HARRISHEALTH
SYSTEM

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 taken under Sections 31.04, 37.04, 37.10, or other portions 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: ____________________________