# VERIFICATION OF EMPLOYMENT
## State of Michigan
Department of Human Services

| | |
|---|---|
| AUTHORITY: 1939 PA 280 as amended (MCL 400.8, MCL 400.83, MCL 400.60)<br>PENALTY: Failure to complete this form could result in issuance of a subpoena.<br>COMPLETION: Required | In accordance with the provisions of 1939 P.A. 280 (MCL 400.60, 400.8 and 400.83), employers are required to provide the Michigan Department of Human Services with copies of certain papers, records, and documents relevant to an inquiry or investigation conducted by the Department. |

**Complete business name and address.**

MEIJER

| | | | | |
|---|---|---|---|---|
| Grantee Name: BOB SIMPSON | | | | |
| Case Number: XXXXXXXXX | | | | |
| Grantee Client ID: 00000000 | | Date | | |
| County | District | Section | Unit | Specialist |

**General Information: (To be completed by Specialist)**

| | | |
|---|---|---|
| Specialist (Name): YOUR NAME | Phone Number: ( ) | **Fax Number**: ( ) |
| County Office (Name and Address): TRAINING OFFICE 1 | | |

| | | | |
|---|---|---|---|
| Employee Name: BOB SIMPSON | Social Security Number: XXX-XX-XXXX | | |
| Address (Number and Street Name, Apt., etc.) | City | State | Zip Code |

**EMPLOYER—Please provide the information requested in the following sections marked with an X.**

**Please return in the enclosed envelope to the specialist and address above by:**

## ☒ SECTION 1 - EMPLOYMENT INFORMATION (To Be Completed By Employer)

**Employment Status**
- ☐ Employed
- ☒ Previously employed
- ☐ Never employed
- ☐ Temporarily off (explain)
- ☐ Laid off
- ☒ Quit
- ☐ Fired
- ☐ Other (explain)

**Occupation**: STOCK PERSON

**Date Employment Began**: 08/01/2006

**Date of First Paycheck**

☐ First Check Full
☐ First Check Partial

**Date Employment Ended or Is Expected to End**: 3RD FRIDAY LAST MONTH

**Number of Hours Expected to Work**: 25 ☒ per week ☐ per pay period

**Rate of Pay**: $ 7.40 ☒ Hour ☐ Piece ☐ Salary

**Differential Pay**: $ ☐ Hour ☐ Shift

**Day of Week Paid**

**How Often Paid**
- ☒ Weekly
- ☐ Twice monthly
- ☐ Every 2 weeks
- ☐ Monthly
- ☐ Other

**Are tips/bonus/commission received?** ☐ Yes ☒ No

**Are they included in gross?** ☐ Yes ☒ No

**Average Amount** $ ☐ per week ☐ per pay period

**Type of Employment**
- ☒ Permanent
- ☐ Temporary

**Date of Last Paycheck**: 4TH FRIDAY LAST MONT

**Estimated Work Schedule (example 9 a – 5 p)**

| Sun | Mon | Tues | Wed | Thurs | Fri | Sat |
|---|---|---|---|---|---|---|
| | | | | | | |

## ☒ SECTION 2 - INSURANCE / RETIREMENT INFORMATION (To Be Completed By Employer)

**Does employer offer health plan?** ☐ Yes ☒ No

**Is health plan available to employee?** ☐ **Yes** ☒ **No**

**Health Plan Premium (even if not enrolled)** $ ☐ per pay ☐ other

**Is employee enrolled in health plan?** ☐ Yes ☒ No If Yes →

**Is anyone, other than the employee, covered under any plan?** ☐ Yes ☒ No

**If yes, who?**

**Which type of coverage?**

**Insurance Contracts that Cover Employee**
- ☐ Hospital
- ☐ Medical
- ☐ Dental
- ☐ Vision
- ☒ None

**Does employee have cafeteria-style benefit plan?** ☐ Yes ☒ No

**Name(s) of Insurance Company(s)**

**Does employee have 401K or other retirement plan?** ☐ Yes ☒ No

**Does / did employee participate in stock, bond, credit union, deferred compensation, retirement or other resource development plan?** ☐ Yes - If Yes → Type ☒ No

**Amount of Deduction** $

## ☒ SECTION 3 - INCOME INFORMATION

**Employer:** Please complete the following information about each pay received during the period specified below.
(Use additional paper or computer printout if necessary.)

Grantee Name: **BOB SIMPSON**

Case Number: **XXXXXXXXX**

**From:** LAST 30 DAYS **To:**

| Date Received | Gross Income | Amount of Tip, Bonus or Commission If Not Included in Gross | Hours Worked | Date Received | Gross Income | Amount of Tip, Bonus or Commission If Not Included in Gross | Hours Worked |
|---|---|---|---|---|---|---|---|
| Each Fri. | $185 | 0 | 25 | | | | |
| of last mo | | | | | | | |
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## ☐ SECTION 4 - DISABILITY / WORKERS COMPENSATION INFORMATION (To Be Completed By Employer)

Were medical or disability benefits paid during the period specified in Section 3?
☒ No ☐ Yes
From:
To:

Name of Insurer Who Paid These Benefits

Address (Number and Street Name)

City | State | Zip Code

Was Worker's Compensation paid during the period specified in Section 3?
☒ No ☐ Yes
From:
To:

Date Awarded | Amount Awarded $ | ☐ Weekly ☐ Monthly

Is Worker's Compensation claim pending?
☐ No ☐ Yes

Date Filed | Next Court Date

## ☐ SECTION 5 - ADDITIONAL INFORMATION/COMMENTS

| Additional Information Requested | Employer's Response (To Be Completed By Employer) |
|---|---|
| | |
| | |

Employer's Comments

## ☒ SECTION 6 – SIGNATURE/BUSINESS INFORMATION (To Be Completed By Employer)

Business Name: **MEIJER CORP**

Business Address: **3333 GRAND RIVER AVE LANSING MI 48933**

Days and Hours of Operation: **24 HOURS A DAY, 7 DAYS A WEEK**

Name of Person Completing Form (Please Print): **THE BIG BOSS**

Business Telephone Number: **(517) 555-1111**

Employer Federal ID (FEIN): **38-1234567**

**Signature of Person Completing Form**

**Title of Person Completing Form:** **MANAGER**

**Date Signed:** **TODAY**

**Anyone who makes a false statement in order to obtain, or help another obtain, assistance for which he/she is not eligible is subject to legal penalties.** If the amount of assistance involved is more than $500, the violator is guilty of a felony; if the amount is $500 or less, the violation is a misdemeanor.

The Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

"The USDA is an equal opportunity provider and employer."