COUNTY OF FRESNO

Department of Social Services

EMPLOYMENT QUESTIONNAIRE

Case Name:
Case Number:
Worker Name:
Worker Number:
Worker Telephone:
Date:

You must complete, sign and date this form and return it by: _____

Since _____ is now employed or has changed jobs, we need the following information:

Date job started: _____ Job Title: _____

Employer's name, address and phone number: _____

_____

Is this seasonal farm work? ☐ Yes ☐ No

Number of hours worked: Per day: _____ Per week: _____

How often are checks received? (check one)

☐ Weekly What day of the week? _____

☐ Every other week What day of the week? _____

☐ Twice monthly What dates? _____

How much are you paid? Per hour $_____ Per week $_____ Per month $_____

Are tips received? ☐ Yes, estimated amount per week $ _____ ☐ No

Date you will receive your first pay check? _____

Do you pay for dependent care due to your job? ☐ Yes ☐ No

If yes, is provider licensed or exempt? ☐ Licensed ☐ Exempt

Name of Child	Age	Amount Paid	How Often

Are you covered by medical insurance through your employer? ☐ Yes ☐ No

Are you covered by dental insurance through your employer? ☐ Yes ☐ No

If yes, list members of your family who are covered: _____

Do you pay the premium? ☐ Yes: How much and how often? _____

☐ No

_____ _____

Signature of Employed Person Date Signed