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 # _____

Employer Information:	**Employee information:**
Company Name, Address, and Phone: _____ _____ _____ _____	Employee Name, Address, and Phone: _____ _____ _____ _____
Name and title of person providing information: _____ _____	Date hired: _____ Date terminated (if applies):_____

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: _____