TEXAS Health and Human Services | Texas Department of State Health Services

# EMPLOYMENT VERIFICATION RELEASE OF INFORMATION

| | |
|---|---|
| | Client Name / Nombre del Cliente |
| | Account Number / Número de Cuenta |

Employee Name:

This individual is a member of a household applying for healthcare assistance from the Texas Department of State Health Services / Newborn Screening Benefits. To determine this household's eligibility, it is necessary to verify all earnings. Since this individual is/was/will be your employee, your help is needed.

Please completely and accurately provide the information requested on the back of this letter. If a question does not apply, mark it N/A. After you complete this form, give it to your employee, mail it to the above address, or fax it to the number listed below.

This information is needed by this date: _____. If you could send it before this date, it would be most appreciated.

Thank you for helping. If you have questions, please feel free to call.

**I give my permission to release the information requested on this form.**

Yo doy mi permiso para que mi empleador dé la información que se pide en esta forma.

_____ _____

**Employee Signature /** Firma **Date /** Fecha

Comments: _____

_____

_____

_____

**Send completed form to NBS Benefits**

**FAX** - 512-776-7593 ***OR*** **e-mail -** NBSBenefits@dshs.texas.gov

Questions? Call (512) 776-2983 or 800-252-8023 ext. 2983

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# EMPLOYMENT VERIFICATION

| Employee Name (as shown on your records) | |
|---|---|
| Employee Address – Street, City, State, ZIP (as shown on your records) | |
| | |

| Is/was/will this person (be) employed by you? ☐ Yes ☐ No<br>If yes → ☐ Permanent ☐ Temporary | Is FICA or FIT withheld?<br>☐ Yes ☐ No |
|---|---|

| Date Hired | | *Rate of Pay* | *$* | *Average Hours Per Pay Period* | *How often is employee paid?* |
|---|---|---|---|---|---|
| ☐ Per Hour ☐ Per Day ☐ Per Week ☐ Per Month ☐ Per Job | | | | | |

| Date First Paycheck Received: | | If employee is/was on Leave Without Pay<br>*Start Date:* *End Date:* |
|---|---|---|
| **If this person no longer works for you:** | | |
| Date Final of Paycheck: | Gross Amount of Final Paycheck: $ | |

| **Is health insurance available?** ☐ Yes ☐ No<br>If Yes, employee is → ☐ Not Enrolled ☐ Enrolled for Self Only ☐ Enrolled with Family Member |
|---|

On the chart below, list all wages received by this employee during the months of:

| Date Pay Period Ended | Date Employee Received Paycheck | Actual Hours | Gross Pay | Other Pay * (Overtime, Tips, Bonuses, Commissions, Pension Plan, Profit Sharing, Tips) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

*Comments: (In the space above, please explain when and how Other Pay is received.)

_____ _____

**Signature and Title of Person Verifying This Information** **Date**

| Company or Employer | Address (Street, City, State, ZIP) | Telephone |
|---|---|---|
| | | |

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