EMPLOYMENT VERIFICATION

Employer's Name & Address

_____

_____

_____

DATE:	
CASE NAME:	
CASE NUMBER:	
Worker NUMBER:	
Worker Phone:	
Worker Address:	

AUTHORIZATION

Name: _____ **SSN**: _____

I hereby authorize disclosure to the San Diego County Health and Human Services Agency the employment information specified below. This information is required to determine my eligibility. I understand I have the right to revoke this authorization at any time, but that failure to cooperate may affect my eligibility.

Signature: _____ **Date**: _____

Employment Begin Date:	First Pay Date:
Number of Hours Worked in the Month of (_____):	Were additional hours of work offered or available? [ ] Yes [ ] No
Hourly Wage:	Is person covered by State Disability Insurance? [ ] Yes [ ] No
Job Title:	Is disability covered by a private carrier? [ ] Yes [ ] No
Work Schedule:	Health Insurance Offered [ ] Yes [ ] No Health Insurance Accepted [ ] Yes [ ] No Health Insurance Co: Health Insurance Number: Name of Persons Covered:
Comments:	

Specific Income Information:

Date Paid	Pay Period	Gross Earnings	Hours Worked	Date Paid	Pay Period	Gross Earnings	Hours Worked

Employment End Date: _____ If terminated, reason: _____

Income expected from termination:

Vacation Pay	Sick Leave Pay	Retirement	Other

_____ _____ _____ _____

Employer Printed Name & Signature | Title | Telephone | Date