

## **WAGE VERIFICATION FORM**

### **FOR EMPLOYER**

Your employee or his/her family member has applied for assistance at Harris Health System. We need to verify his/her gross income and employment status to process the application.

With your employee's written authorization below, please complete the items on the back of this form as soon as possible. Your accurate information will affect the employee and/or family member(s) eligibility status and benefits.

After completion, please give this form to your employee.

Thank you,

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Eligibility Counselor  
Patient Eligibility Services

### **FOR APPLICANT: Employee Consent**

"I authorize my employer to provide the requested information regarding my income and employment status to Harris Health System"

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Applicant / Employee Signature

Harris Health System  
**WAGE VERIFICATION**

For Employer Use Only

**This is an Official Government Record. False or incomplete information given on this form may result in criminal action being taken under Sections 31.04 and 37.10, or other sections of the Texas Penal Code.**

Date: \_\_\_\_\_ Employee's Name: \_\_\_\_\_

Employee's Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Please provide Employee's Social Security#: \_\_\_\_\_ Employee's Occupation: \_\_\_\_\_

1. Is the person named above employed by you?  Yes  No
2. Hourly Wage: \$ \_\_\_\_\_
3. How often paid?  Weekly  Every Two Weeks  Twice Monthly  Monthly
4. Is employee paid commission or tips?  Yes  No
5. Does employee receive overtime pay?  Yes  No
6. Does employee participate in a profit sharing, stock purchase, or pension plan?  Yes  No

If yes, what is the current value? \$ \_\_\_\_\_

7. Does the employee have health coverage?  Yes  No  
 Dependent coverage?  Yes  No

Name of Insurance Carrier: \_\_\_\_\_ Group #: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
 Certificate #: \_\_\_\_\_ HMO  Yes  No

**On the chart below, list gross wages of the employee for the last 30 days.**

For New Employees
Date Hired:
Date First Check Received:
Average Number of Hours Per Week:

Date Pay Period Ending	Date Employee Received Paycheck	Actual Hours	Gross Pay	Other Pay (e.g. tips, commissions)

For Terminated Employees
Date Terminated:
Are Cobra Insurance Benefits available?
Date Final Check Received:
Gross Amount \$

Comments (Will there be any changes in the next few months?): \_\_\_\_\_

Name of Company or Employer: \_\_\_\_\_

Address (Street, City, State, and Zip Code): \_\_\_\_\_

Signature of Person Providing Information: \_\_\_\_\_ Title: \_\_\_\_\_

Date: \_\_\_\_\_ Telephone No: \_\_\_\_\_