

# KANSAS HOUSING

## 2020 ESG - CV

### VERIFICATION OF INCOME

ESG-CV 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-CV 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: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Fax: \_\_\_\_\_  
Email: \_\_\_\_\_

Employment Income

**ESG-CV Applicant Release: I hereby authorize the release of the following employment information.**

ESG-CV 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 person named above)

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

ESG-CV 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: \_\_\_\_\_