

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.  
 يحرم 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)**

<b>Employment Status</b> <input type="checkbox"/> Employed <input type="checkbox"/> Previously employed <input type="checkbox"/> Never employed <input type="checkbox"/> Temporarily off (explain)	<b>Occupation</b>	<b>Number of Hours Expected to Work</b> <input type="checkbox"/> per week <input type="checkbox"/> per pay period		
	<b>Date Employment Began</b>	<b>Rate of Pay</b> \$ <input type="checkbox"/> Hour <input type="checkbox"/> Piece <input type="checkbox"/> Salary	<b>Differential Pay</b> \$ <input type="checkbox"/> Hour <input type="checkbox"/> Shift	<b>Day of Week Paid</b>
	<b>Date of First Paycheck</b>	<input type="checkbox"/> First Check Full <input type="checkbox"/> First Check Partial	<b>How Often Paid</b> <input type="checkbox"/> Weekly <input type="checkbox"/> Twice monthly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Other	<b>Are tips/bonus/commission received?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Laid off <input type="checkbox"/> Quit <input type="checkbox"/> Fired <input type="checkbox"/> Other (explain)	<b>Date Employment Ended or Is Expected to End</b>	<b>Are they included in gross?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Average Amount</b> <input type="checkbox"/> per week \$ <input type="checkbox"/> per pay period
<b>Type of Employment</b> <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary	<b>Date of Last Paycheck</b>	<b>Estimated Work Schedule (example 9 a – 5 p)</b> Sun   Mon   Tues   Wed   Thurs   Fri   Sat		

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

<b>Does employer offer health plan?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is health plan available to employee?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Health Plan Premium (even if not enrolled)</b> \$ <input type="checkbox"/> per pay <input type="checkbox"/> other
<b>Is employee enrolled in health plan?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes →	<b>Insurance Contracts that Cover Employee</b> <input type="checkbox"/> Hospital <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> None	<b>Does employee have cafeteria-style benefit plan?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Name(s) of Insurance Company(s)</b>
<b>Is anyone, other than the employee, covered under any plan?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, who?</b> <b>Which type of coverage?</b>		

Name		Case Number	Specialist
Does employee have 401K or other retirement plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does / did employee participate in stock, bond, credit union, deferred compensation, retirement or other resource development plan? <input type="checkbox"/> Yes - If Yes → Type		Amount of Deduction \$ <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes From: _____ To: _____	Date Awarded	Amount Awarded \$	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
	Is Worker's Compensation claim pending? <input type="checkbox"/> No <input type="checkbox"/> 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.