**COC FORM 8: Verification of Income**

|  |  |  |
| --- | --- | --- |
| **COC Applicant Name:** |  | **Date:** |

**Instructions for Employer/Payment Source Representative:** This is to certify the income received by the above named individual for purposes of participating in the U.S. Department of Housing & Urban Development’s Continuum of Care (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.**

**EMPLOYMENT INCOME**

**COC Applicant Release: I hereby authorize the release of the employment information noted below.**

COC 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 BENEFITS 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  Foster Care Payments

Alimony Payments  Workers Compensation  Child Support Payments

Armed Forces Income

Other (pls. specify):

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

COC 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 Rep. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Name, Title:

Address and Phone:

**Please return this form to:**

Name & Title:       Phone:

Address:       Fax:

Email: