Continuum of Care Program

VERIFICATION OF INCOME

Applicant Name: _____

Instructions for Employer/Payment Source Representative: This is to certify the income received by the above named individual for purposes of participating in the COC program. This information will be used only to determine the eligibility status and level of benefit of the household. **Complete only the selected section below that includes an authorization to release information.**

Please return this form to:

Name & Title: _____ Phone: _____
Address: _____ Fax: _____
E-mail: _____

☐ Employment Income

Applicant Release: I hereby authorize the release of the following employment information.

Applicant Signature: _____ Date: _____

Employer representative to complete this section:

The person named above is employed by _____since _____. He/she is paid $_____ on a _____ basis and is currently working an average of _____ hours per _____.

Additional compensation please specify (if any):_____
Probability of continued employment: _____

Authorized Employer Representative Signature: _____ Date: _____
Name & Title: _____
Address & Phone: _____

☐ Payments and/or Benefit Income (complete one form for each distinct source of income for person named above)

CIRCLE ONE:

Social Security/SSI	Pension/Retirement	TANF
Public Assistance	Unemployment Compensation	Workers Compensation
Alimony Payments	Foster Care Payments	Child Support Payments
Armed Forces Income		

Other (please specify): _____

Applicant Release: I hereby authorize the release of the following payment and/or benefit information.

Applicant Signature: _____ Date: _____

Payment source representative to complete this section:

Payments or benefits in the amount of $_____ are paid on a _____ basis. The expected duration of the payments or benefits is _____.

Authorized Payment Source Representative Signature: _____ Date: _____
Name & Title: _____
Address & Phone: _____