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

Date/Fecha	**Case Record No.**/Núm de Caso
Office Address and Telephone 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.

I give my permission to release the information requested on this form.

Yo doy mi permiso para que mi empleador dé la información que se pide en esta forma.

_____ _____

Signature / Firma **Date** / Fecha

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? ☐ Yes ☐ No If yes → ☐ Permanent ☐ Temporary	**Is FICA or FIT withheld?** ☐ Yes ☐ No

Rate of Pay $ ☐ Per Hour ☐ Per Day ☐ Per Week ☐ Per Month ☐ Per Job	**Average Hours per Pay Period**	**How often is employee paid?**

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	Other Pay * (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, employee is → ☐ Not Enrolled ☐ Enrolled for Self Only ☐ Enrolled with 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.)**