Medi-Cal 250% Program
Employment Verification Form

I, _____ the employer of the

Medi-Cal beneficiary named_____

Address_____ City _____ZIP___

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

EMPLOYER INFORMATION

Employer name _____

Employer address _____

Date_____ Employer Signature _____

AUTHORIZATION RELEASE INFORMATION/REPRESENTATION FORM

I, _____named below, 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 the person mentioned below, including an attorney.

Date: _____ _____ _

Signature of Employee/Medi-Cal Beneficiary

Name of person/organization being authorized

Kevin Aslanian
CCWRO, 1111 Howe Ave., Suite 635, Sacramento, CA 95825-8551
Tel. 916-712-0071 Email: kevin.aslanian@ccwro.org