Los Angeles County Department of Mental Health Stipend Program

MFT Employment Verification Form

This Employment Verification Form is to be completed by the employer and submitted to: **MFT Stipend Program, Phillips Graduate Institute, c/o Jose Luis Flores, M.A., 19900 Plummer Street, Chatsworth, CA 91311.** The first page of the form is to be completed at initial hire, and the second page at the completion of 12 months full time employment. Only forms with original signatures are accepted.

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 educational stipend awarded 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. _____

Service Area (SPA) where employee provided care: _____ Does employee provide in the field services? _____

Name of Authorized Agency Representative: _____ Title: _____

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 Stipend Program/Phillips Graduate Institute use only.

Verified by: _____ **Date:** _____

Los Angeles County Department of Mental Health Stipend Program

MFT 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 Stipend Program/Phillips Graduate Institute use only.

Verified by: _____ **Date:** _____

The information requested on this form is required for completion of the LAC DMH Stipend Contract Obligation and Employment Payback.

Please mail the form with original signatures to:

Jose Luis Flores, M.A.
MFT Stipend Program
Phillips Graduate Institute
19900 Plummer Street
Chatsworth, CA 91311