



Employment Verification Form

Use ONLY if Spouse/Parent/Legal Guardian (not unmarried partner) 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 SFL Spouse/Parent/Legal Guardian Section, submit this document to your current employer. Please return the completed form to the SFL/HCC Office either via email to dhss_dph_healthaccesssde@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 Spouse/Parent/Legal Guardian Section

I, _____ (SFL Spouse/Parent/Legal Guardian 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 Spouse/Parent/Legal Guardian (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

Signature of Employer (Live)

_____/_____/2025
Date

**Any alterations made will void this document*

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)