Employment Verification Form

Use ONLY if Spouse/Parent/Legal Guardian (not unmarried partner) does not receive Pay Stubs through their employer

By signing this document, you are authorizing the listed employer to release employment and wage information to the Screening for Life **(SFL)** and Health Care Connection **(HCC)** Programs. The information below will **ONLY** be used to verify eligibility for the programs. Once you complete the SFL Spouse/Parent/Legal Guardian Section, submit this document to your current employer. Please return the completed form to the SFL/HCC Office either via email to **dhss_dph_healthaccessde@delaware.gov**, by FAX to **302-736-7940 or to 302-739-2545**, or by mail to **SFL/HCC Office, Division of Public Health, 540 S. DuPont Highway, STE. 11, Dover, DE 19901**

SFL Applicant's Name: ____ **SFL ID# (if assigned):** ________________________

SFL Spouse/Parent/Legal Guardian Section

I, ________________________________ **(SFL Spouse/Parent/Legal Guardian Name)**, hereby authorize my employer to release my employment and wage information to the **SFL** and **HCC** Programs for the purpose of verification of eligibility.

____ _____ /______ /**2024**

Signature of SFL Spouse/Parent/Legal Guardian (Live) **Date**

Employer Section

(The following section is to be completed by your employer *One form per employer*)

Company Name: ____

Company Address: ____

____

Employee's Job Title: ____

Frequency of Pay (Pay Period): ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Semi-Monthly ☐ Yearly

Income Type: ☐ Hourly **Rate:** **$**______ . _____ per hour

☐ Salary **Salary:** **$**______ . _____ per pay period

Total hours per pay period: ________________ hours

If the employee is a seasonal worker, how many months are they employed at this pay level? ________________ months

____ ____________________________________

Employer's Name and Title (Print) **Employer's Contact Number**

____ _____ /______ /**2024**

Signature of Employer (Live) **Date**

**Any alterations made will void this document*

FOR SFL/HCC OFFICE USE ONLY

Verified By (SFL/HCC Employee Name and Title): ____________________________

Employer Contacted (Name and Title): _____________________________

Date of Verification: _____/_______/**2024**

(SFL/HCC Receipt Date Stamp Above)