MCHD HCAP EMPLOYER VERIFICATION FORM

HCAP #: _____

Employer: Please fill out the following information according to your records:

Employee Name: _____

Employee Address: _____

_____

Is (or was) this person employed by you? Yes [ ]No [ ]

If yes, what type of job? [ ] Full time [ ] Part time [ ] Permanent [ ] Temporary

Amount Paid $ _____

Rate of pay: [ ] Daily [ ] Weekly [ ] Every 2 weeks [ ] Twice monthly
[ ] Monthly [ ] Other: _____

Did employee receive commission or tips? Yes [ ]No [ ]

Did employee participate in profit sharing, stock purchase, or pension plan? Yes [ ]No [ ]

Is health insurance available to employee? Yes [ ]No [ ]

If yes, employee is: [ ] Not enrolled [ ] Self enrolled [ ] Family enrolled

What is the name of Insurance Company? _____

Using the chart below, list all wages received by this employee from: _____ to _____.
Alternatively, you may list the last four (4) consecutive paychecks received:

Date employee received check	Actual Hours	Gross Pay	Tips/Commis.	EITC Advance

For all NEW employees: Date hired: _____ Date of first check: _____

Hours per week: _____ Termination Date: _____

Employer Information:

Name of Company (or Employer): _____

Address of Company (or Employer): _____

_____

Signature of person providing information: _____

Title: _____ Telephone Number: _____ _____