BHSF Employer
Rev. 04/01
Prior Issues Obsolete
IV

MEDICAID PROGRAM

Current, Past, OR Anticipated Wage Verification

TO: _____ FROM: **Bureau of Health Services Financing**

_____ _____

_____ _____

DATE: _____

_____ _____ _____

Name of Applicant/Recipient SSN Case ID No.

You are authorized to provide any information concerning my current, past, or anticipated employment and insurance coverage to Louisiana's Medicaid Program.

_____ _____

Signature of Applicant/Recipient Date

❑ The individual named above applied for/is receiving _____.

❑ It is necessary to verify his/her current or anticipated income and health insurance coverage to determine Medicaid eligibility. A form is provided on the back of this letter for your convenience in providing this information. If this individual has not actually started to working, please anticipate as accurately as possible what his/her wages will be and whether he/she will have insurance coverage.

❑ We are reviewing the past participation of the individual named above in the **Medicaid Program**. We must have exact information to complete our investigation.

❑ We understand that the individual named above was employed by your firm during the period from _____ to _____. It is necessary that we have exact gross income amounts earned during each pay period. A form is provided on the back of this letter for your convenience in providing this information. Please check the Social Security number we have provided carefully against your records.

❑ We have contacted your employer, _____, concerning your employment there from _____ to _____. Our inquiries have not been answered and we are unable to determine the actual _____ _____ which you received. Please contact your employer and have him fill out the back of this letter.

Please return the information requested above to us by _____. Enclosed is a stamped, self-addressed envelope for your convenience in replying.

Thank you for your cooperation. Your assistance is appreciated.

Sincerely,

_____

Agency Representative

1. Name of Employee Social Security No.

Address of Employee

Name of Employer Date Started Expected to Start

2. If terminated, give: Reason _____

Last Day Worked _____ Amount of Last Check $_____

3. Check how often the employee is (was or will be) paid and complete the chart below (as indicated in the corresponding parentheses:

❑ Weekly (Show 4 most recent) ❑ Twice Monthly (Show 2 most recent)

❑ Every Two Weeks (Show 2 most recent) ❑ Monthly (Show 1 most recent)

Date Wages Received OR Anticipated	Period Ending (Not applicable to Anticipated Wages)	Number of Hours Worked OR Anticipated	Gross pay Before Deductions OR Anticipated Pay	Earned Income Tax Credit Paid
			$	$
			$	$
			$	$
			$	$

4. If employment is new, please provide:

_____# hours expected to work $_____ hourly rate of pay _____ how often paid.

5. Are you aware of any other income this person may be receiving, such as other wages, compensation or pensions? ❑ Yes ❑ No If yes, please indicate the source:

_____

6. Is/was employee covered by health insurance? ❑ Yes ❑ No If yes, please provide:

Name of insurance company _____

Claims filing address _____

Policy No. _____ Date of entitlement _____

Type of coverage (group, hospital, major medical) _____

Who is/was covered? _____

_____ _____ (_____) _____

Signature of Employer Date Telephone Number