

Employment or Volunteer Verification Form

ATTENTION! The completed form must bear an original ink signature. Photocopies and faxed copies of the completed form are not acceptable.

FORM TO BE COMPLETED BY AN OFFICIAL IN THE PERSONNEL OR HUMAN RESOURCES DEPARTMENT
(The person signing this form may not be related to the applicant by blood, marriage, or adoption)

Employee's or Volunteer's Name: _____

Job Title: _____

On a weekly basis, how much time (average amount of hours) does the applicant spend providing the following services:

Face-to-face interaction: _____ Advocacy: _____ Administration: _____ Supervision, management, or training: _____

Employment or Volunteer Average Monthly Hours Worked _____ F/T or P/T Start Date: ____/____/____

Facility Name: _____

Address (NO P.O. BOXES): _____

City: _____ State: _____ Zip Code: _____

County: _____

Through our selection process, I have determined that the applicant can speak the following Medi-Cal threshold language(s):

- | | | | |
|------------------------------------|---------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Farsi | <input type="checkbox"/> Mandarin | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Armenian | <input type="checkbox"/> Hmong | <input type="checkbox"/> Other Chinese | <input type="checkbox"/> Tagalog |
| <input type="checkbox"/> Cambodian | <input type="checkbox"/> Korean | <input type="checkbox"/> Russian | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Cantonese | | | |

I certify that the facility will pay the applicant (if in a paid capacity) prevailing wages and that I agree not to use the Program's award of educational loan repayments as a means to reduce the recipient's salary or offset those salaries (e.g., deduction of funds from paychecks, etc.).

I certify that I am the administrative officer at this facility, which meets the definition of a "qualified facility.*" This information will be verified with the Health Professions Education Foundation.

I declare under penalty of perjury that these statements are true and correct.

Name: (Please Print) _____

Signature: _____

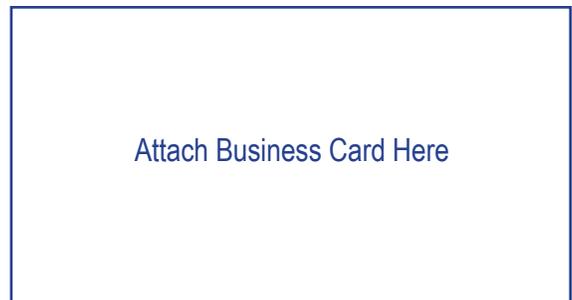
Title: _____

Phone Number: _____

Fax Number: _____

Email: _____

Date: _____



*Qualified facilities are defined as one of the following: (1) "A publicly funded facility," which means a health facility, as defined by Health and Safety Code Sections 1200, 1200.1, and 1250, conducted, maintained, or operated by this state or by any of its political subdivisions or districts, or by any city. (2) "A publicly funded or public mental health facility," which means a hospital, clinic, or long-term care facility licensed and/or certified by the California Department of Mental Health and/or the California Department of Health Services that is conducted, maintained, or operated by this state or by any of its political subdivisions or districts, or by any city, and that provides mental health services. (3) "A non-profit private mental health facility," which means a hospital, clinic, or long-term care facility licensed and/or certified by the California Department of Mental Health and/or the California Department of Health Services that is operated by a non-profit entity that contracts with a county mental health entity or facility to provide mental health services.