

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Email: \_\_\_\_\_



**CHILD NUTRITION**

ARKANSAS

DEPARTMENT OF EDUCATION

CHILD NUTRITION UNIT

2020 West Third Street, Suite 404

Phone: (501) 324-9502

Submit form to [Ade.ffvp@ade.arkansas.gov](mailto:Ade.ffvp@ade.arkansas.gov)

**Confirmation of Hourly Pay Rate for FFVP Grant Workers:**

You may use this form to confirm hourly rate of pay for FFVP workers instead of sending a copy of the employee's contract. **As of July 1, 2012, OVERTIME will not be reimbursed.**

List names and hourly pay rate for each FFVP worker who are assigned to the FFVP grant project in order for hour worked on this grant to be reimbursed to the district.

Have the Superintendent sign this form and fax to me for your grant files. Keep a copy in your records. Please only send new forms when new workers are added. Thank you.

Worker(s) Name	Regular Pay Rate	Fringe Percent

Signature below verifies the hourly rate of pay for workers listed above in the FFVP grant.

\_\_\_\_\_  
Signature of District Superintendent

\_\_\_\_\_  
Date