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| **WISCONSIN DEPARTMENT OF HEALTH SERVICES**Division of Medicaid ServicesF-10146 (02/2022)**EVFE** |  |
| Employer Verification of earnings form |
| This form is to verify employment and wage information for the employee listed below. You are required by law to complete and return this form by the due date indicated below. This form will be scanned so write clearly using blue or black ink. Write any additional comments in Section 4, the Employer Comments section. **Only employers can sign and complete this form. Printouts or paystubs can be submitted in lieu of this form. Include all of the requested information on the printouts.****Section 1**-Complete the employment status information by checking whether or not the employee is currently employed. If not, fill out the end date, final paycheck, gross pay, and reason employment ended**Section 2**-If the employee listed is employed by your company, provide the start date and date of the first paycheck received below. Include the employee’s position title, employment type, and pay frequency.**Section 3**-If the employee has any pre-tax deductions, fill out the information including type of deduction, how much the deduction is, and how often the deduction occurs.**Section 4**-Use the section below to add any comments concerning the employee’s employment.**Section 5**-By signing this form, you are saying that the information you provided is correct and complete to the best of your knowledge. This form **must be completed, signed, and dated** by the employer or designee. Please provide the title of the person completing the form, a telephone number, and/or fax number if available.**Submission Options**Submit your completed form by: (     )You can either return the completed form to the local agency or give the form to the employee to return. To return to the local agency, fax or mail the completed form to:      Make sure you complete and return the form to the employee or local agency as soon as possible so that the local agency receives it by the indicated due date.

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| Employer Name | Employee Name |
|       |  |
| Federal Employer Identification Number (FEIN) | Employee Case Number |
|       |  |

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| section 1 | Employment Status Information | See the source image |
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| Is the employee listed above currently employed by your company?[ ]  Yes [ ]  No*If yes, go to Section 2. If no, complete the rest of this section and then go to Section 4 to sign and date the form.*  |
| Employment End Date       | Reason Employment Ended [ ]  Never employed [ ]  Quit [ ]  Strike [ ]  Fired [ ]  Other |
| Date of Final Paycheck | Gross Pay (before deductions) for Final Month |
|       | $      |
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| section 2 | Employment Information |  |
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| Employment Start Date | Date First Paycheck Received |
|       |       |
| Position Title      | Job Type[ ]  Manager [ ]  Non-Manager |
| Employment Type[ ]  Full-time [ ]  Part-time [ ]  Temporary [ ]  On Call [ ]  Seasonal | Months Worked (for example, Sept. to Dec.)      |
| Pay Frequency[ ]  Paid Weekly [ ]  Paid every Two Weeks [ ]  Paid Twice a Month [ ]  Paid Monthly [ ]  Paid Irregular |
| Please provide an estimate for the next 30 days of the hours the employee is expected to work for each week. If the type of pay is regular, holiday, other shift, overtime, weekend, or other type of pay, write in the rate of pay the employee earns per hour.  |
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| **Type of Pay** | **Hours to be Worked Per Week** | **Rate of Pay** | **Regular Work Hours**(for example, Monday-Friday, 8:00 a.m.–4:30 p.m.) |
| Regular  |       | $      |       |
| Overtime |       | $      |  |
| Other shift pay |       | $      |
| Weekend/shift differential pay |       | $      |
| Other |       | $      |

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| **Salary Pay Details** | **Salary Per Week** |
| Salary:       | $      |

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| Will the employee receive any of the following? | **How Much:** | **How Often:** |
| Tips (including cash)BonusesCommissions | [ ]  Yes [ ]  No[ ]  Yes [ ]  No[ ]  Yes [ ]  No | $     $     $       |                 |
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| Section 3 | Pre-Tax Deduction Information | See the source image |
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| Does this employee have any of the following pre-tax or other deductions? |
| **Type:** | **How much is the deduction?** | **How often?** |
| Health Insurance Premiums | $      |       |
| Health Care Savings Account | $      |       |
| Parking and Transit Cost | $      |       |
| Group Life Insurance Premiums | $      |       |
| Retirement Contributions | $      |       |
| Flex Savings Account for Child Care or Other Dependent Care | $      |       |
| Other Deductions | $      |       |

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| Section 4 | Employer Comments |

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| Section 5 | Signature and Date  |   |
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|  | **SIGNATURE** – Employer/Designee | Date Signed |
| Print Name – First, Last, and Middle Initial      | Phone Number      |
| Title      | Fax Number (if available)      |

## USDA Nondiscrimination Statement

This institution is an equal opportunity provider.