EMPLOYMENT VERIFICATION FORM

For Health Care Assistance Eligibility

INSTRUCTIONS FOR EMPLOYER:

This individual is a member of a household applying for health care assistance. To determine the household's eligibility, it is necessary to verify all earnings. Since this individual is/was/will be your employee, your help is needed.

Please completely and accurately provide the information requested on this form. If a question does not apply, mark it **N/A**. After you complete the form, you may give it to your employee, mail it, or fax it to the number listed above.

Thank you for your assistance. If you have any questions, contact our office at the number above.

This information is needed no later than: *

EMPLOYEE CONSENT TO RELEASE INFORMATION:

I, _____, give my permission to release the information requested on this form.

Employee Signature *

_____

Date *

_____

SECTION 1: EMPLOYEE INFORMATION

Employee First Name *

Employee Last Name *

Social Security Number

Applicant Name & Address

SECTION 2: WAGE INFORMATION

List Gross Wages Received by Month:

Example: January 2024: $2,500 | February 2024: $2,750

SECTION 3: EMPLOYMENT STATUS & PAY INFORMATION

Employment Status:

☐ Full-Time ☐ Part-Time ☐ Permanent ☐ Temporary ☐ N/A

Rate of Pay: _____

(e.g., $15.00 per hour, $3,000 per month)

How Often Paid: _____

(Weekly, Bi-weekly, Semi-monthly, Monthly)

Average Hours per Pay Period: _____

Does the employee receive Commissions, Tips, or Bonuses?

☐ Yes ☒ No

Is Overtime Paid?

☐ Frequently ☐ Rarely ☐ Never

Are FICA (Social Security) and FIT (Federal Income Tax) Withheld?

☐ Yes ☐ No

SECTION 4: EMPLOYMENT DATES

Date Hired: _____

First Paycheck Received: _____

Leave Without Pay - Start Date: _____

Leave Without Pay - End Date: _____

Date Final Paycheck Received: _____

Gross Amount of Final Paycheck: _____

SECTION 5: HEALTH INSURANCE

Is Health Insurance Available Through Employer?

☐ Yes ☐ No

If Yes, Employee Is:

☐ Not Enrolled ☐ Enrolled (Self Only) ☐ Enrolled (Family Members)

SECTION 6: EMPLOYER/VERIFIER INFORMATION

Company/Employer Name:

_____

Employer Address (Street, City, State, ZIP):

_____

Name of Person Verifying: **Title:**

_____ _____

Phone Number:

_____

SECTION 7: ADDITIONAL COMMENTS

Comments or Additional Information:

EMPLOYER VERIFICATION:

I certify that the above information is true and correct to the best of my knowledge.

Verifier Signature: **Date:**

Signature of Person Completing This Form | Date Form Completed

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This form is to be completed by the employer and returned to the applicant or mailed/faxed to the address provided.