Health Care Assistance Program
1400 South Loop 336 West
Conroe, Texas 77304
Phone: 936-523-5100
Fax: 936-539-3450

MONTGOMERY COUNTY HOSPITAL DISTRICT

HCAP #:_____

Employer Verification Form

Please have this form completed and signed by your employer

_____ _____
Company Name (Please Print) Supervisor Name (Please Print)

_____ _____
Company Address Telephone

Employee (Applicant) Information:

_____ _____/_____/_____ _____/_____/_____
Employee Name (Please Print) Hire Date End Date (if applicable)

Type of Job: ☐ Full time ☐ Part time ☐ Permanent ☐ Temporary

Rate of Pay: ☐ Hourly ☐ Salary ☐ Commission ☐ Other _____ Hourly wage: $_____

Pay Period: ☐ Daily ☐ Weekly ☐ Bi-weekly ☐ Bi-monthly ☐ Monthly ☐ Other _____

Please check all that apply:

☐ Insurance offered by company If yes, when do they become eligible? _____

☐ Insurance not offered by company

☐ Insurance accepted by employee

☐ Insurance declined by employee

Please use chart below to list all wages received by this employee for the last four (4) consecutive pay periods:

Date Employee Received Check	Actual Hours	Gross Pay	Tips/Commission	EITC Advance

_____ _____
Supervisor's Signature (REQUIRED) Date (REQUIRED)

_____ _____
Employee/Applicant Signature (REQUIRED) Date (REQUIRED)