TEXAS
Health and Human
Services Commission

Date:

Return form to:
Health and Human Services Commission
PO Box 149027
Austin TX 78714-9027
or
Fax number: 1-877-447-2839

EMPLOYMENT VERIFICATION (MEDICAID BUY-IN FOR CHILDREN)

Employee name	Social Security number

The person named above is a member of a household applying for assistance from the Texas Health and Human Services Commission or has income that affects another household member's application for assistance. To determine the household's eligibility, we must verify all earnings and group health insurance. Because this person is (or was) your employee, we need your help.

Here's how you can help: Please provide the information requested in this letter. Be sure all information is complete and correct, because it will affect someone's eligibility and benefits. If a question does not apply, mark it N/A. After you complete the form: (1) give it to your employee, OR (2) mail it in the enclosed pre-paid envelope, OR (3) fax it to the number listed above.
Authorization to furnish this information (Form H0003) is attached. Thank you for helping.
Questions about this form? Call 2-1-1.

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? ☐Yes ☐No	If yes, what type of job?	☐Full-time ☐Part-time ☐Permanent ☐Temporary

Rate of pay $	☐Per hour ☐Per day ☐Per week ☐Per month ☐Per job	How often paid?	Avg. hrs. per pay period

Commissions/ tips/bonuses ☐Yes ☐No	Overtime pay ☐Frequently ☐Rarely ☐Never	Health insurance available? ☐Yes ☐No	Does employer pay at least 50% of family premium? ☐Yes ☐No Amt: $

Mark below the employee's current status regarding employer-offered health insurance: ☐Not enrolled ☐Enrolled for self only ☐Enrolled with family members	If family is not enrolled, when is open enrollment period?	Name and address of insurance company Insurance policy number

If enrolled, amount paid by employee $	If family is enrolled, list names of family members covered:	If family is (or was) enrolled, provide start and end dates of coverage:	
Frequency of payment		Start date:	End date:

If any member of this family has been denied or lost coverage under the employer-offered health insurance, please explain:		
Name:	Name:	Name:
Reason:	Reason:	Reason:
Date coverage was lost or denied:	Date coverage was lost or denied:	Date coverage was lost or denied:

Do you expect any changes to the insurance provider or benefits? ☐Yes ☐No	**If yes, explain:**

On the chart below, list all wages received by this employee for the last six months.

Date pay period ended	**Date employee received paycheck**	**Actual hours**	**Gross pay**	**Other pay*** (tips, commissions, bonuses)	**Net amount of check**

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

If this person is no longer in your employ:

Date separated	Reason for separation	Date final check received	Gross amount of final check

Comments:

Company or employer	Address (street, city, state, ZIP)

This information is true and correct to the best of my knowledge and belief.

Title Phone number

Signature of person verifying this information Date

Thank you for taking the time to complete all of the information on this form. Your help is greatly appreciated.