

# JPS Health Network

## Employment Verification for JPS Connection Indigent Healthcare Program

Employee name (as shown on your records)			
Employee Address - Street, City, State, ZIP (as shown on your records)			
Is (or was) this person employed by you? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Part Time <input type="checkbox"/> Full Time <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary			Average Hours Per Week
Hire Date	Date of First Check	If Employee is / was on Leave Without Pay: Start Date                      End Date	
Termination Date (if applicable)	Date Final Check Received	Gross Amount of Final Check	
Rate of Pay \$ <input type="checkbox"/> Per Hour <input type="checkbox"/> Per Day <input type="checkbox"/> Per Week <input type="checkbox"/> Per Month		Frequency of pay? <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Semi-monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Irregular	
Commissions/Tips/Bonuses <input type="checkbox"/> Yes <input type="checkbox"/> No	Receives Overtime Pay <input type="checkbox"/> Frequently <input type="checkbox"/> Rarely <input type="checkbox"/> Never	Profit Sharing/Pension Plan <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, current value \$
Do you expect any changes to the rate of pay or hours per pay period within the next 90 days? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Has the employee asked to have the rate of pay or hours reduced? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes to either question please explain:			

### Health Insurance

Health Insurance Available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employee is: <input type="checkbox"/> Enrolled w/ Family Members <input type="checkbox"/> Enrolled Employee Only <input type="checkbox"/> Not Enrolled
Name of Insurance Company: _____ Phone #: _____	
Claims Address _____	
Group Number: _____ Policy #: _____ Effective Date: _____	
Has the employee reported additional insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, name of company, insured, group and policy #: _____	
If employment terminated Cobra Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	

### Payroll Information

On the chart below, list all wages received by this employee during the months of : _____ <b>Please list the four most recent pay periods.</b>				
Date Employee Received paycheck	Actual Hours	Gross Pay	Net Pay	Other Pay * (Tips, Commissions, Bonuses)

\* Please explain (in the comments section below) when and how often tips, commissions, or bonuses are received.

Comments: \_\_\_\_\_  
 \_\_\_\_\_

Name of Employer	Address (Street, City, State, ZIP)
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**This information is true and correct to the best of my knowledge and belief.** "I understand that anyone who knowingly lies or misrepresents the truth or arranges for someone to knowingly lie or misrepresent the truth in the completion of this application is committing a crime which can be punished under Federal law, State law, or both. Everything on this application is the truth as best I know it."

	Title	Telephone No.
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Signature - Person Verifying This Information \_\_\_\_\_ Date \_\_\_\_\_

**JPS Health Network**  
**Employment Verification for**  
**JPS Connection Indigent Healthcare Program**

DATE \_\_\_\_\_

\_\_\_\_\_ (Soc. Sec. No. \_\_\_\_\_) is a member of a household applying for assistance. To determine the household's eligibility, we must verify all earnings. Since this person is (or was) your employee, your assistance is needed.

Please complete the items on the back of this form as soon as possible so that we can evaluate the household's situation. Please ensure all information you provide is accurate since it will affect someone's eligibility and benefits. If a question does not apply, mark it N/A. After completion, please give this form to your employee, fax it to 817-927-3834 or mail it to the address below. Thank you for your help.

John Peter Smith Hospital  
1500 South Main  
Fort Worth, Texas 76104  
(817) 927-1001

\_\_\_\_\_  
Patient Representative

I, \_\_\_\_\_ give my permission to release the information requested on this form.

Yo, \_\_\_\_\_ doy mi permiso para que mi empleador dé la información que se pide en esta forma.

\_\_\_\_\_  
**Signature/Firma**

\_\_\_\_\_  
**Date/Fecha**

**Esta forma esta disponible en Español a su rogar. Por favor comunícese con el número de teléfono sobre arriba.**