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 workspace in my home.
I do not have a separate, dedicated workspace 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 cannot 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 _____