Medi-Cal 250% Program Employment Verification

This is to confirm that ______________________________________

SSN __________________ has been working for me commencing with

___________________________ and each and every month thereafter for

______ hours each week for $________ a week for a total monthly sum of

$__________ a month doing the following work for me:

____.

EMPLOYER NAME: _______________________________________

EMPLOYER ADDRESS: ____________________________________

DATE: __________________

EMPLOYER SIGNATURE: __________________________________

Authorization to Release Information/Representation Form

I, _________________________,
hereby authorize the person/organization named below, or any other person/attorney designated them to be my authorized representative, and to represent me, relative to my Medi-Cal benefits, **or any other matter**, including the right to make statements on my behalf, or the filing for any fair hearing and the initiation of any litigation.

This authorization shall also be construed as an authorization to release any and all information to any person designated by him, including an attorney.

Dated: __________

____
Signature of Medi-Cal Recipient/Applicant

Name of Person and/Organization

NAME: Kevin Aslanian

ADDRESS 1111 Howe Ave. 150

PHONE: 916-712-0071

EMAIL: kevin.aslanian@ccwro.org