Children with Special Health Care Needs (CSHCN) Services Program

Employment Verification

Employer – Please provide the employee and wage information requested. Thank you for taking the time to complete all the information. Your help is appreciated.

Client's Name:	Date of Birth:	CSHCN Case No.

Employee Name:	Employee Address *(City, State, ZIP Code)*:
Company or Employer:	Address:

Is or was this person employed by you? ◯ Yes ◯ No If yes, what type of job? ______

Pay Rate: ______ ◯ Per Hour ◯ Per Day ◯ Per Week ◯ Per Job

How often is the employee paid?: ______ Average hours per pay period: ______

On the chart below, list all wages received by this employee during the month(s) of:

Date Pay Period Ended	Actual Hours	Gross Pay	Other Pay *(tips, commission, bonuses)**

*Explain (in comments section below) when and how often the employee receives tips, commission or bonuses.

If this person is longer your employee, please insert the date when the last paycheck was issued, including the gross amount.

Date Separated:	Reason for Separation:
Comments:	

This information is true and correct to the best of my knowledge.

Signature of HR Rep. or Employer	**Date**	**Title**	**Area Code and Phone No.**