

## PRIMARY HEALTH CARE PROGRAM / EXPANDED PRIMARY HEALTH CARE PROGRAM EMPLOYMENT VERIFICATION

	Date/Fecha	Case Record No./Núm de Caso
	Office Address and Telepl	none No./Oficina y Teléfono
	Fax:	

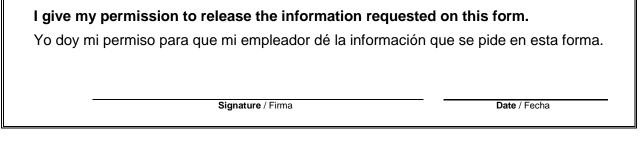
Employee	Social Security Number

This individual is a member of a household applying for health care assistance from the Primary Health Care Program or Expanded Primary Health Care Program. To determine this household's eligibility, it is necessary to verify all earnings. Since this individual is/was/will be your employee, your help is needed.

Please completely and accurately provide the information requested on the back of this letter. If a question does not apply, mark it N/A. After you complete this form you may, give it to your employee, mail it in the envelope provided, or fax it to the number listed above.

This information is needed not later than this date: \_\_\_\_\_\_.

Thank you for your assistance. If you have any questions, please feel free to contact our office.



Comments:



## EMPLOYMENT VERIFICATION

Employee Name (as shown on your records)			
Employee Address – Street, City, State, ZIP (as shown on your records)			
Is/was/will this person (be) employed by you?	Is FICA or FIT withheld?		
Yes No If yes → Permanent Temp	oorary Yes No		
Rate of Pay Average Hot	urs per Pay Period How often is employee paid?		
\$ Per Per Per Per Per Per Solution Per Day Week Month Job			
On the chart below, list all wages received			

by this employee during the months of:

Date Pay Period Ended	Date Employee Received Paycheck	Actual Hours	Gross Pay	<b>Other Pay</b> * (Bonuses, Commissions, Overtime, Pension Plan, Profit Sharing, Tips)
	* In (	Comments Section	below, please explain when	and how Other Pay is received.

Date Hired	Date First Paycheck Received	If employee is/was on Leave Without Pay	
		Start Date:	End Date:
If this person is no longer in your employ			
Date Final Paycheck Received: Gross Amount of Final Paycheck: \$			
Is health insurance available?			
Yes	No If Yes, employ	ee is $\rightarrow$ Not Enrolled	Enrolled for Enrolled with Self Only Family Members

Comments:

Signature and Title of Person Verifying This Information		Date	
Company or Employer	Address (Street, City, State, ZIP)	Telephone Number (Include area code.)	