

# MEDI-CAL 250% PROGRAM EMPLOYMENT VERIFICATION FORM

I, \_\_\_\_\_ the employer of the Medi-Cal beneficiary named\_

Name of Employer

\_\_\_\_\_  
Name of Medi-Cal Beneficiary

Residing at: \_\_\_\_\_  
Address City ZIP

Case #/ \_\_\_\_\_ has been working for me since \_\_\_\_\_ and each month thereafter and hereinafter for \_\_\_\_\_ hour a week, for a total compensation of \$\_\_\_\_\_ a month performing the following work for me:

\_\_\_\_\_  
Type of work performed

## EMPLOYER INFORMATION

Employer name \_\_\_\_\_

Employer address \_\_\_\_\_

Date \_\_\_\_\_ Employer Signature \_\_\_\_\_