Child Support Services
Jefferson County

3500 Illinois Street, Suite 1300
Golden, CO 80401 Phone 303-271-4300
Fax 303-271-4091 or 303-271-4480

Serving the Tri-County Region

VERIFICATION OF EARNINGS

Date mailed:	March 22, 2016
Employer:	CORPORATE MANAGEMENT GROUP INC 12000 WASHINGTON ST STE 350 THORNTON, CO 80241-3136
Regarding:	NATHAN ANTHONY GONZALES
IV-D Case Number:	30-391245-44-3A
Social Security Number:	652-07-5959
Date of Birth:	02/11/1994

The JEFFERSON County Delegate Child Support Services Unit has determined that the above named individual has been employed by your firm. Please provide the following information pursuant to §26-13-107(3)((a)(I), (c) and (e) Colorado Revised Statutes (C.R.S.) The requirement to collect this information is provided to States pursuant to 42 U.S.C. TITLE 42, CHAPTER 7 SUBCHAPTER IV, PART D §666(c)(1)(C) and (D):

§26-13-107(3)(c) and (e). State parent locator service.

(c) The state parent locator service or the equivalent of a state child support services agency or delegate child support services unit of any other state may initiate a request requiring any employer, trustee, payor of funds, or other employer located within this state or doing business in this state to provide any information on the employment, compensation, and benefits of any individual for whom information is known. Compliance with such a request shall not subject the employer, trustee, or payor of funds to liability to the obligor for disclosing such information without a subpoena pursuant to this paragraph (c).

(e) The state parent locator service or a delegate child support services unit may initiate a request requiring any person located within this state or doing business in this state who is in possession or control of personal property or information concerning the location, benefits, income, and assets of parents with a child support obligation to provide such information to the requesting agency. Compliance with such request shall not subject the holder to liability to the obligor for disclosing such information without a subpoena pursuant to this paragraph (e).

FEIN: 20-1535646

Date employment began: 4/6/2015 Date of termination: 2/12/16

Reason for Termination: Voluntarily quit due to job abandonment
(i.e., quit voluntarily, fired, laid off due to lack of work, etc.)

Employee's job title: Packager SSN: 652-07-8247 DOB:_____

Employee's last known address or where last W-2 form was mailed, whichever is more recent:
Address:_____
City: _____ State: _____ Zip Code:_____
Telephone: (_____)_____

Number of hours hired to work: _____ Are more hours available? Yes ____ No ____
If Yes, how many? _____

Pay Frequency: Monthly _____ Bi-Monthly _____ Weekly _____ Other _____
Hourly Rate $ _____ Overtime Rate $ _____ Overtime Mandatory? Yes ____ No ____

Does the employee have direct deposit? Yes _____ No _____
If Yes, Bank Name _____ Acct No._____

Is this employee currently enrolled in a pension plan? Yes _____ No _____
If Yes, please list plan administrator, address, and phone number.
Administrator: _____
Address:_____
City: _____ State: _____ Zip Code:_____
Telephone: (_____)_____

Employee Worksite Address:_____
City: _____ State: _____ Zip Code:_____

Gross Monthly Income: It is important that you provide accurate information for the most recent 2-year period, as this document may be used in a court of law.

JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC

Please indicate years documented above: Year 1 _____ Year 2 _____

WHO ACCEPTS NOTICES TO EMPLOYERS? _____

Is medical coverage available to this employee and dependents? Yes ____ No ____
If this person is eligible, please complete the information below.

Insurance Carrier: _____ Is this an HMO? Yes ____ No ____
Address:_____
City: _____ State: _____ Zip Code:_____
Telephone: (_____)_____

Policy Number: _____ Group Number:_____
Effective Date:_____
Monthly Premium Cost to Employee: $_____
Monthly Premium Cost per Covered Dependent: $_____
Names of Individuals Covered by Policy:_____
_____
_____

Income assignments should be sent to: _____ this address
_____ corporate or billing address
Address:_____
City: _____ State: _____ Zip Code:_____

Order for health insurance should be sent to: _____ this address
_____ corporate or billing address
Address:_____
City: _____ State: _____ Zip Code:_____

If this person has terminated employment with you, please provide his/her current employer if known:
Address:_____
City: _____ State: _____ Zip Code:_____

Please include a printout of the employee's payroll summary indicating the earnings for the last pay period, if available.

Thank you for your help in this matter. If you need additional information to complete this form, please contact:

DENISE E LUJAN
Legal Technician/Paralegal
(303) 271-4300

_____ _____
Person completing this report Title

_____ _____
Date Phone

The completed form can be faxed to _____.