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 verify eligibility for our sliding fee program.

1. Date of hire: _____Date started: _____ Date first check received: _____
2. How often paid: Daily_____ Weekly ____ Every other week ___ Twice a month ___ Monthly_____
3. Is the employee's income: fluctuating (varies) ___ or stable (same amount every month)? ____
4. If stable, what is the gross daily, weekly, bi-weekly, semimonthly or monthly pay? $_____
5. If fluctuating, what is the average number of hours worked per week? _____
   Rate per hour? _____ Average number of hours per day? _____

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

1. New daily/weekly/monthly gross pay $ _____
2. Effective date of change: _____

*****EMPLOYMENT ENDED*****

1. Date employment ended: _____
2. Date of final check: _____ Gross Amount: $ _____

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

_____
Business Name

_____
Business Address

_____ _____
Business Phone Number Date