Employment Wage Verification

For use with Medicaid applications

This form is used to verify employment information for Medicaid eligibility. Please complete the form and attach any supplemental paystubs, W-2s, or tax returns. Both the employee (client) and employer must complete and sign their sections.

- If you are paid weekly: Provide the last 6 pay stubs
- If you are paid bi-weekly: Provide the last 4 pay stubs
- If you are paid monthly: Provide the last 4 pay stubs

Applicant Name **Date**

Case Number **Date of Birth**

Home Address

Mailing Address

Phone Number **Email**

Release of Information:

I authorize the employer below to release employment information to the US Virgin Islands Department of Human Services for purposes of determining eligibility for Medicaid.

Client or Authorized Representative Printed Name

Client or Authorized Representative Signature **Date**

Client Perjury Statement:

Under penalty of perjury, I certify that the information presented in this document is true and accurate to the best of my knowledge. By signing below, I understand that providing false statements may result in termination, denial, or recovery of benefits.

Client Printed Name

Client Signature **Date**

OR

Authorized Representative Name **Date**

Authorized Representative Signature

Phone Number **Email**

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What is the employees' start date? Did their employment end? If so, please provide the date employment ended and when they will receive their last pay.

How often is the employee paid? Weekly Bi-weekly Monthly If other:

Does the employee receive tips or gratuity? Yes No

If Yes, how much do you receive weekly/bi-weekly/monthly?

If additional space is needed, you may attach extra sheets of paper or additional copies of this form. Once all fields have been filled out, the form may be submitted in-person, by email, or by mail.

Employer Information:

Company/Employer Name Phone

Mailing Address

Email

This is to certify that is employed by the company. The following information is true and correct to the best of my knowledge.

Employer's Printed Name Title

Employer's Signature Today's Date

	Paystub 1	Paystub 2	Paystub 3	Paystub 4	Paystub 5	Paystub 6
Pay Date						
Pay Period Ending						
Gross Earnings						
Social Security						
Income Tax						
Medical Insurance						
Total Deductions						
NET PAY						

Disclaimer: We do not discriminate on the basis of race, ethnicity, color, national origin, religion, sex, age, or disability. Free language assistance services are available for people whose primary language is not English. We also provide free aids and services to assist with communicating the information effectively (such as interpreters, captioning, Braille, or large print). If you need these services, please contact us by phone or email.

St Thomas/St. John District: 340-774-0930 ext. 4104 or sttjmap@dhs.vi.gov | St. Croix: 340-772-7100 or stxmap@dhs.vi.gov

Privacy Notice: The information provided on this form will be used only for purposes of determining and verifying Medicaid eligibility. Your information is protected under state and federal privacy laws.