OSHPD
Office of Statewide Health Planning and Development

Employment Verification Form (EVF)

Licensed Mental Health Services Provider Education Program (LMHSPEP)

This form is to be completed for each practice site applicants provide direct client care at and should pertain to the individual provider at the practice site.

Must be completed by applicant

Applicant's First and Last Name: _____

This authorization is to release information concerning my employment as required below. To establish eligibility for the Office of Statewide Health Planning and Development Loan Repayment Program, verification of employment is required. Please complete this form as soon as possible and return it to me. Your cooperation and prompt return of this information is appreciated.

_____ _____

Signature of Applicant | Date

Must be completed by direct supervisor or appropriate designee
(All questions are required)

Facility's Full Name:	
Telephone #:	
Facility Address: **(Address of the facility where the applicant works at and not the headquarters)**	
Check all that Apply to Facility:	☐Non-profit mental health facility that contracts with a county entity ☐Publicly funded mental health facility ☐Health Professional Shortage Area – Mental Health (HPSA-MH) ☐Public mental health facility
Applicant's Start Date:	
Applicant's Profession:	
Applicant's Job Title:	

1. What are the applicant's total hours worked per week?	_____ (total hours)
2. What are the applicant's total hours providing direct client care per week? **Direct client care: Includes assessment, treatment, counseling, procedures, self-care, patient education and documentation relating to patient encounter.**	_____ (direct client care hours)
3. What are the applicant's total hours providing first line supervision of direct client care per week?	_____ (direct supervision hours)
4. What are the applicant's total hours serving adults ages 65 or older per week?	_____ (geriatric hours)

5. Does the applicant speak additional languages at work in addition to English? **(Languages must be spoken in client care interactions without the use of translator services.)** If so, which language(s):

6. What are the applicant's primary responsibilities or job functions?

I declare under penalty of perjury that these statements are true and correct

_____ _____

Signature of Direct Supervisor or Appropriate Designee | Date

_____ _____

Printed First and Last Name | Email

Revised 7/8/2021