ILIULIUK FAMILY AND HEALTH SERVICES, INC.

Employment Verification Form

Employee Name: Social Security Number:

The above named person has applied for the sliding scale fee at the clinic. To determine eligibility for the person/family, all earnings must be verified.

THIS SECTION MUST BE FILLED OUT BY EMPLOYER IN INK:

1. Is the person named above employed by you? Yes No Date hired:

   Give total gross income for previous year if worked:

   Estimated length of employment since first hired: (Months) (Years)

   Date terminated (if applicable):

   If employee is or has been on leave of absence, give date leave began:

   Date of expected return: Is employee seasonal? Yes No

   If yes, give current year's (reg. time) total income: & contracted hours:

2. How often is employee paid? Weekly Every 2 weeks Monthly Twice monthly

   Average number of hours worked per week:

3. Please state hourly wage:

4. Are any changes expected in employee's pay or status during the next six months?

   If yes, please explain:

5. On the chart below, please state all earnings for the last four (4) weeks:

PLEASE INDICATE EARNINGS BEFORE DEDUCTIONS

DATE PAID	GROSS AMOUNT
Week 1:	
Week 2:	
Week 3:	
Week 4:	

Does the employee have health insurance? Yes No

If yes, please fill in the information below:

Name of insurance company:

Policy Number:

Group Number: Effective Date:

Name(s) of insured dependents:

Name of person representing the employer: **Date:**

I authorize my employer, to release wage information to IFHS.

SIGNATURE OF PATIENT/EMPLOYEE DATE