



**EMERGENCY SOLUTIONS GRANT
NORTH DAKOTA HOMELESS GRANT
VERIFICATION OF INCOME**
PLANNING AND HOUSING DEVELOPMENT DIVISION
SFN 59246 (05/23)

Applicant Name

RETURN THIS FORM TO

Name	Title		
Address	City	State	ZIP Code
Email Address	Telephone Number	Fax Number	

EMPLOYMENT INCOME

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

Applicant Signature	Date
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EMPLOYER REPRESENTATIVE

Instructions for Employer/Payment Source Representative: This is to certify the income received by the above-named individual for purposes of participating in the Emergency Solutions Grant (ESG) and North Dakota Homeless Grant (NDHG) programs. 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.

Employer		Date Employed	
Salary/Wages	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	Hours Worked	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
Specify Additional Compensation		Probability of Continued Employment	
Authorized Employer Representative Signature	Telephone Number	Date	
Name		Title	
Address	City	State	ZIP Code

PAYMENTS AND/OR BENEFIT INCOME

Complete one for each distinct source of income for person named above.

<input type="checkbox"/> Social Security/SSI	<input type="checkbox"/> Pension/Retirement	<input type="checkbox"/> TANF
<input type="checkbox"/> Unemployment Compensation	<input type="checkbox"/> Workers Compensation	<input type="checkbox"/> Alimony Payments
<input type="checkbox"/> Foster Care Payments	<input type="checkbox"/> Child Support Payment	<input type="checkbox"/> Armed Forces Income
<input type="checkbox"/> Public Assistance	<input type="checkbox"/> Other (specify)	

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

Applicant Signature	Date
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PAYMENT SOURCE REPRESENTATIVE

Amount of Payment/Benefit	Payment Frequency	Expected Duration of Payment/Benefits
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Authorized Employer Representative Signature	Date		
Name	Title		
Address	City	State	ZIP Code