MAP ID: _____

HOUSEHOLD ID: _____

Employment Verification Form

Employer must fill out in ink.

Date of appointment: _____

Applicant name: _____ has applied for assistance.

To determine eligibility, all earnings must be verified.

1. Company/Employer name: _____

   Address: _____

   City, state, zip code: _____ Telephone: _____

2. Is the applicant named above employed by you? ☐ Yes ☐ No.

   If No, date employment ended: _____. If Yes, complete questions 3–8.

3. If the employee is or has been on leave of absence, give date leave began: _____

   Give the expected date employee will return: _____

4. Is the employee enrolled in health insurance through the company? ☐ Yes ☐ No.

5. What is the average number of hours the employee works per week? _____

   What is the hourly rate of pay? _____

6. How often is the employee paid?

   ☐ Daily ☐ Weekly ☐ Every two (2) weeks ☐ Twice a month ☐ Monthly

You must complete the form on the back. →

7. On the chart below, provide all earnings for the prior four (4) weeks.

   State gross earning (before deductions):

DATE PAID (enter as mm/dd/yy)	**GROSS AMOUNT** (before any deductions)

Example only

DATE PAID (enter as mm/dd/yy)	**GROSS AMOUNT** (before any deductions)
12/6/24	$250.25
12/13/24	$275.00
12/20/24	$200.75
12/27/24	$277.50

8. Are federal income taxes deducted from the employee's pay? ☐ Yes ☐ No.

Signature: _____ Date: _____

(Employer representative)

After completion, give this form to your employee. For questions, call our Central Health Navigation Center at 512.978.8130, option 1.