Name: _____ Title: _____	

**Equal Opportunity Employer/Program**

Auxiliary aids and services are available upon request to individuals with disabilities by calling 801-526-9240. Individuals who are deaf, hard of hearing, or have speech impairments may call Relay Utah by dialing 711. Spanish Relay Utah: 1-888-346-3162.