LOS ANGELES COUNTY – DEPARTMENT OF HEALTH SERVICES
COMMUNITY PARTNERS
MY HEALTH LA

Name of Employer/Company:
Name (of person writing letter):
Address:
City, State, Zip:
Telephone number:

Date:

To whom it may concern:

You have been identified as the employer of the above named person. Since he/she has been unable to supply this office with the income information needed to determine eligibility for the My Health LA, we have been requested to obtain that information directly.

This is a confidential request and your response will be treated likewise. Thank you in advance for your cooperation.

I certify that _____ is an employee of _____.
(Name of person receiving income or employee) (Company name)

_____ gross income for this pay period is $_____ and frequency of pay
(Employee's name)
is (**once a week, twice monthly, every two weeks, or once a month**).

I certify that the information presented in this letter is true and correct.

Sincerely,

Name:

Job Title or Position:

Please complete the following statement of earnings.

Paycheck s received in the month of _____

Date of Issue					
Gross					
Federal Tax					
State Tax					
FICA					
SDI					

Other Deductions – please specify (retirement, union dues, etc.)

Paychecks received in the month of:_____

Date of Issue					
Gross					
Federal Tax					
State Tax					
FICA					
SDI					

Other Deductions – please specify (retirement, union dues, etc.)

I hereby authorize you to release to the Department of Health Services, My Health LA, the specific information requested concerning my earnings and deductions.

_____ _____

(Company's Name) (Employee's Signature) (Date)

_____ _____

(Company's Street Address) (Employer's Signature) (Date)