UFHealth
JACKSONVILLE

VERIFICATION OF INCOME AND MEDICAL INSURANCE COVERAGE
This form must be completed by the **Employer's Payroll Department**.)

This form must be hand delivered or mailed to the UF Health Jacksonville Outpatient Financial Evaluation Department at 655 W. 8th St. Jacksonville, FL 32209.

Please complete the required information below.

I, _____, hereby authorize the release of all requested information to SHANDS Jacksonville.

_____ _____
Employee's Signature Date

1. Name of Employee: _____Social Security No._____
2. Date Current Employment Began: _____ Last Date Employed/Termination Date:_____
3. How often is employee paid? (circle one) **Daily** **Weekly** **Bi-Weekly** **Monthly** **Semi-Monthly**
4. Number of hours worked per week? _____ Current Rate of Pay _____
5. Is the employee covered by Medical Group Health Insurance through the employer? **Y or N** Are dependents covered**?** **Y or N**

   Effective Date of Coverage_____ Name of Insurance Carrier_____

   Group No._____Policy # _____

   If No - Is Medical Group Health Insurance coverage available to the employee? **Y or N**

   If Yes - Is the employee responsible for any portion of the insurance premium? **Y or N**

   If Yes - What is the employee cost of the premium? $_____/mo

6. ***Complete the following table regarding wages or salary paid to this employee: to include OVERTIME, TIPS, BONUS, and etc**…
   Please document each pay date and the gross pay received for the past 4 months or 12 months. Please include additional pay on a separate verification form.

Date Paid	Gross Earnings	**Date Paid**	Gross Earnings	**Date Paid**	Gross Earnings

Signature of Official_____ Print Name of Official_____

Official's Position_____ Name of Firm_____

Address_____ Telephone Number_____

_____

Date Completed_____

NOTICE OF FLORIDA HOSPITAL

(1) Whoever shall, willfully and with intent to defraud, obtains or attempts to obtain goods, products, merchandise or services from any hospital in this state shall be guilty of a misdemeanor of the second degree, punishable as provided in 775.082 or 775.083.

(2) If any person shall give to any hospital in this state a false or fictitious name, a false or fictitious address, any other false or fictitious information required to be obtained by such hospital in compliance with 382.31 et seq., or shall assign to any hospital the proceeds of any insurance contract, then knowing that such contract is no longer in force or is invalid or is void for any reason, any such action shall be prima facie evidence of the intent of such a person to defraud such hospital. VIOLATION of Florida Statues 817.50 is punishable by imprisonment not exceeding sixty (60) days or fine not in excess of $500.00, or both, as may be provided by law upon conviction.

***UF Health Jacksonville reserves the right to verify the validity of the information provided on this form.**