

[Employer Name]  
[Employer Address]  
[City, State, Zip Code]  
[Phone Number]

[Date]

To the Medicaid Eligibility Office,

This letter is to verify the employment of [Employee Name].

**Employment Details:**

- **Employment Status:** [Active / Terminated]
- **Hire Date:** [Date]
- **Job Title:** [Title]
- **Pay Frequency:** [Weekly / Bi-weekly / Monthly]
- **Hourly Wage / Salary:** \$[Amount]
- **Average Hours Per Week:** [Number of Hours]

**Recent Gross Earnings (Last 4 Pay Periods):**

1. Pay Date: [Date] - Gross Amount: \$[Amount]
2. Pay Date: [Date] - Gross Amount: \$[Amount]
3. Pay Date: [Date] - Gross Amount: \$[Amount]
4. Pay Date: [Date] - Gross Amount: \$[Amount]

Regarding health insurance, the employee [is / is not] currently enrolled in an employer-sponsored health plan. This coverage [is / is not] available to the employee.

If you require any further information, please contact me at [Phone Number] or [Email Address].

Sincerely,

[Signature]

[Printed Name]  
[Title]  
[Company Name]