

CareLink



WAGE VERIFICATION

EMPLOYEE NAME/NOMBRE DE EMPLEADO: _____

ADDRESS/DIRECCION: _____ ZIP CODE/CODIGO POSTAL: _____

PHONE #/NUMERO DE TELEFONO: _____ MRN #: _____

"I hereby authorize my employer to release the requested information regarding my income and employment status to the University Health System." Yo autorizo a mi jefe que comparta la información requerida por el University Health System acerca de mis ingresos y estado de empleo.

Employee Signature/Firma de Empleado Date/Fecha

FOR EMPLOYER USE ONLY

TO WHOM IT MAY CONCERN:

Your employee or a member of his/her family has applied for medical services at one of the University Health System facilities. To determine the status of his/her eligibility for these services, we need verification of his/her gross income and employment status. With your employee's written authorization, please provide us with the requested information

This is an Official Government Record. Untrue or Incomplete information given on this form may and probably will result In Criminal Action being taken under Section 31.04, 37.10, or other portions of the Texas Penal Code.

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

1. Is the person named employed by you? Yes No Date hired: _____

2. Is the person named On Leave of Absence: Yes No Last day worked: _____

3. Will employee be paid for Sick or Vacation Leave? Yes No

4. Do you offer health insurance? Yes No Is employee covered under your plan? Yes No

Name of Insurance Carrier: _____ Group #: _____

Certificate #: _____ HMO PPO Dependent coverage? Yes No

| Date Pay – Period Started | Date Pay- Period Ended | Date Employee Receive Check | Average # of Hours worked per week | Gross Pay | Comments |
|---------------------------|------------------------|-----------------------------|------------------------------------|-----------|----------|
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COMPANY NAME: _____ ADDRESS: _____

COMPLETED BY SIGNATURE: _____ DATE: _____

TITLE: _____ TELEPHONE #: _____

CareLink



STATEMENT OF SELF-EMPLOYMENT INCOME/DECLARACIÓN DE NEGOCIO INDEPENDIENTE

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PARA USO OFICIAL SOLAMENTE

Este es un documento Oficial del Gobierno. Información incompleta o incorrecta dada en esta forma puede y probablemente resulte En Acción Criminal bajo Sección 31.04, 37.10, o en otra porción del código penal de Texas.

EMPLOYEE NAME/NOMBRE DE EMPLEADO: _____

ADDRESS/DIRECCION: _____ ZIP CODE/CODIGO POSTAL: _____

PHONE #/NUMERO DE TELEFONO: _____ MRN #: _____

| Date/Fecha | Amount/Cantidad | | Date/Fecha | Amount/Cantidad |
|------------|-----------------|--|------------|-----------------|
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I certify under penalty of perjury that the information I have provided on this form is true and complete to the best of my knowledge, including income of each household member. I understand that giving false information could result in my being disqualified for fraud.
Yo certifico bajo pena de perjurio que la información proporcionada en esta forma es cierta y completa con lo mejor de mi conocimiento incluyendo información de ingresos de cada uno de los miembros de mi casa. Yo comprendo que dando información falsa puede resultar en fraude y no califique.

Member Signature/Firma de miembro

Date/Fecha