Los Angeles County Department of Mental Health Stipend Program
Employment Verification Form (MFT)

This Employment Verification Form is to be completed by the employer and submitted to: **MFT Consortium, Phillips Graduate Institute, c/o Jose Luis Flores, M.A., 5445 Balboa Blvd., Encino, CA 91316-1506.** 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? _____

Does employee have bilingual capacity? _____

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 MFT Consortium/Phillips Graduate Institute use only.

Verified by: _____ **Date:** _____

Los Angeles County Department of Mental Health Stipend Program
Employment Completion Form

Employment Information – 12 Months Completed Employment

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

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: _____

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

Name of Authorized Agency Representative: _____ Title: _____

Address: _____ City, Zip: _____

Business phone #: _____ Email address: _____

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 MFT Consortium/Phillips Graduate Institute 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:

Jose Luis Flores, M.A.
MFT Consortium of Greater Los Angeles
Phillips Graduate Institute
5445 Balboa Blvd.
Encino, CA 91316-1506