REQUEST FOR EMPLOYER STATEMENT

Employer's Name and Address:

_____

_____

_____

Date: _____

Employee's SSN: (optional) _____

_____

All Kids/FamilyCare Applicant's Name:

_____(employee) has applied for medical coverage for his/her family.

We need information from you so that we can determine eligibility for your employee's family. Please provide the following information and return the form to the address or fax number listed below at your earliest convenience.

How frequently is the employee paid? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly

What is the rate of pay? _____ Hours worked/week? _____

Please provide the following information for the most recent pay received by employee.

PAY PERIOD (**Beginning and end date**)	**PAY DATE** (**Date employee received check**)	**GROSS PAY** (**Do not include Earned Income Credit**)

I certify that the above information is correct to the best of my knowledge and belief.

_____ _____

Signature Date

_____ _____

Title of Person Completing Form Phone Number

Please return this form to:

Employer's completion of this form or compliance with instructions is voluntary. However, failure to do so may affect All Kids' action. Form approved by the Forms Management Center.