California Educational MFT Stipend Program

Instructions for Completing Employment Verification Form

The information requested on this form is in compliance with the California Educational MFT Stipend Payback Agreement that each stipend recipient has signed. It is the stipend recipient’s responsibility to submit the MFT Employment Verification Form to the agency and to consult with the stipend regional coordinator prior to submitting the form.

The employment information section is completed by an agency representative that is knowledgeable about the employment information and funding sources of the agency, such as human resources or program director.

1. Does this agency receive funding from a county mental health/behavioral health department? – If yes, identify the county’s mental health/behavioral health department that directly operates or contracts with the agency.

2. MFT Intern Job title – Provide employee’s position that requires a BBS MFT intern number. Indicate if employee is hired as a temporary employee.

3. Number of hours per week – Provide number of hours employee was hired to work per week.

4. The start date of employment – If employee began employment pre-degree, include date employee changed to an MFT Intern level position.

5. The employee can provide clinical services in the following language(s) – The agency has hired the employee to provide clinical services for language capacity in the language(s) stated.

6. Name of Agency, Clinic/Program – Provide the agency name and only include the clinic/program if employee works in a specialized program/site within the agency.

MHSA funded Program – Check yes if the employee’s position or program specifically receives Mental Health Services Act funding such as Full Service Partnerships (FSP), Field Capable Clinical Services (FCCS), and Multi-disciplinary Assessment Team (MAT). An answer of “no” does not disqualify the employee for employment compliance from the stipend program.

7. Address, City, Zip Code – Provide address of the clinic or program employee works; this may differ from the agency’s administrative office. If the site location is confidential (for example, battered women’s shelter) notate that administrative office is included.

8. Name of Agency Representative and Title – Agency representative must be someone at the agency that can verify that all the information provided is correct.

9. Phone, email – Provide work phone and email as clarifying information may be required.
## California Educational MFT Stipend Program

### MFT Employment Verification Form

### Employee Information (completed by MFT Stipend Recipient)

<table>
<thead>
<tr>
<th>Full Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>City, Zip:</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td>Email:</td>
<td></td>
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</tbody>
</table>

Regional Coordinator: 
Consortium: 

I consent to release the employment information requested below and consent to any follow-up required to clarify. I have consulted with my regional coordinator about this position prior to employment.

Employee Signature: _____________________________ Date: ____________

### Employment Information (completed by Agency Representative)

#### Review Instructions Prior to Completing Form

1. Does this agency receive funding from a county mental health/behavioral health department?
   - □ Yes □ No
   - If yes, County Providing Funding: ____________________________

2. MFT Intern Job Title: ____________________________________ Temporary Employee □ Yes □ No

3. Number of hours per week: ____________________________

4. The start date of employment as MFT Intern (*post-degree*): ______/______/______

5. The employee can provide clinical services in the following language(s): ________________

6. Name of Agency: ____________________________
   - Clinic/Program: ____________________________ MHSA-funded Program □ Yes □ No

7. Address: ____________________________ City: ____________________________ Zip Code: ________

8. Name of Agency Representative: ____________________________ Title: ____________________________

9. Phone: ____________________________ E-mail Address: ____________________________

The information I have given on this form is true and correct. I understand that the purpose of this form is to provide employment information to the California Educational MFT Stipend Program for the employee.

Signature: ____________________________ Date: ____________

### DO NOT COMPLETE - For MFT Stipend Office Use Only

Regional Coordinator verifies that the information provided qualifies for the California Educational MFT Stipend Program as payback for stipend recipients under this program.

Verified by Regional Coordinator: ____________________________ Date: ____________

Mail Employment Verification Form to:
Phillips Graduate Institute-MFT Stipend Program  19900 Plummer Street  Chatsworth, CA 91311
Telephone: (818) 654-1702  Facsimile: (818) 386-5611  Web: www.pgi.edu

Revised 2014