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: **Monica Malin, MSW, CSULB – School of Social Work, 1250 Bellflower Blvd, MS-4602, SS/PA-161, Long Beach, CA 90840-4602, monica.malin@csulb.edu**. 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:

Monica Malin, MSW
CSULB – School of Social Work
1250 Bellflower Blvd, MS-4602, SS/PA-161
Long Beach, CA 90840-4602
Phone: 213 764-1511
Email: monica.malin@csulb.edu