



**Employment Verification**  
**(For Sliding Fee Program Application)**

Please provide to FHCSO any of the following information requested from your records concerning my employment.

Printed name:

\_\_\_\_\_

Date of birth: \_\_\_\_\_ SS or ITIN #: \_\_\_\_\_

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

Employee

To determine if the above-named individual is eligible for the benefits of an income-based program at the FHCSO, it is necessary to have information regarding the employment status of:

\_\_\_\_\_

Please complete the information on the following pages of this form and sign on the line indicated by the "X." The form must be returned to the FHCSO prior to the individual being considered for benefit eligibility.

Your cooperation in supplying this information is appreciated.

\_\_\_\_\_  
Name and title

\_\_\_\_\_  
Ph. No.

\_\_\_\_\_  
Fax:



Employee name: \_\_\_\_\_

1. Date employment started: \_\_\_\_\_  
 Date first pay was received or is to be received: \_\_\_\_\_  
 Number of hours worked in first pay period: \_\_\_\_\_  
 Does this number of hours reflect a regular "full" pay period? Y\_\_\_ No \_\_\_  
 Gross amount (before taxes) of first pay period: \_\_\_\_\_
  
2. Number of hours worked in a regular workweek: \_\_\_\_\_  
 If hours vary, please explain: \_\_\_\_\_  
 Hourly pay rate: \_\_\_\_\_  
 Overtime hourly pay rate: \_\_\_\_\_
  
3. Check how often the employee is paid:
  - a. Monthly: \_\_\_\_\_ Date: \_\_\_\_\_
  - b. Every two weeks: \_\_\_\_\_ Day of week: \_\_\_\_\_
  - c. Twice monthly: \_\_\_\_\_ Dates: \_\_\_\_\_
  - d. Weekly: \_\_\_\_\_ Day of week: \_\_\_\_\_
  - e. Daily: \_\_\_\_\_

4. Please provide below the requested information for each pay amount this employee received within the last two full months.

Date check received	Gross pay	Payroll period dates	Tips	Overtime	Bonuses



Employee name: \_\_\_\_\_

5. Does the employee have health insurance coverage? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, give name of company, policy number, and group number, type of coverage, persons covered, and effective date. \_\_\_\_\_

6. Is the employee required to have health insurance coverage? Yes \_\_\_\_ No \_\_\_\_

7. If employment has been terminated, please provide the information listed below:

- Date employment terminated: \_\_\_\_\_
- Total gross income (before taxes) received in last month of employment: \_\_\_\_\_
- Gross amount (before taxes) and date of receipt of final paycheck: \_\_\_\_\_
- Reason for termination: Quit \_\_\_\_\_ Fired \_\_\_\_\_  
Comments: \_\_\_\_\_

- If employee is eligible for benefits listed below, please check:  
\_\_\_\_\_ Unemployment      \_\_\_\_\_ Worker's Compensation  
\_\_\_\_\_ Insurance              \_\_\_\_\_ Paid accrued leave

\_\_\_\_\_  
Employer name  
(Please Print)

\_\_\_\_\_  
Work-site Supervisor Name  
(Please Print)

\_\_\_\_\_  
Authorized signature of employer

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone Number