State Of Hawaii
DEPARTMENT OF HUMAN SERVICES

Benefit Employment & Support Services Division

# NEW EMPLOYMENT VERIFICATION FORM

TO _____ DATE: _____

_____ RE: _____

_____ SSN: _____ DOB: _____

To Whom It May Concern:

Employment information on the above-named individual is being requested. Your immediate attention to this matter is appreciated. Please respond by _____ Thank you.

_____ _____

(ELIGIBILITY WORKER) (UNIT ADDRESS/TELEPHONE NUMBER)

I, _____ hereby give my permission for the release of information to the Department of Human Services regarding my employment and earnings.

_____ _____

(APPLICANT/RECIPIENT'S SIGNATURE) (DATE)

1. Date of hire: _____ Full-time _____ Part-time _____
2. Rate of pay: $ _____ Per _____ Salaried? Yes _____ No _____
3. Dates paid in the month? _____
4. Pay period ends (e.g., 15th and 30th, Sundays, etc.) _____
5. Number of hours anticipated per day: _____ Days per week: _____
6. Scheduled work days? (e.g., Monday thru Friday, Saturday only): _____
7. First pay expected: _____ For period: _____ To: _____
8. Is health insurance available? _____ YES _____ NO If yes, plan number: _____

   Type of coverage (e.g., Basic, Drug, Vision, Dental): _____

   Effective date of coverage: _____

   Name of persons covered by plan: _____

   If health insurance is not available, please state reason(s) why the employee is not eligible for service.

9. Position title and job responsibilities: _____
10. Other comments (tips, commissions, etc.): _____

_____

(SIGNATURE OF PERSON PROVIDING INFORMATION) (DATE)

_____

(PRINT/TYPE - NAME) (TITLE) (TELEPHONE NUMBER)