BHSF Wages
Rev. 01/01
Prior Issues Usable
IV

MEDICAID PROGRAM
PERSONAL WAGE RECORD

Work Record for: ___________________ SSN _______________ Case ID # ________________________

Please keep a record of your employment as indicated below. Return this form to the Medicaid Program representative by __________________________.

Dates Worked	Employer	Employer Address	Employer Phone	# of Hours Worked	Gross Amount Earned	Date Wages Received

____ ______________________

Signature of Applicant/Recipient Date