Date

HHSC Staff
Office Address/Telephone No./FAX No.

Employer Name and Address

EMPLOYMENT VERIFICATION (Aged and Disabled Programs)

Employee/Household Member	**Social Security No.**

This individual is a member of a household applying for assistance from the Texas Health and Human Services Commission or has income that affects another household member's application for assistance. To determine the household's eligibility, it is necessary to verify all earnings. Since this person is (or was) your employee, your help is needed.

HERE'S HOW YOU CAN HELP: Please provide the information requested in this letter. Please ensure that all information is complete and correct, since it will affect someone's eligibility and benefits. If a question does not apply, mark it N/A. After you complete the form, give it to your employee or mail it in the envelope provided – or you may FAX it to the number listed above.

This information is needed by ____________________ , so if you could send it before this date it would be most appreciated.
(Due Date)

Authorization to furnish this information is attached. Thank you for helping. If you have questions, please feel free to call.

FEDERAL TAX INFORMATION (Check the appropriate box.)

☐ **Yes**

☐ **No**

THANK YOU for taking the time to complete all of the information on pages 2 and 3. Your help is greatly appreciated.

On the chart on page 3, list all wages received by this employee during the month(s) of:

Beginning Month (MM,DD,YYYY) ______________________ **through** ______________________ **Ending (or current) Month (MM,DD,YYYY)**

______________________ Signature–HHSC Staff

______________ Date

Telephone No. (inc. area code)

EMPLOYER–PLEASE COMPLETE AND RETURN PAGES 2 & 3

EMPLOYMENT VERIFICATION

(Aged and Disabled Programs)

PLEASE COMPLETE AND RETURN PAGES 2 AND 3 ONLY

THANK YOU for taking the time to complete all of the information on pages 2 and 3. Your help is greatly appreciated.

Employee Name (as shown on your records)

Employee Address—Street, City, State, ZIP (as shown on your records)

Is (or was) this person employed by you? ☐ **Yes** ☐ **No**	If yes, what type of job?	☐ **Full Time** ☐ **Part Time** ☐ **Permanent** ☐ **Temporary**

Rate of Pay $	☐ **Per Hour** ☐ **Per Day** ☐ **Per Week** ☐ **Per Month** ☐ **Per Job**	How often paid?	Avg. Hrs. per Pay Period

Commissions/Tips/Bonuses ☐ **Yes** ☐ **No**	Overtime Pay ☐ **Frequently** ☐ **Rarely** ☐ **Never**	FICA or FIT Withheld ☐ **Yes** ☐ **No**	Profit Sharing/Pension Plan?–If yes, Current Value ☐ **Yes** ☐ **No** **$**

Health Insurance Available? ☐ **Yes** ☐ **No**	If yes, employee is: ☐ **Not Enrolled** ☐ **Enrolled With Family Members** ☐ **Enrolled for Self Only**	Name of Insurance Company

Date Hired	Date First Check Rec'd	Average Hrs. Per Week	**If Employee is/was on Leave Without Pay:**	Start Date	End Date

Do you expect any changes to the above information within the next few months? ☐ **Yes** ☐ **No**

If yes, explain:

RETURN FORM TO:

Eligibility Specialist	Telephone No.	Fax No.

Address

Please remember to complete page 3

EMPLOYMENT VERIFICATION (Aged and Disabled Programs) — Continued

THANK YOU for taking the time to complete all of the information on this form. Your help is greatly appreciated.

On the chart below, list all wages received by this employee during the month(s) of:	Beginning Month (MM, DD, YYYY)	through	Ending (or Current) Month (MM, DD, YYYY)		
DATE PAY PERIOD ENDED	**DATE EMPLOYEE RECEIVED PAYCHECK**	**ACTUAL HOURS**	**GROSS PAY**	**OTHER PAY*** (tips, commissions, bonuses)	**NET AMOUNT OF CHECK**

* Please explain (in comments section below) when and how often tips, commissions or bonuses are received.

IF THIS PERSON IS NO LONGER IN YOUR EMPLOY:

Date Separated	Reason for Separation	Date Final Check Received	Gross Amount of Final Check

COMMENTS:

Company or Employer	Address (Street, City, State, ZIP)

This information is true and correct to the best of my knowledge and belief.

Title	Telephone No.

Signature–Person Verifying this Information

Date