



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

-Please bring copy to your appointment: