



Harris County Hospital District

Patient Eligibility Services Administration
P.O. Box 300488
Houston, TX 77230

WAGE VERIFICATION LETTER

TO WHOM IT MAY CONCERN:

Your employee or a member of his/her family has applied for assistance at Harris County Hospital District. To determine the status of his/her eligibility, we must have verification of his/her gross income and employment status. With your employee's written authorization, please provide us with the requested information.

Please complete the items on the back of this form as soon as possible. Please ensure all information you provide is accurate; it will affect the employee and/or family member(s) eligibility status and benefits. If a question does not apply, mark it N/A. After completion, please give this form to your employee.

"I hereby authorize my employer to release the requested information regarding my income and employment status to the Harris County Hospital District".

Applicant / Employee Signature

Thank you,

Patient Eligibility Representative
Patient Eligibility Services

Harris County Hospital District
WAGE VERIFICATION

For Employer Use Only

This is an Official Government Record. Untrue or incomplete information given on this form could result in Actions taken under Sections 31.04, 37.10, or other portions of the Texas Penal Code.

Date: _____ Employee's Name: _____

Employee's Address: _____ City: _____ Zip Code: _____

Employee's Social Security Number: _____ Employee's Occupation: _____

1. Is the person named above employed by you? [] Yes [] No
2. Hourly Wage: \$ _____
3. How often paid? [] Daily [] Weekly [] Every Two Weeks [] Twice Monthly [] Monthly
4. Is employees 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, Zip Code): _____

Signature of Person Providing Information: _____ Title: _____

Date: _____ Telephone No.: _____