OKLAHOMA
Health Care Authority

INCOME VERIFICATION FORM

This Income Verification form is used to verify employment income. **If you have 30 days of current paystubs, please provide copies of them**. If you are self-employed, please fill out the Self-Employed Cash Income Statement or send in a current profit/loss sheet (not from your taxes).

When completed, upload this document to your SoonerCare member portal or mail it to:

Oklahoma Health Care Authority
P.O. Box 548804
Oklahoma City, OK 73034

MEMBER INFORMATION					
Member printed name:				Today's Date:	
Fill out one of the following:					
SoonerCare case #:		Member ID #:		SSN#:	

Please give the Oklahoma Health Care Authority any information requested from your records concerning my employment.

EMPLOYER INFORMATION	
Employer company name:	
Employer address:	
	(Street address) (City, state) (Zip)

EMPLOYMENT INFORMATION			
Complete this section if the employee is currently employed with your business.			
Date of hire:		Date first pay was or is to be received:	
Number of hours in first paycheck:			
Gross amount *(before taxes)* of first paycheck:	**$**		
Is the first paycheck for a full pay period?	☐ **Yes** ☐ **No**		
Number of hours worked in a regular work week:			
Hourly pay rate: **$**		Overtime hourly pay rate: **$**	
Check how often paid and when:			
☐ Monthly, date paid:			
☐ Every two weeks, date paid:			
☐ Twice monthly, dates paid:			
☐ Weekly, day paid:			
☐ Daily			
Is the employee on paid leave?	☐ **Yes** ☐ **No**		
What kind of paid leave?	*(medical, workers comp, disability, etc.)*		
Is employee currently on leave without pay?	☐ **Yes** ☐ **No**		
Expected return to work date:			

OKLAHOMA
Health Care Authority

List the last 30 days of paycheck information including any pretax deductions below.
If taxable gross is known, do not list the pretax deductions.

Date check received	Taxable Gross	Gross amount of check	Total pretax deductions	401k-pretax IRA	Bonuses/commission, overtime, other:

IRREGULAR EMPLOYMENT			
Complete this section if the employee is currently employed with your business and has irregular hours.			
How many days per month do you work?			
How many hours have you worked in the last 30 days?			
What is your hourly pay rate:	$	Daily rate:	$
Check how often paid and when:			
☐	Monthly, date paid:		
☐	Every two weeks, date paid:		
☐	Twice monthly, dates paid:		
☐	Weekly, day paid:		
☐	Daily		

List 30 days of paycheck information including any pretax deductions below.
If taxable gross is known, do not list the pretax deductions.

Date check received	Taxable Gross	Gross amount of check	Total pretax deductions	401k-pretax IIRA	Bonuses/commission, overtime, other:

1099 CONTRACTOR OR PAID IN CASH			
I am employed as a:	☐	1099 contractor	☐ Person paid in cash
What is your hourly pay rate:			
Hours worked per week:			
Check how often paid and when:			
☐	Monthly, date paid:		
☐	Every two weeks, date paid:		
☐	Twice monthly, dates paid:		
☐	Weekly, day paid:		
☐	Daily		

OKLAHOMA
Health Care Authority

List 30 days of paycheck information including any pretax deductions below.
If taxable gross is known, do not list the pretax deductions.

Date check received	Taxable Gross	Gross amount of check	Total pretax deductions	401k-pretax IIRA	Bonuses/commission, overtime, other:

TERMINATED EMPLOYMENT INFORMATION			
If the employee no longer works for your business, please provide the information below:			
Employer company name:			
Date employment ended:			
Total gross income *(before taxes)* received in the final month of employment:	**$**		
Gross amount *(before taxes)* of final paycheck:	**$**		
Date of final paycheck:			

EMPLOYER SIGNATURE			
Employer printed name		Employer signature	
Today's date:		Contact phone number:	

MEMBER SIGNATURE

The information I give on this form is true and correct to the best of my knowledge. I realize if I make any false statement or misrepresent facts to receive benefits or payments under the Medicaid Program, I can be lawfully punished for fraud and/or perjury. I may also have to repay the State of Oklahoma for any payments or claims incurred which were paid based on representations that I made herein. (OAD 317:35-13-6 and OAC 317:35-13-7).

The signature must be handwritten or drawn with your cursor. Typed in signatures are not valid.

_____
Member or authorized representative signature

Please upload this document to your SoonerCare member portal or mail it to:
Oklahoma Health Care Authority
P.O. Box 548804
Oklahoma City, OK 73034