Income Verification Form

Section I. Release of Information (To be completed by employee)

Employee Name_____ SSN or TIN_____

I authorize the release of the following information to NC MedAssist. I understand that additional information may be required from my employer and/or clients.

_____ _____

Employee Signature Date

----------**To Be Completed By Employer**----------

Section II. Employer Information

Employer Name_____ Title_____

Business Name_____ Phone_____

Business Address_____

Section III. Income from Employment

Pay Period *(circle one)*: Weekly Bi-Weekly Bi-Monthly Monthly Other_____

In the space below, please provide the most current and consecutive income for the last month.

Pay Date	Pay Period Begin Date	Pay Period End Date	Gross Earnings

Section IV. Employer Verification

The information provided on this form is true and complete to the best of my knowledge.

_____ _____

Employer Signature Date

Please return completed form by mail or fax to:

NC MedAssist
4428 Taggart Creek Rd, Suite 101 Charlotte, NC 28208
Fax: 704-536-9865 | Phone: 866-331-1348