Medi-Cal 250% Program Employment Verification

This is to confirm that _____
Name of Medi-Cal beneficiary

SSN_____has been working for me commencing with

_____ and each month thereafter for
date

_____ hours each week for $_____a week for a total monthly sum of

$_____a month doing the following work for me:

_____
Specify type of work being done

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

DATE: _____ EMPLOYER SIGNATURE: _____

Authorization to Release Information/Representation Form

I,_____,
hereby authorize the person/organization named herein, or any other person/attorney designated them to be my authorized representative, and to represent me, relative to my Medi-Cal benefits, or any other matter, including the right to make statements on my behalf, or the filing for any fair hearing and the initiation of any litigation.

This authorization shall also be construed as an authorization to release any and all information to any person designated by him, including an attorney.

Dated: _____

_____
Signature of Medi-Cal Recipient/Applicant

Authorized Representative Name of Person and/Organization
Name
Organization, if any
Address
Phone Number