County of San Diego – Health & Human Services Agency

EMPLOYMENT VERIFICATION

Employer's Name & Address

_____

_____

_____

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

AUTORIZACIÓN

Nombre: _____ **No. de Seguro Social**: _____

Por este medio yo autorizo le sea otorgada a la Agencia de Servicios Humanos y de Salud del Condado de San Diego la información de empleo especificada a continuación. Esta información es requerida para determinar mi elegibilidad. Yo entiendo que tengo el derecho de revocar esta autorización en cualquier momento, pero que la falta de cooperación podrá afectar mi elegibilidad.

Firma: _____ **Fecha**: _____

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