CAO NAME AND ADDRESS

pennsylvania
DEPARTMENT OF HUMAN SERVICES

RESET

CASE IDENTIFICATION				
CO	RECORD NUMBER	CAT	CSLD	DIST
RECORD NAME				DATE

Employment Verification Form

TO:	
CASE #:	SSN:
FROM:	TELEPHONE #:

You have notified this office that you have obtained employment. Please have this form completed and return it no later than:

A self-addressed return envelope is enclosed or you can fax this form to:

Your employer must complete this form:

EMPLOYER'S NAME:	EMPLOYER'S TELEPHONE NUMBER:
EMPLOYER'S ADDRESS:	
DATE EMPLOYMENT STARTED (MOST RECENT START DATE):	NUMBER OF HOURS PER WEEK TO BE WORKED (ESTIMATE):
HOW OFTEN PAID (CHECK ONE): ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Twice a month	
STARTING HOURLY RATE: $	DATE OF FIRST PAY:
REGULAR HOURLY RATE/EFFECIVE DATE: $	
MEDICAL COVERAGE (CHECK ONE): ☐ Yes ☐ No	IF YES, NAME OF INSURANCE CARRIER:
GROUP/CONTRACT POLICY #:	DATE COVERAGE BEGAN:
WHO IS COVERED:	

EMPLOYER SIGNATURE	DATE
TITLE	TELEPHONE #