



EMPLOYMENT VERIFICATION – RELEASE OF INFORMATION

Date	Case Record Number
Office Address	

Employee	Social Security Number
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This individual is a member of a household applying for health care assistance from the Texas Department of State Health Services / Newborn Screening 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 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 to the above address, or fax it to the number listed below.

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.

Employee Signature / Firma **Date / Fecha**

Comments: _____

Send completed form to NBS Benefits
FAX - 512-776-7593 OR Email - irma.hernandez@dshs.state.tx.us
 Questions? Call (512) 776-2983 or 800-252-8023 ext. 2983



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
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Rate of Pay \$ <input type="checkbox"/> 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?
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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 * <small>(Bonuses, Commissions, Overtime, Pension Plan, Profit Sharing, Tips)</small>

* 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: _____
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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)	Area code and Phone #

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