## **Private Duty Nursing Verification of Employment/School Attendance**

Employee/Student:	SS#:
(Print Name) Address:	
Dependent's Name(s):	SS#:
	SS#:
I, give the	Alabama Medicaid Agency permission to verify my employment
and/or student status.	
PART I. To be completed by employee/student and employer Employer/School Official: The above-named individual has a dependent(s) that receive information is needed to determine initial or continuing elig	ployer/school official es or has applied for Medicaid. The following employment and/or student gibility and must be completed by the employer or the school.
food stamps be matched against certain state and federal computer files. A	al Security Numbers provided by applicants/recipients of public assistance, Medicaid, and/or is a result of these required matches, the information below is needed in order to determine been informed of this use of Social Security Numbers and have agreed to provide required forms.
information disclosed to such officer or employee can be only used for aut punishable upon conviction by a fine of as much as \$5,000 or imprisonmentals also notify each such officer or employee that any such unauthorized fur	nation is or may be disclosed shall be notified in writing by such person that Social Security thorized purposes and to that extent and any other unauthorized use herein constitutes a felony ent for as long as five years, or both, together with the cost of prosecution. Such person shall rther disclosure of Social Security information may also result in an award of civil damages respect to each instance of unauthorized disclosure. These penalties are prescribed by IRC
552a. Specifically, 5 USC 552a (1) (1), which is made applicable to contivirtue of his/her employment or official position, has possession of or ac which is prohibited by the Privacy Act or regulations established there under that material in any manner to any person or agency not entitled to receive	ad employees of penalties for improper disclosure implied by the Privacy Act of 1974, 5 USC tractors by 5 USC 552a (m) (1), provides that any officer or employee of a contractor, who by ceess to agency records which contain individually identifiable information, the disclosure of der, and who knowing that disclosure of the specific material is prohibited, willfully discloses it, shall be guilty of a misdemeanor and fined not more than \$5,000.
Name and title of person completing form:	
Contact Number:	
Check most appropriate:	IPLOYMENT
Begin date (MM/DD/YYYY):	
Hours worked/classes attended per week:	
How many hours each day (ex: 8Mon,8Tues,4V	Wed,etc):
If hours are not regular, please indicate:  How many scheduled hours:  When: weekly biweekly Other	
Last day of employment/school attendance (MI	M/DD/YYYY):
Reason for discontinuation:	
Approximate travel time to and from work/sch	ool:

Form 387 Effective 05/26/2005

## PART II. To be completed by employee/student. Employee/student should list requested information below. List each day actually worked/attended school and the total number of hours on each respective day. Indicate the applicable period by month/year. Please attach additional sheets if necessary.

**THRU** 

DATES WORKED/ATTENDED SCHOOL (MM/DD/YY)	NUMBER OF HOURS (Actual hours not credit hours)

**Employee** should attach all applicable pay stubs.

<u>Student</u> should attach verification to include a current course selection guide, validated class schedule, curriculum guide and transcript of prior coursework. Courses taken must be consistent with the requirement for obtaining a GED, college degree, or some other type of certification for employment.

**Employee/Student** should attach verification of travel time. If in excess of one hour, documentation must be submitted to support an increase.

## **CERTIFICATION STATEMENT:**

PERIOD COVERED (MM/YYYY):

I have reviewed the above and I affirm that all information given on this document, or in support of, is true. I understand that anyone who knowingly makes a false statement or misrepresents material facts in an application to determine eligibility for Medicaid services may be committing a crime punishable under Federal or State law, or both.

Employee's/Student's Signature:	Date:
Employer's/Student Official's Signature:	Date:

Return completed form and attachments to the appropriate Private Duty Nursing Agency. A self-addressed stamped envelope is provided for your convenience. Your cooperation is appreciated.