# Albany County DSS Child Care Subsidy Program –Employer's Form

| Please return to: Application Unit, Child Care Subsidy Unit | | |
|---|---|---|
| **Phone:** 518-447-7435 (main number) | **Fax:** 518-447-7664 | **Email**: DSSCCSU@albanycountyny.gov |

To Employer Name/Address_____ Phone No._____

Please complete the information below so that my assistance benefit may be computed on an accurate and timely basis. You have my permission to relate all information requested on this form. Thank you for your cooperation.

Date: _____ Employee Signature:_____

| | |
|---|---|
| Employee Social Security #:_____-_____-_____ | Case Name: |
| Employee's Name: | Case Number: |

**Section I To be completed by employer**

**Please provide most current pay information (last 12 paychecks if available)**

| | Period Ending | Date Received | Number of Hours | Gross Pay | Tips |
|---|---|---|---|---|---|
| **1** | | | | | |
| **2** | | | | | |
| **3** | | | | | |
| **4** | | | | | |
| **5** | | | | | |
| **6** | | | | | |
| **7** | | | | | |
| **8** | | | | | |
| **9** | | | | | |
| **10** | | | | | |
| **11** | | | | | |
| **12** | | | | | |

Start Date: _____ 1ST Pay Date: _____ # Hours scheduled: Daily: _____ Weekly: _____

Full-time ☐ Part-time ☐ Days scheduled to work: (check all that apply) Mon___Tues___Wed___Thurs___Fri___Sat___Sun___

Scheduled Time: _____ AM or PM - to - _____ AM or PM Wage: Hourly rate $_____

Pay Period: weekly ☐ bi-weekly ☐ semi-monthly ☐ monthly ☐

Is Health Insurance available to your employee? Yes ☐ No ☐

Date job has, or will, terminate (if applicable):_____

Reason for termination (if applicable):_____ _____

Employer Signature: _____ Date: _____
Employer Name Printed:_____Title:_____Phone #:_____
Employer email:_____