Employment Verification Form

(Use ONLY if Applicant does not receive Pay Stubs through their Employer)

By signing this document, you are authorizing the listed employer to release employment and wage information to the Screening for Life **(SFL)** and Health Care Connection **(HCC)** Programs. The information below will **ONLY** be used to verify eligibility for the programs. Once you complete the Applicant Section of this document, submit this document to your current employer. Please return the completed form to the SFL/HCC Office either via email to **dhss_dph_healthaccessde@delaware.gov**, by FAX to **302-736-7940 or to 302-739-2545**, or by mail to **SFL/HCC Office, Division of Public Health, 540 S. DuPont Highway, STE. 11, Dover, DE 19901**

SFL Applicant's Name: _____ **SFL ID# (if assigned):** _____

SFL Applicant Section

I, _____**(SFL Applicant Name)**, hereby authorize my employer to release my employment and wage information to the **SFL** and **HCC** Programs for the purpose of verification of eligibility.

_____ _____/_____/ **2025**

Signature of SFL Applicant (Live) **Date**

Employer Section

(The following section is to be completed by your employer *One form per employer*)

Company Name: _____

Company Address: _____

_____

Employee's Job Title: _____

Frequency of Pay (Pay Period): ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Semi-Monthly ☐ Yearly

Income Type: ☐ Hourly **Rate:** **$**_____. _____per hour

☐ Salary **Salary:** **$**_____. _____per pay period

Total hours per pay period: _____hours

If the employee is a seasonal worker, how many months are they employed at this pay level? _____months

_____ _____

Employer's Name and Title (Print) **Employer's Contact Number**

_____ _____/_____/ **2025**

Signature of Employer (Live) **Date**

FOR SFL/HCC OFFICE USE ONLY

Verified By (SFL/HCC Employee Name and Title): _____

Employer Contacted (Name and Title): _____

Date of Verification: _____/_____/**2025**

(SFL/HCC Receipt Date Stamp Above)

**Any alterations made will void this document*