Verification of Earnings

Health and Human Services Division
Indigent Health Care

Client Name: _____ Client DOB: _____

Effective Date: _____ Date of First Visit: _____

The following information is required for use in determining if services rendered by client are eligible to be covered through funding provided by the Indigent Health Care 1/2 cent sales surtax. Information will be used solely for this purpose. Eligibility determination for coverage under this funding does not approve or deny client to receive services at the facility. Please complete the below for any household member of the client needing verification of earnings (including client).

Employee Name: _____ Employee Phone: _____

Employee Address: _____
Street City State Zip

Employer Name: _____ Employer Phone: _____

Employer Address: _____
Street City State Zip

Date Employment Began: _____ Date Employment Ended: _____

If terminated, is it permanent or temporary? _____ Date expected to return: _____

Gross Earnings

☒ From _____ To _____ Amount: $ _____

☐ ~~From January 1st through current date~~ Amount: $ _____

☐ ~~As reported on Employees w-2 statement for prior year~~ Amount: $ _____

Insurance Coverage

Is/Was employee covered by health insurance? ☐ Yes ☒ No

If yes, are/were any dependents covered? ☐ Yes ☐ No

If current health insurance is available, what is the cost of coverage? Amount: $ _____

Signature of Employer: _____ Date: _____

Name and Title of Employer Authorized Representative: _____

I certify that the information provided in this form is accurate and true.

Signature of Client: _____ Date: _____