For MCHA use only:

Date & Time Received

VERIFICATION OF EMPLOYMENT

MCHA IS REQUIRED TO VERIFY THE EMPLOYMENT STATUS FOR ALL APPLICANTS AND CURRENT PARTICIPANTS IN THE FEDERAL HOUSING PROGRAMS WE ADMINISTER. WE ASK YOUR COOPERATION IN SUPPLYING THE INFORMATION REQUESTED. THE APPLICANT/PARTICIPANT SIGNATURE BELOW AUTHORIZES VERIFICATION OF EMPLOYMENT INFORMATION TO BE RELEASED TO THE MARION COUNTY HOUSING AUTHORITY.

EMPLOYEE INFORMATION

Employee's Full Name:_____ Social Security Number: _____

Employee's Full Address: _____

THIS SECTION IS TO BE COMPLETED BY EMPLOYER ONLY

INSTRUCTIONS:

- The human resources or personnel staff, supervisor, or accounting staff should complete this form.
- **Under no circumstances should the employee fill out this form.**
- **Only complete section below that applies to employee's current status,** BOX 1, 2 OR 3.
- Authorization for this verification was granted on HUD form 9886 and is available by request.
- Please print legibly. You may e-mail the form to info@mchahomess.org or fax to **618-532-2024.**

1. COMPLETE IF EMPLOYEE IS NO LONGER EMPLOYED

Date of Termination:_____ Last day employee actually worked:_____

Is the employee on Maternity, Parental, Medical or other leave? ◯Yes ◯No *if yes, anticipated return to work date:*_

Is the employee on short/long-term disability with compensation? ◯Yes ◯No *Amount: $*_____*Per:* Year

Does the employee have a current or pending worker's compensation claim? ◯Yes ◯No

Do you anticipate re-hiring this employee? Yes No *if yes, when:*_____

2. COMPLETE IF EMPLOYEE IS LAID OFF

Layoff date:_____ Last day employee actually worked: _____

Date employee is expected to return to work:_____ Reason for layoff:_____

Is the employee on Maternity, Parental, Medical or other leave? ◯Yes ◯No *if yes, anticipated return to work date:* ___ __

Is the employee on short/long-term disability with compensation? ◯Yes ◯No *Amount: $*_____*Per:* Year __

Does the employee have a current or pending worker's compensation claim? ◯Yes ◯No

3. COMPLETE IF EMPLOYEE IS WORKING IRREGULAR, REDUCED HOURS OR ON-CALL

What are the employee's regular hours worked per week:_____ Hourly Rate: $ _____

Reason for change in hours: _____

What are the employee's *NEW WEEKLY* work hours:_____ Date of change of hours: _____

Does the employee receive tips, bonuses or any other compensation? ◯Yes ◯No *Amount: $*_____*Per:* Week

Date you anticipate the employee's hours to go back to normal schedule: _____

EMPLOYER CERTIFICATION

I HEREBY CERTIFY THAT THE STATEMENTS ABOVE ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Name of Person Completing Form:_____ Phone No.:_____

Employer Name:_____ E-Mail:_____

Address:_____

_____ _____

Signature of Person Completing Form Date