

CORPORATE MANAGEMENT GROUP INC  
12000 WASHINGTON ST STE 350  
THORNTON, CO 80241-3136

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MAY 09 2016

BY:.....



# 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: May 06, 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: \_\_\_\_\_

Date employment began: \_\_\_\_\_ Date of termination: \_\_\_\_\_

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

Employee's job title: \_\_\_\_\_ SSN: \_\_\_\_\_ 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:

TAYLOR L GOLDBERG  
Legal Technician/Paralegal  
(303) 271-4300

_____	_____
Person completing this report	Title
_____	_____
Date	Phone

The completed form can be faxed to \_\_\_\_\_.