



Los Angeles County Department of Mental Health Stipend Program Employment Verification Form - MSW

This Employment Verification Form is to be completed by the employer and submitted to: **The Long Beach Foundation, c/o James Ferreira, M.S.W., 6300 E. State University Drive, Suite 180, Long Beach, CA 90815.** The form is to be completed once at initial hire, and then again at the completion of 12 months full time employment.

Employee Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

City *State* *ZIP Code*

Home Phone: () _____ Alternate Phone: () _____

E-mail Address: _____

Birth Date: _____ Social Security Number: _____

I understand I can be penalized by law, and will be required to repay the stipend financial aid if I misrepresent or purposely give false information on this form.

Employee Signature: _____ Date: _____

Employment Information – Initial Hire Date

What position does this employee hold? _____

Number of hours per week the employee works? _____

What is the start date of continuous employment for this employee? _____

Name of Agency/Program: _____

Is this position within
Specialized Foster Care, or
MHSA Funded? Please explain.

Name of Authorized Agency
Representative: _____ Title: _____

Address: _____ City, Zip: _____

Business phone #: _____ SPA / Service Area: _____

I certify that the information I have given on this form is true and correct. I understand that purposefully providing false information on this form may lead to legal penalty and the forfeiture of stipend financial aid for the employee.

Signature: _____ Date: _____

DO NOT COMPLETE THIS SECTION – For Long Beach Foundation use only.

Verified by: _____ Date: _____

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Employment Information – 12 Months Completed Employment

What position does this employee hold? _____

Number of hours per week the employee worked? _____

Employee Initial Start Date: _____

What is the date of completion of 12 months full time employment for this employee? _____

Has this employee been on leave, outside of regular vacation or sick time, in the last 12 months? If so, what was the time period? _____

Name of Agency/Program: _____

Name of Authorized Agency Representative: _____ Title: _____

Address: _____ City, Zip: _____

Business phone #: _____ SPA / Service Area: _____

I certify that the information I have given on this form is true and correct. I understand that purposefully providing false information on this form may lead to legal penalty and the forfeiture of stipend financial aid for the employee.

Signature: _____ Date: _____

DO NOT COMPLETE THIS SECTION – For Long Beach Foundation use only.

Verified by: _____ Date: _____

The information requested on this form is required for completion of the DMH Stipend Contract Obligation and Employment Payback.

Please send this form to:

**James Ferreira, M.S.W.
The Long Beach Foundation
6300 E. State University Drive, Suite 180
Long Beach, CA 90815**