TEXAS
Health and Human Services

Date:	Case Record No.:
Office Address:	
Office Area Code and Phone No.:	
Office Area Code and Fax No.:	

Employment Verification

Employee Name:	Social Security No.:

This individual is a member of a household applying for health care assistance from the Primary Health Care Services Program, Title V Fee-for-Service Program, and/or epilepsy benefits. To determine this 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 this form, you may give it to your employee, mail it in the envelope provided or fax it to the number listed above.

This information is needed not later than this date: [date field] .

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

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

Employee Signature _____ Date _____

Employment Verification – To be Completed by Employer

Employee Name (as shown on your records)	
Employee Address – Street, City, State, ZIP Code (as shown on your records)	
Is/was/will this person (be) employed by you? ◯ Yes ◯ No If yes: ◯ Permanent ◯ Temporary	**Is FICA or FIT withheld?** ◯ Yes ◯ No

Rate of Pay	Average Hours Per Pay Period	How Often is Employee Paid?
$ ◯ Per Hour ◯ Per Day ◯ Per Week ◯ Per Month ◯ Per Job		

On the chart below, list all wages received by this employee during the months of: _____

Date Pay Period Ended	Date Employee Received Pay	Actual Hours	Gross Pay	Other Pay* (bonuses, commissions, overtime, pension plan, profit sharing, tips)

*In the Comments section below, explain when and how Other Pay is received.

Date Hired:	Date First Paycheck Received:	If Employee is/was on Leave Without Pay	
		Start Date:	End Date:

If this person is no longer in your employ:

Date Final Paycheck Received: _____ Gross Amount of Final Paycheck: $ _____

Is health insurance available? ◯ Yes ◯ No

If yes, employee is: ◯ Not Enrolled ◯ Enrolled for Self Only ◯ Enrolled with Family Members

Comments

Company or Employer Name:	Address (Street, City, State, ZIP Code):	
Area Code and Phone No.:	**Name of Person Verifying Information:**	**Title:**