



COUNTY INDIGENT HEALTH CARE PROGRAM EMPLOYMENT VERIFICATION

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|--|------------------------------------|
| Date/Fecha | Case Record No./Núm de Caso |
| Office Address and Telephone No./Oficina y Teléfono | |
| Fax: | |

| | |
|-----------------|-------------------------------|
| Employee | Social Security Number |
|-----------------|-------------------------------|

This individual is a member of a household applying for health care assistance from the County Indigent Health Care Program. 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 the back of this letter. If a question does not apply, mark it N/A. After you complete this form, give it to your employee, mail it in the envelope provided, or fax it to the number listed above.

This information is needed by **this date:** _____. If you could send it before this date, it would be most appreciated.

Thank you for helping. If you have questions, please feel free to call.

| | |
|--|---------------------|
| I give my permission to release the information requested on this form. | |
| Yo doy mi permiso para que mi empleador dé la información que se pide en esta forma. | |
| _____ | _____ |
| Signature / Firma | Date / Fecha |

Comments: _____



EMPLOYMENT VERIFICATION

| | |
|---|--|
| Employee Name (as shown on your records) | |
| Employee Address – Street, City, State, ZIP (as shown on your records) | |
| Is/was/will this person (be) employed by you? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes → <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary | Is FICA or FIT withheld? <input type="checkbox"/> Yes <input type="checkbox"/> No |

| | | |
|---|---------------------------------------|--------------------------------------|
| Rate of Pay \$ _____ Per Hour <input type="checkbox"/> Per Day <input type="checkbox"/> Per Week <input type="checkbox"/> Per Month <input type="checkbox"/> Per Job | Average Hours per Pay Period _____ | How often is employee paid? _____ |
|---|---------------------------------------|--------------------------------------|

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

| Date Pay Period Ended | Date Employee Received Paycheck | Actual Hours | Gross Pay | Other Pay * (Bonuses, Commissions, Overtime, Pension Plan, Profit Sharing, Tips) |
|-----------------------|---------------------------------|--------------|-----------|---|
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* In Comments Section below, please 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? | | | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | If Yes, employee is → | <input type="checkbox"/> Not Enrolled <input type="checkbox"/> Enrolled for Self Only <input type="checkbox"/> Enrolled with Family Members |

Comments: _____

| | |
|---|---------------|
| Signature and Title of Person Verifying This Information | Date |
|---|---------------|

| | | |
|---------------------|------------------------------------|---------------------------------------|
| Company or Employer | Address (Street, City, State, ZIP) | Telephone Number (Include area code.) |
| | | |

PURPOSE

Use to verify a household member's income.

PROCEDURE

Issue the Form 128 to the employer or instruct the household member to take the Form 128 to the employer for completion.

File the completed Form 128 in the case record.

DETAILED INSTRUCTIONS

Page 1. Enter the employer's name and address; the date the Form 128 is issued; the case record number; the office address, telephone number, and fax number; the employee's name and social security number, if available.

If applicable, the employee signs and dates the information release statement in the box provided on Page 1 of the Form 128.

Page 2. Enter the month(s) that wage information is needed.

The employer completes the rest of Page 2.

FORM RETENTION

Maintain the records at least until the end of the third complete state fiscal year following the date on which the application is submitted.