Washington State Department of Social & Health Services
Transforming lives

Employment Verification

LOCAL OFFICE	
ACCESSHEALTH	
TELEPHONE NUMBER **281-342-4530**	FAX NUMBER
PATIENT NUMBER	DATE

Please use blue or black ink and print or type.

Section 1: To be filled out by the client/employee.

I authorize my employer to release information to the Department of Social and Health Services.

EMPLOYEE'S SIGNATURE	SOCIAL SECURITY NUMBER (OPTIONAL)	DATE
X		

Section 2: To be filled out by the employer.

EMPLOYEE'S NAME	EMPLOYER'S NAME
EMPLOYEE'S JOB TITLE	EMPLOYER'S ADDRESS

Is this a new job? ☐ No ☐ Yes	DATE EMPLOYEE STARTED WORK	DATE FIRST CHECK WAS RECEIVED

AVERAGE HOURS PER WEEK	RATE OF PAY OR SALARY (HOURLY, DAILY OR PIECE RATE)	Has job ended? ☐ No ☐ Yes If yes, when: why:

Pay frequency: ☐ Daily ☐ Weekly ☐ Every two weeks ☐ Two times a month ☐ Monthly

Is this job Work Study? ☐ Yes ☐ No	IF YES, PROVIDE VERIFICATION OF TOTAL FINANCIAL AID AWARD	WHEN WILL YOUR POSITION END?

Actual gross income (or attach payroll printout) for last three months:

MONTH:	MONTH:	MONTH:
$	$	$

Actual gross income for current month and anticipated gross income for next two months:

CURRENT MONTH:	MONTH:	MONTH:
$	$	$

Tips ☐ No ☐ Yes; if yes, how often and how much? _____

Commissions ☐ No ☐ Yes; if yes, how often and how much? _____

Bonuses ☐ No ☐ Yes; if yes, how often and how much? _____

Overtime ☐ No ☐ Yes; if yes, how often and how much? _____

Work schedule (include exact times when possible):

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

Is Health Insurance available? ☐ Yes ☐ No

If yes, is employee enrolled in the health plan? ☐ Yes ☐ No

When does the coverage begin?

What is the employee's portion of premiums?

EMPLOYER/REPRESENTATIVE'S SIGNATURE	DATE
X	X
EMPLOYER/REPRESENTATIVE'S PRINTED NAME AND TITLE	PHONE NUMBER
X	X