EMPLOYER'S STATEMENT

Employee's Printed Name: _____ Last four of SSN: _____
Employee's Signature: _____

*****STOP HERE! THE REST OF THIS FORM IS TO BE COMPLETED BY YOUR EMPLOYER OR DESIGNEE*****

HealthWorks requests income verification to determine eligibility for our sliding fee program.

1. Date of hire: _____Date started: _____ Date first check received: _____
2. How often is the employee paid: _____
3. Does the employee's wage change frequently? _____ If yes, additional information may be requested.
4. Wages/tips (before taxes) $_____ ☐Hourly ☐Weekly ☐Every 2 Weeks ☐Twice a month ☐Monthly ☐Yearly
5. What is the average number of hours worked per week? _____ Rate per hour? _____

If your employee has had changes in wages, hours, or other, please complete the following:

*****EMPLOYMENT CHANGES*****

1. New daily/weekly/monthly gross pay $ _____ Effective date of change: _____
2. No longer employed? Date employment ended: _____ Date of Final Check: _____
   Gross Amount of Final Check: $ _____

_____ _____
Employer or Employer's Designee Printed Name and Title Employer or Designee Signature

_____
Business Name

_____
Business Address

_____ _____
Business Phone Number Date

Revised 8-7-2023