NOTE: You can save this form electronically, together with the data you enter on it.

CLEAR FORM

LOS ANGELES COUNTY – DEPARTMENT OF MENTAL HEALTH
CONTRACT PROVIDER TECHNOLOGICAL NEEDS PROJECTS

PRINT

EMPLOYEE PAY VERIFICATION FORM

Contractor Name: _____

Legal Entity No.: _____

Project Name: _____

Project ID No: _____

Invoice Period: _____ _____
Start Date *End Date*

Employee Name: _____

Title/Role: _____

Hours During Invoice Period: _____
Hours

Hours on Project: _____
Hours

OR

Percentage Time on Project: _____
Percentage

Proportion of Time Billable to MHSA: _____
Percentage

Gross Pay Amount: _____

Requested Reimbursement Amount: _____

Description of Employee's Work on Project During the Invoice Period:

_____

_____

_____

Contractor's Project Manager or Project Director Signature _____

Date: _____

Revised: April 5, 2010