FLORIDA KIDCARE EMPLOYMENT STATEMENT

General Directions: Copy this form and have it completed by each employer that provides income to a family member on the KidCare application. If you provide recent pay stubs, you do not need this form completed.

Complete Section A and submit to employer for completion. Completed form must be returned to Florida KidCare, P O Box 591, Tallahassee, Florida, 32302-0591.

Section A – To Be Completed by Employee	
Family Account Number:	
I authorize the release of employment information for the purpose of determining KidCare eligibility.	
Employee Signature:	Date:
Employee Name:	Employee SSN:
Section B – To Be Completed by Employer	
Directions: This information is needed to help determine eligibility for KidCare Health Insurance. Please assist us by answering the following questions for the employee listed above, and returning this form to: Florida KidCare, PO Box 591, Tallahassee, Florida, 32302-0591.	
(1) Number of Hours Worked Per Week:	Number of Days Worked Per Week:
(2) How often is the employee paid: Daily	WeeklyBi-WeeklyMonthly
	Twice MonthlyOther:(explain)
(3) Rate of gross pay: \$ per Hour/D	
(4) If hours or rate of pay has varied in the above period, please state why (include tip information here):	
(5) Employer Statement: What I have written on this form is true to the best of my knowledge. I know that if I give false information on purpose, I may be subject to prosecution for fraud.	
Signature of Employer	Employer's Title
Name of Employer (please print)	() Employer's Telephone Number
Name of Business	Date Completed
Business Address	City, State, Zip T24m