



## Employer Income Attestation

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Dear Employer,

The above-named individual identified you as a source of income for their household. In order to complete their enrollment in various assistance programs, we need verification of wages.

Thank you for your assistance!

White House Clinics

1. Employer Name \_\_\_\_\_

2. Amount of Employee's Typical Paycheck \_\_\_\_\_

3. How often do you pay the employee?

- Weekly
- Every Other Week
- Monthly
- Twice a Month
- Other (please explain) \_\_\_\_\_

**Please read the following statement and sign below.**

I certify the above information is true and correct. I understand that this information will be used to determine eligibility for the patient assistance programs at White House Clinics.

\_\_\_\_\_  
**Employer Signature**

**Internal Use Only (should be completed by WHC employee who completes financial statement with patient)**

I certify that I asked the applicant/recipient about all sources of income received by the household and, before using this form, used best efforts to obtain other possible sources of documentation.

\_\_\_\_\_  
**Employee Signature**

\_\_\_\_\_  
**Printed Name of WHC Employee**

\_\_\_\_\_  
**Date**