HCAi Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
hcai.ca.gov

California State Loan Repayment Program (SLRP)
Grantee Employment Verification Form (EVF)

This form is to be completed for each practice site the Grantee provides direct patient care at and should pertain to the Grantee's work only at that site.

The below portion must be completed by Grantee

Grantee's First and Last Name: _____

This authorization is to release information concerning my employment as required below. To establish eligibility for the Department of Health Care Access and Information Loan Repayment and scholarship programs, verification of employment is required. Your cooperation and prompt return of this information is appreciated.

_____ _____
Signature of Grantee Date

The below portions must be completed by the Grantee's direct supervisor or an appropriate designee.
(All questions are required)

Practice Site Name:		
Practice Site Telephone #:		
Practice Site Address: **(Address of the practice site where the applicant works)**	Street Adress:	
	City:	State:
	Zip Code:	County:

EVF Reporting Period: through

Enter the Grantee's average number of direct patient care hours per week during the EVF Reporting Period listed above. **(Direct Patient Care includes telecare, assessment, treatment, counseling, procedures, self-care, patient education and documentation related to patient care.)**	_____ (Direct patient care hours)
Enter the Grantee's average number of administrative hours per week during the EVF Reporting Period listed above. **(Administrative work includes any clinic-related work not described above.)**	_____ (Administrative hours)
Enter the Grantee's average number of total hours worked per week during the EVF Reporting Period listed above. **(Total of average Direct Patient Care hours per week and average Administrative hours per week.)**	_____ (Total hours)
Enter the Grantee's total number days missed during the EVF Reporting Period listed above. **(Do not include regular days off.)**	_____ (Missed days)
What percentage of the Grantee's patients are adults aged 65 years or older?	_____ (Percentage of geriatric patients)

I certify that I am knowledgeable about the Grantee's employment schedule.
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