3rd Party Income Verification Form

Participant Name: _____ **Date of Birth:** _____ **Date**: _____

Instructions for Employer/Payment Source Representative: This is to certify the income received by the above-named individual is for purposes of participating in a LAHSA funded 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:** _____

Address: _____

Fax: _____ **Phone:** _____ **Email:** _____

I. Employment Income:

I, _____, hereby authorize the release of the following employment information.

Participant Signature: _____ **Date**: _____

Employer Representative to complete this section:

The person named above is employed by _____.

He/she has been employed since_____ **(Start Date)**

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: _____

Employer Certification:

Printed Name: _____ **Title**: _____

Address _____

Authorized Employer Representative Signature: _____ **Date:** _____

Phone Number: _____ **Email:** _____

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

☐ General Relief/Cal Works	☐ Social Security/SSI	☐ Workers Compensation	☐ Alimony Payments
☐ TANF	☐ Pension/Retirement	☐ Unemployment Compensation	☐ Foster Care Payments
☐ CAPI	☐ Armed Forces Income	☐ Child Support Payments	☐ Other (pls. specify): _____

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

Participant 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 _____.

Payment/ Benefit Certification:

Printed Name: _____ **Title**: _____

Address: _____

Authorized Payment Source Representative Signature: _____ **Date**: _____

Phone Number: _____ **Email:** _____