



Health Care Assistance Program  
 1400 S Loop 336 W, Conroe, TX 77304  
 936-523-5100 Fax 936-539-3450

## MCHD HCAP EMPLOYER VERIFICATION FORM

**Please have form completed by employer**

CASE # \_\_\_\_\_

<b>Employer Information:</b>  Company Name, Address, and Phone: _____ _____ _____ _____  Name and title of person providing information: _____ _____	<b>Employee information:</b>  Employee Name, Address, and Phone: _____ _____ _____ _____  Date hired: _____  Date terminated (if applies): _____
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**What type of job?**     Full time     Part time     Permanent     Temporary

**Rate of Pay:** \_\_\_\_\_ How:     Hourly     Salary     Commission     Other \_\_\_\_\_

**How often paid:**     Daily     Weekly     Bi-Weekly     Semi-Monthly     Monthly     Other \_\_\_\_\_

**Do you offer profit sharing, stock purchase, pension plan, or benefits to employee:**     Yes     No

If yes, what is offered and is employee enrolled: \_\_\_\_\_

**Is health insurance offered to employee:**     Yes     No

If yes, when do they become eligible: \_\_\_\_\_

If offered is employee:     Not Enrolled     Self Enrolled     Family Enrolled

If not enrolled, when is open enrollment: \_\_\_\_\_

What is name of the insurance company: \_\_\_\_\_

Please use chart below to list all wages received by this employee for the last four (4) consecutive pay periods:

Date Employee Received Check	Actual Hours	Gross Pay	Tips/Commission	EITC Advance

**For New Employee:**

When will they receive first check: \_\_\_\_\_                      Average scheduled hours per week: \_\_\_\_\_

Signature: \_\_\_\_\_    Date: \_\_\_\_\_