FLORIDA KIDCARE EMPLOYMENT STATEMENT

General Directions: Copy this form and have it completed by each employer that provides income to a family member on the KidCare application. If you provide recent pay stubs, you do not need this form completed.

Complete Section A and submit to employer for completion. Completed form must be returned to Florida KidCare, P O Box 591, Tallahassee, Florida, 32302-0591.

Section A – To Be Completed by Employee	
Family Account Number:	
I authorize the release of employment information	on for the purpose of determining KidCare eligibility.
Employee Signature:	Date:
Employee Name:	Employee SSN:
(piease print)	
Section B – To Be Completed by Employer	
	determine eligibility for KidCare Health Insurance. estions for the employee listed above, and returning llahassee, Florida, 32302-0591.
(1) Number of Hours Worked Per Week:	Number of Days Worked Per Week:
(2) How often is the employee paid:	ailyWeeklyBi-WeeklyMonthly
	Twice Monthly Other:
	(explain)
(3) Rate of gross pay: \$ per	our/Day/Week/etc. Other:(explain)
Ho	our/Day/Week/etc. (explain)
(4) If hours or rate of pay has varied in the above period, please state why (include tip information here):	
(5) Employer Statement: What I have written of I know that if I give false information on purpose	•
Signature of Employer	Employer's Title
Name of Employer (please print)	() Employer's Telephone Number
Name of Business	Date Completed
Business Address	City, State, Zip

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