Supportive Services for Veteran Families (SSVF) Program

VERIFICATION OF INCOME

SSVF Participant 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 SSVF Program. This information will be used only to determine the eligibility status and level of the 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:

Email:

☐ Employment Income

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

SSVF Participant Signature:_____ Date:

Employer representative to complete this section:

The person named above is employed by since .

He/she is paid $ on a(n) (select) basis and is currently working an average of hours per (select)

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)

CHECK ONE:

☐ Social Security/SSI ☐ Pension/Retirement ☐ TANF
☐ Public Assistance ☐ Unemployment Compensation ☐ Workers Compensation
☐ Alimony Payments ☐ Child Support Payments
☐ Armed Forces Income ☐ Other (specify):

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

SSVF Participant Signature:_____ Date:

Payment source representative to complete this section:

Payments or benefits in the amount of $ are paid on a(n) (select) basis.

The expected duration of the payments or benefits is

Authorized Payment Source Representative Signature _____ Date:

Name: Title:

Address: Phone: