GPW Health Center *Dedicated to Your Health!*

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INCOME VERIFICATION

(This information is required only to determine eligibility for our Discount Fee Program)

EMPLOYEE / NON-EMPLOYEE SECTION- To be completed by employee / non-employee.

Employee / Non-employee Name: _____ Signature: _____ Date: _____

Income Verification – Submitted when employee / non-employee is unable to provide required pay stubs or is paid in cash.

If an employee is unable to provide required **pay stubs** (i.e., pay stubs are not available and/or employee has started employment and pay stubs have not been yet received) the employee must provide a completed and signed Income Verification form from **each** employer. Once verified, the employee will be considered for eligibility determination for Sliding Fee Discount Program.

If the applicant is paid from one or more employer's (individuals, businesses and/or organization), or is **paid cash** from nonemployee individual, business and/or organization for casual labor, day labor and/or domestic service (e.g., gardening, landscaping, housekeeping, daycare, babysitting, etc.) and the cash paid is **not** included on the employee / non-employee's tax return, the employee / non-employee must provide a completed and signed Income Verification form from **each** employer and **each** non-employer (i.e., individual, business and/or organization) for services. Once verified, the employee / non-employee will be considered for eligibility determination for Discount Fee Program.

EMPLOYER / NON-EMPLOYER - This section must be completed by the employer / non-employer.

Name of Supervisor/ Manager /Individual _____ Phone Number of Supervisor /Manager/Individual _____

TO BE FILLED BY **EMPLOYER:** Verification of income:

1. Date of Hire: _____/_____/_____
2. Pay Rate/Salary: $_____
3. Frequency of pay: ☐Hourly ☐Daily ☐ Weekly ☐Bi-weekly ☐Monthly
4. Tips/ commission $_____

TO BE FILLED BY **NON-EMPLOYER:** Verification of Additional income: □ Child Support □ Alimony □ Rent paid to Applicant □ Other_____

Cash amount: $_____monthly

I verify that I provide additional Income (cash and/or non-cash) to pay for my basic living needs to applicant or to provide child support, alimony, rent paid to applicant or other

I understand GPW Health Center may contact me to verify this information. Furthermore, I understand providing false information or information subsequently determined to be false will result in the employee / non-employee eligibility for Discount Fee Program to be revoked and the full balance of the account(s) restored and payable immediately.

Completed By (Printed Name and Title): _____

Signature: _____ Date: _____

Effective Date: **Immediate**
Approved Date: **06/2010, 06/2011, 05/2013**
Revision Date: **04/29/2015, 04/08/2018**