Azar Harah Birth Services, LLC

Telephone: 478-353-5764

Employment Verification Form

Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above-named person has applied for the sliding scale fee with Azar Harah Birth Services, LLC. 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 total income: \_\_\_\_\_\_\_\_& if applicable, 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

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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