Employment Verification (To Be Completed by Employer Only)

Return completed form to:

Centralized Scanning Unit (CSU)
P.O. Box 181
Concord, NH 03301
Or Fax to (603) 271-5623

Employee Name: ______________________________
SSN: ______-_____-________

1. NEW or CURRENT EMPLOYMENT

Date of Hire: ____/_____/_____ Job Title: ______________________________ Employer EIN: ____________________

Date of First Paycheck: ____/_____/_____ Frequency of Pay: **Weekly** / **Bi-weekly** / **Semi-monthly** / **Monthly** (circle one)

Avg. Hrs per Week: _____ Current Rate of Pay $______ per: _____ (hour/day) **Full time** / **Part time** / **Per Diem** (circle one)

Is this employment **Permanent** / **Temporary** / **Seasonal** (circle one)? If temporary, seasonal or per diem please explain:

____

____

Any anticipated changes in rate of pay or average hours? Yes ☐ or No ☐ (**If Yes**, use back of form to explain)

Does the employee work overtime? Yes ☐ or No ☐ **If Yes**, how often ________ # of hours ______

Does the employee have any of the following deductions?

Check all that apply and indicate the amount and frequency i.e., per week, month etc. (*use back of form if more space is needed*)

☐ Profit Sharing $ ______ per _____ ☐ Savings Bond(s) $ ______ per _____ ☐ Life Insurance $ ______ per _____

☐ Retirement/IRA $ ______ per _____ ☐ Other Pretax Deduction (i.e. union dues): Type _________ $ ______ per _____

☐ Mandatory Wage Garnishments (i.e. child support): Type: ______________________ $ ______ per _____

Is FIT OR FICA withheld? Yes ☐ or No ☐ Is health insurance available? Yes ☐ or No ☐

Leave of Absence:

On a Leave of Absence? Yes ☐ or No ☐ Begin Date: ____/_____/_____ Expected End Date: ____/_____/_____

Actual Date Final Paycheck was Received: ____/_____/_____ Gross Amount of Final Paycheck: $ ___________

Workers' Compensation **Pending** / **Being Paid** / **Denied or N/A** (circle one) Carrier's Name: ______________________

Short-Term Disability / **Long-Term Disability** or **N/A** (circle one) Frequency: (wkly, mth etc.) ________ Amount $ _________

2. LOSS OF EMPLOYMENT

Date Employment Ended: ____/_____/_____

Reason: ____

____

____

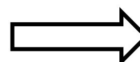
Actual Date Final Paycheck was Received: ____/_____/_____ Gross Amount of Final Paycheck: $ ___________

Did the employee receive money from another source? Yes ☐ or No ☐ **If Yes,** Indicate the source, type, frequency and amount (i.e., severance pay, workers comp, etc.): ____

____

Did the employee have health insurance? **Yes** ☐ or **No** ☐

If **Yes**, End Date: ____/_____/_____ COBRA: Yes ☐ or No ☐

Turn Page Over - signature required 

3. HEALTH INSURANCE (If known)

Does the employee have health insurance? Yes ☐ or No ☐ If **No**, did the employee decline? Yes ☐ or No ☐

1. Type (i.e., medical, vision, dental): ________________________________ Name of Carrier: ______________________

Policy Start Date: ____/_____/_____ Policy Number: _______________________ Group Number: ___________________

Address (No., Street): ___________________________City: ____________________ State: _____ ZIP Code: _________

Self or **Family** (circle one) Premium Amount $ ________ per (weekly, monthly etc.): _____

2. Type (i.e., medical, vision, dental): ________________________________ Name of Carrier: ______________________

Policy Start Date: ____/_____/_____ Policy Number: _______________________ Group Number: ___________________

Address (No., Street): ___________________________City: ____________________ State: _____ ZIP Code: _________

Self or **Family** (circle one) Premium Amount $ ________ per (weekly, monthly etc.): _____

4. WAGES RECEIVED

Complete this section for all employment types **(new, current, leave of absence or loss of employment)**

Please list the employee's gross wages for the last 4 weeks, ***and indicate all bonuses, tips, or commissions*** that are not already included in the gross wages. If the employee receives an Earned Income Tax Credit (EITC), indicate the amount of the credit.

				If not already included in Gross Wages…		
Actual Date Paid	**Gross Wages**	**EITC**	**# of Hours**	**Tips**	**Bonus**	**Commission**
	$	$		$	$	$
	$	$		$	$	$
	$	$		$	$	$
	$	$		$	$	$

Are ***ALL*** types of tips indicated? Yes ☐ or No ☐ **If NO,** explain: ____

Additional Information: ____

____

____

____

____

____

____

Thank you for your cooperation!

If you have any questions or need help completing this form please call our Customer Service Center at:
1-844-ASK-DHHS (1-844-275-3447) or 603-271-9700

Signature & Title of Person Completing this Form	Date
Printed Name of Person Completing this Form	Telephone Number
Company Name	Fax Number

Company Address	City	State	Zip

The Institution is an equal opportunity provider.