VERIFICATION OF EMPLOYMENT

Recipient's Name: _____
Recipient's Medicaid ID Number_____

Caregiver Name_____

This form is to be used only when verification of employment by the employer is unavailable.

A. ☐ I am self-employed.
☐ I am an independent contractor.
☐ I am an employee of_____.

B. I work as a_____.

C. ☐ I do most of my work outside the home.
☐ I do most of my work at my home.

D. If I do most of my work at my home,
☐ I have a separate, dedicated work space in my home.
☐ I do not have a separate, dedicated work space in my home.

E. If I do most of my work at my home,
☐ I can arrange my hours, interrupt my work, or be otherwise available for care if needed.
☐ I can not be available for care; I would need to hire a caregiver to supplement the hours that PDN could not provide

F. My typical work hours are (do not include on-call hours):

Monday_____	Thursday_____	Saturday_____
Tuesday_____	Friday_____	Sunday _____
Wednesday_____		

G. My typical work schedule:
☐ never or rarely varies.
☐ varies sometimes.
☐ varies a lot.

H. My typical work hours are:
☐ very flexible.
☐ somewhat flexible.
☐ not flexible.

I. Please elaborate on any of the above or include any additional relevant information on the back of this form.

An individual who certifies a material and false statement in this assessment will be subject to investigation for Medicaid fraud and, if applicable, will be referred to the appropriate professional licensing agency for investigation.

Signature_____Date_____