**Employment Verification (To Be Completed by Employer Only)**

**Return completed form to:**
**Centralized Scanning Unit (CSU)**
**P.O. Box 181**
**Concord, NH 03301**
**Or Fax to (603) 271-5623**

Employee Name: Scott Michael
SSN: 771 - 239 - 458

## 1. NEW or CURRENT EMPLOYMENT

Date of Hire: 08 / 15 / 2024 Job Title: Associate Employer EIN: 208843930
Date of First Paycheck: 08 / 30 / 2024 Frequency of Pay: **Weekly** / **Bi-weekly** / **Semi-monthly** / **Monthly** (circle one)
Avg. Hrs per Week: 40 Current Rate of Pay $ 200 per: hour (hour/day) **Full time** / **Part time** / **Per Diem** (circle one)
Is this employment **Permanent** / **Temporary** / **Seasonal** (circle one)? If temporary, seasonal or per diem please explain:

Any anticipated changes in rate of pay or average hours? Yes ☐ or No ☑ (**If Yes**, use back of form to explain)
Does the employee work overtime? Yes ☐ or No ☑ **If Yes**, how often _____ # of hours _____

**Does the employee have any of the following deductions?**

Check all that apply and indicate the amount and frequency i.e., per week, month etc. (*use back of form if more space is needed*)

☐ Profit Sharing $ _____ per _____ ☐ Savings Bond(s) $ _____ per _____ ☐ Life Insurance $ _____ per _____
☐ Retirement/IRA $ _____ per _____ ☐ Other Pretax Deduction (i.e. union dues): Type _____ $ _____ per _____
☐ Mandatory Wage Garnishments (i.e. child support): Type: _____ $ _____ per _____
Is FIT OR FICA withheld? Yes ☑ or No ☐ Is health insurance available? Yes ☑ or No ☐

**Leave of Absence:**

On a Leave of Absence? Yes ☑ or No ☐ Begin Date: 09 / 01 / 2025 Expected End Date: 09 / 12 / 2025
Actual Date Final Paycheck was Received: 08 / 29 / 2025 Gross Amount of Final Paycheck: $ 1600
Workers' Compensation **Pending** / **Being Paid** / **Denied or N/A** (circle one) Carrier's Name: ADP
**Short-Term Disability** / **Long-Term Disability** or **N/A** (circle one) Frequency: (wkly, mth etc.) _____ Amount $ _____

## 2. LOSS OF EMPLOYMENT

Date Employment Ended: 07 / 31 2024
Reason: Medical Reasons

Actual Date Final Paycheck was Received: 08 / 07 / 2024 Gross Amount of Final Paycheck: $ 1000
Did the employee receive money from another source? Yes ☐ or No ☐ **If Yes**, Indicate the source, type, frequency and amount (i.e., severance pay, workers comp, etc.): _____

Did the employee have health insurance? **Yes** ☑ or **No** ☐
If **Yes**, End Date: 07 / 31 / 2024 COBRA: Yes ☑ or No ☐

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## 3. HEALTH INSURANCE (If known)

Does the employee have health insurance? Yes ☑ or No ☐ If **No**, did the employee decline? Yes ☐ or No ☐

1. Type (i.e., medical, vision, dental): Medical Name of Carrier: United

Policy Start Date: 08/15/2024 Policy Number: _____ Group Number: _____

Address (No., Street): 30 High Street City: Hoboken State: NJ ZIP Code: 07302

**Self** or **Family** (circle one) Premium Amount $ _____ per (weekly, monthly etc.): _____

2. Type (i.e., medical, vision, dental): _____ Name of Carrier: _____

Policy Start Date: ____/____/____ Policy Number: _____ Group Number: _____

Address (No., Street): _____ City: _____ State: _____ ZIP Code: _____

**Self** or **Family** (circle one) Premium Amount $ _____ per (weekly, monthly etc.): _____

## 4. WAGES RECEIVED

**Complete this section for all employment types (new, current, leave of absence or loss of employment)**

Please list the employee's gross wages for the last 4 weeks, ***and indicate all bonuses, tips, or commissions*** that are not already included in the gross wages. If the employee receives an Earned Income Tax Credit (EITC), indicate the amount of the credit.

| | | | | ***If not already included in Gross Wages...*** | | |
|---|---|---|---|---|---|---|
| **Actual Date Paid** | **Gross Wages** | **EITC** | **# of Hours** | **Tips** | **Bonus** | **Commission** |
| 08/01/2025 | $ 1600 | $ | 40 | $ | $ | $ |
| 08/08/2025 | $ 1600 | $ | 40 | $ | $ | $ |
| 08/15/2025 | $ 1600 | $ | 40 | $ | $ | $ |
| 08/22/2025 | $ 1600 | $ | 40 | $ | $ | $ |

Are ***ALL*** types of tips indicated? Yes ☐ or No ☐ **If NO,** explain: _____

**Additional Information:** _____

**Thank you for your cooperation!**

If you have any questions or need help completing this form please call our Customer Service Center at:
1-844-ASK-DHHS (1-844-275-3447) or 603-271-9700

Associate — Signature & Title of Person Completing this Form

09/09/2025 — Date

Scott Micheal — Printed Name of Person Completing this Form

351-609-1235 — Telephone Number

CGI — Company Name

Fax Number

65 Washighming — Company Address

Tempa — City

FL — State

07221 — Zip

***The Institution is an equal opportunity provider.***