

**VERIFICATION OF INCOME**

ESG 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 ESG program. This information will be used only to determine the eligibility status and level of household benefit. **Complete only the selected section below that includes an authorization to release information.**

**Please return this form to:**

Name &amp; Title: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

 Employment Income**ESG Applicant Release: I hereby authorize the release of the following employment information.**

ESG 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 and Phone: \_\_\_\_\_

Payments and/or Benefit Income (complete one form for each distinct source of income for each adult member of household and attach supporting evidence to this form in case file)

**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 (pls. specify): \_\_\_\_\_

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

ESG 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 and Phone: \_\_\_\_\_