Case Name:
Case Number:
Date:
DHS Office:
Co: District: Section: Unit: Worker:
Specialist:
Phone:
Fax:
Specialist ID:

STATE OF MICHIGAN
Department of Human Services

If you do not understand this, call a DHS office in your area.
DHS employees are prohibited by law from providing legal advice.
Si usted no entiende esto, llame a una oficina de DHS en su área.
La ley prohíbe a los empleados de DHS proporcionar asesoría legal.
إذا واجهت صعوبة في فهم هذا الطلب، فاتصل بمكتب DHS الموجود في منطقتك.
يحرّم القانون على موظفي DHS إعطاء النصيحة القانونية.

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

VERIFICATION OF EMPLOYMENT

EMPLOYER—Please provide the information requested in the following sections marked with an X.

Please return in the enclosed envelope to the specialist and address above by: Return Date

Employee Name	Social Security Number		
Address (Number and Street Name, Apt., etc.)	City	State	Zip Code

In accordance with the provisions of 1939 P.A. 280 (MCL 400.60, 400.8 and 400.83), employers are required to provide the Michigan Department of Human Services with copies of certain papers, records, and documents relevant to an inquiry or investigation conducted by the Department.

☒ SECTION 1 - EMPLOYMENT INFORMATION (To Be Completed By Employer)

Employment Status
- ☐ Employed
- ☐ Previously employed
- ☐ Never employed
- ☐ Temporarily off (explain)

Occupation

Date Employment Began

Date of First Paycheck

Number of Hours Expected to Work
☐ per week ☐ per pay period

Rate of Pay
$
☐ Hour
☐ Piece
☐ Salary

Differential Pay
$
☐ Hour
☐ Shift

Day of Week Paid

- ☐ Laid off
- ☐ Quit
- ☐ Fired
- ☐ Other (explain)

☐ **First Check Full**
☐ **First Check Partial**

Date Employment Ended or Is Expected to End

How Often Paid
- ☐ Weekly
- ☐ Twice monthly
- ☐ Every 2 weeks
- ☐ Monthly
- ☐ Other

Are tips/bonus/commission received?
☐ Yes ☐ No

Are they included in gross?
☐ Yes ☐ No

Average Amount ☐ **per week**
$ ☐ **per pay period**

Type of Employment
- ☐ Permanent
- ☐ Temporary

Date of Last Paycheck

Estimated Work Schedule (example 9 a – 5 p)

Sun	Mon	Tues	Wed	Thurs	Fri	Sat

☒ SECTION 2 - INSURANCE / RETIREMENT INFORMATION (To Be Completed By Employer)

Does employer offer health plan? ☐ Yes ☐ No

Is health plan available to employee? ☐ **Yes** ☐ **No**

Health Plan Premium (even if not enrolled)
$ ☐ per pay ☐ other

Is employee enrolled in health plan? ☐ Yes ☐ No If Yes →

Is anyone, other than the employee, covered under any plan? ☐ Yes ☐ No
If yes, who?
Which type of coverage?

Insurance Contracts that Cover Employee
- ☐ **Hospital**
- ☐ **Medical**
- ☐ **Dental**
- ☐ **Vision**
- ☐ **None**

Does employee have cafeteria-style benefit plan?
☐ Yes ☐ No

Name(s) of Insurance Company(s)

Name	Case Number	Specialist

Does employee have 401K or other retirement plan?	Does / did employee participate in stock, bond, credit union, deferred compensation, retirement or other resource development plan?	Amount of Deduction
☐ Yes ☐ No	☐ Yes - If Yes → Type ☐ No	$

☒ SECTION 3 - INCOME INFORMATION

Employer: Please complete the following information about each pay received during the period specified below.
(Use additional paper or computer printout if necessary.)

From:				To:			
Date Received	**Gross Income**	**Amount of Tip, Bonus or Commission If Not Included in Gross**	**Hours Worked**	**Date Received**	**Gross Income**	**Amount of Tip, Bonus or Commission If Not Included in Gross**	**Hours Worked**

☐ SECTION 4 - DISABILITY / WORKERS COMPENSATION INFORMATION (To Be Completed By Employer)

Were medical or disability benefits paid during the period specified in Section 3? ☐ No ☐ Yes From: To:	Name of Insurer Who Paid These Benefits		
	Address (Number and Street Name)		
	City	State	Zip Code
Was Worker's Compensation paid during the period specified in Section 3? ☐ No ☐ Yes From: To:	Date Awarded	Amount Awarded $	☐ Weekly ☐ Monthly
	Is Worker's Compensation claim pending? ☐ No ☐ Yes		
	Date Filed	Next Court Date	

☐ SECTION 5 - ADDITIONAL INFORMATION/COMMENTS

Additional Information Requested	Employer's Response (To Be Completed By Employer)

Employer's Comments

☒ SECTION 6 – SIGNATURE/BUSINESS INFORMATION (To Be Completed By Employer)

Business Name	Days and Hours of Operation	
Business Address		
Name of Person Completing Form (Please Print)	Business Telephone Number ( )	Employer Federal ID (FEIN)
Signature of Person Completing Form	**Title of Person Completing Form**	**Date Signed**

Anyone who makes a false statement in order to obtain, or help another obtain, assistance for which he/she is not eligible is subject to legal penalties. If the amount of assistance involved is more than $500, the violator is guilty of a felony; if the amount is $500 or less, the violation is a misdemeanor.

"This institution is an equal opportunity provider."

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AUTHORITY: 1939 PA 280 as amended (MCL 400.8, MCL 400.83, MCL 400.60) **COMPLETION:** Required
PENALTY: Failure to complete this form could result in issuance of a subpoena.