# 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,

_____

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"

_____

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) |
|---|---|---|---|---|
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| 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: _____