State of Illinois
Department of Human Services

5/7 (Permanent)

Request for Employment Verification

Date: _____

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_____
Family Community Resource Center

Re: Employee: _____

Alias: _____

SSN: _____

Address: _____

Case Name: _____

Case Number: _____

To ensure that public assistance funds are properly disbursed, information concerning the above named person is needed.

We are informed that this person is/was in your employ. Please complete this form and return it in the enclosed envelope.

Employment began: _____ ended: _____ . Number of Hours per week: _____

Payment frequency: weekly _____ biweekly _____ twice monthly _____ . Rate of pay $ _____

Employee's Social Security Number (if different from above) _____

Employee's address: (if different from above): _____

Has he/she received any financial benefits through your firm other than earnings? ☐ Yes ☐ No

If yes, please identify and give the date of last payment:

Has he/she received any disability benefits through your firm? ☐ Yes ☐ No

If Yes, please identify and give the date of last payment:

Are earned income credit payments being paid with wages? ☐ Yes ☐ No If Yes, how much? _____

Is/was employee covered by your health plan? ☐ Yes -- Complete the HEALTH INSURANCE REPORT on the reverse.

☐ No - Complete #2B on the reverse.

Reason for termination: _____

Do you plan to rehire? _____ If so, when? _____

Please provide pay information on an individual pay period basis for the period of _____

through _____

Pay Period Ending	Date Paid	Gross Pay	Tips

Pay Period Ending	Date Paid	Gross Pay	Tips

Employer's completion of this form or compliance with instructions is voluntary. However, failure to do so may affect this Department's action.

SEE REVERSE

State of Illinois
Department of Human Services

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Health Insurance Report

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1. Case Name: _____

LAST FIRST MI

Case Number: _____

2a. Policy Holder/Employee Last, First and MI: _____

DATE OF BIRTH | SOCIAL SECURITY NUMBER | INSURANCE BEGIN DATE | INSURANCE END DATE

2b. ☐ Check if employee/dependent is not covered by a group health plan through your organization.
Employee/dependent may enroll on _____ .
Check if health insurance is available at no cost to ☐ employee or ☐ dependent.

2c. Check if health insurance is available but has not been chosen for: ☐ employee Monthly Premium $_____
☐ dependents Monthly Premium $_____

3. Complete for insurance through Employer/Union
Employer/Union: _____ Union Local #: _____
Street: _____
City: _____ State: _____ Zip: _____
Insurance Company: _____ Group: _____
Certificate/Policy Number: _____

4. Where Are Claims Mailed?
Medical Claims sent to Name _____
Street: _____
City: _____ State: _____ Zip: _____
Prescription Drug Claims to - Name: _____
Street: _____
City: _____ State: _____ Zip: _____

5. Check all the Following Benefits that are Provided
☐ Major Medical ☐ Dental ☐ Vision ☐ LTC ☐ RX Drug RX Card #: _____

6. Complete for Employee and Dependent Coverage

Last Name First Name	Recipient Number (DHS Use Only)	Date of Birth	Insurance Began Date	Insurance End Date	*

*ENTER RELATIONSHIP TO POLICYHOLDER CODE (POLICYHOLDER-0, SON-1, DAUGHTER-2, SPOUSE-3, STEPCHILD-4, GRANDCHILD-5, OTHER-6)

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7. Complete if person(s) in #6 were insured by you under a previous plan.

Name of Previous Carrier: _____ Group Number: _____

Begin Date: _____ End Date: _____

Street: _____

City: _____ State: _____ Zip: _____

8. Completed By:

Signature _____

Telephone Number: _____ Date: _____

9. DHS USE ONLY: SEND PHOTOCOPY OF COMPLETED FORM TO THIRD PARTY LIABILITY, BUREAU OF COLLECTIONS.

Check One ☐ ORIGINAL ☐ UPDATE CHECK

☐ IF TPL IDENTIFIED THROUGH DATA EXCHANGE - CROSSMATCH OR PAL CODE: _____

Worker: _____ REMARKS: (IDENTIFY LIMITED POLICY, REASON FOR UPDATE, ETC.)

Date: _____ _____

FRC: _____ Referring Office (if not Local Office): _____

CENTRAL OFFICE USE ONLY ☐ OLD TPL ☐ RDB