WAGE VERIFICATION LETTER

TO WHOM IT MAY CONCERN:

I have applied for medical services for myself and/or family members. To determine the status of my eligibility for these services, the clinic must have verification of my gross income and employment status. With my written authorization, please provide the clinic with the requested information.

Please note that this information will be used for the purpose of determining eligibility for services at the Wesley Health & Wellness Center and/or Bishop Ernest T. Dixon Jr. Clinic. Such information is confidential and will not be reported to outside agents (INS, IRS, TDHS, ETC) without my written authorization.

Please complete the items on the back of this form as soon as possible so that the clinic can evaluate my household's eligibility for services. Please ensure all information you provide is accurate since it will directly affect eligibility for services. If questions do not apply, please mark it "N/A". After completion, please return this form to me.

"I hereby authorize my employer to release the requested information regarding my income and employment status to the Wesley Health & Wellness Center and/or Bishop Ernest T. Dixon Jr. Clinic."

_____

Employee Signature / Date

_____

Registration Clerk / Date

Methodist Healthcare Ministries of South Texas, Inc.
Wage Verification

For Employer Use Only

Date_____ Employee's Name_____

Employee's Address_____City_____ZipCode_____

Employee's Social Security Number_____-_____-_____Employee's Occupation_____

1. Is the person named employed by you? [ ] **Yes** [ ] **No**
2. Hourly Wage $_____
3. How often paid? [ ] **Daily** [ ] **Weekly** [ ] **Every Two Weeks** [ ] **Twice Monthly** [ ] **Monthly**
4. Is employee paid commission or tips? [ ] **Yes** [ ] **No**
5. Does employee receive overtime pay? [ ] **Frequently** [ ] **Rarely** [ ] **Never**
6. Does employee participate in a profit sharing, stock purchase or pension plan? [ ] **Yes** [ ] **No**
   If Yes, what is the current value? $_____

   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:
Hourly Wage:
Average Number of Hours Per Week:

For Terminated Employees
Dates of Employment:
Hourly Wage at Termination:

Date Pay Period Ended	**Date Employee Received Check**	**Actual Hours**	**Gross Pay**	**Other Pay (e.g. tips, commissions)**

Comments (Will there be any changes in the next few months?)

_____

_____

_____

Name of Employer_____

Address (Street, City, State, Zip Code)_____

Signature of Person Providing Information_____ Title_____

Date_____ Telephone No._____