Income Verification Form

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

Employee Name________________________________ SSN or ITIN______________________________

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 Rate: $__________/hr $____________/week $____________/month Other:______________

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

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Please return completed form by mail or fax to:

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