MaineHousing
MAINE STATE HOUSING AUTHORITY

VERIFICATION OF INCOME AND RELEASE FORM

Name: _____

Instructions for Employer/Payment Source Representative: This is to certify the income received by the above named individual. **Complete only the selected section below that includes an authorization to release information. Please provide at least 12 weeks of income/benefit verification.**

Please return this form to:
Name: _____ Phone: _____
Fax: _____

☐ Employment Income

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

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/SSDI	Pension /Retirement	TANF
Public Assistance	Unemployment Compensation	Workers Compensation
Alimony Payments	Foster Care Payments	Child Support Payments
Armed Forces Income		

Other (specify): _____

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

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: _____

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CERTIFICATION OF ZERO INCOME

Household Name:	SSN:
Address:	Phone:

I hereby certify that I do not individually receive income from any of the following sources:

1. Employment **wages** including: overtime, commissions, tips, bonuses, fees etc.
2. Unemployment compensation.
3. Income from operation of a business: sales from self-employment resources.
4. Rental income from real estate or personal property.
5. Interest/dividends from Assets: savings/checking accounts, annuities, insurance policies, retirement funds, pensions or death benefits.
6. Social Security (SS) and/or Supplemental Security Income (SSI) benefits.
7. Public assistance payments including: General Assistance, TANF and/or Food Stamps.
8. Regular contributions/gifts received from person not living in the household.
9. Alimony and/or Child Support payments.

Dates of zero income: _____to_____

Under penalty of perjury, I certify that the information presented in this certification is true and accurate to the best of my knowledge. The undersigned further understand(s) that providing false representations herein constitutes an act of fraud. I understand that providing false, misleading or incomplete information may result in the termination of my housing assistance.

_____ _____ _____

Tenant/Applicant Signature Printed Name Date

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SELF–CERTIFICATION OF EMPLOYMENT
For use when paid by cash or taxes are not deducted

WARNING: Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements of misrepresentation to any Department or Agency of the U.S. as to any matter within it's jurisdiction. I certify that the below information is true and complete to the best of my knowledge and understand that my subsidy may be terminated, or other actions taken, if I do not report all income coming into my household.

Household Name:	SSN:
Address:	Phone:

I receive $_____ ☐ Hourly ☐ Weekly ☐ Daily ☐ Bi-monthly ☐ Monthly

I receive my pay by: ☐ Check ☐ Cash ☐ Money Order ☐ Other _____

Dates of certification (for the previous 12 weeks): From _____ to _____

Payment received from (attach documentation):

Name: _____ Address: _____

Phone: _____ _____

Add additional payers on a separate form as necessary

_____ _____

Signature Date

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CHILD CARE SELF-VERIFICATION

Federal law and regulations require us to verify the sources and amounts of income and expenses for all applicants for admission as tenants to our federally assisted housing programs and to re-examine periodically the **under 13 years old, and children with a documented disability under 18 years old can be deducted from and reduce overall gross income. This can potentially reduce the tenant portion of the rent**.

Household Name:	SSN:
Address:	Phone:

Childcare provider name: _____

Name(s) of children in childcare:

_____ _____

_____ _____

Days per week: _____ Hours per week: _____

Charge: _____ ☐ Hourly ☐ Daily ☐ Weekly

Do charges vary for any reason? (example: child in school) If yes, please explain:

_____

_____

Do you receive money from any other person or agency towards the amount you pay for the above named child(ren)? If yes, who and how much?

Name/Agency: _____ Relationship (if applicable): _____

Amount: $_____ ☐ Hourly ☐ Daily ☐ Weekly ☐ Sporadically

Total amount received in the past 12 weeks: _____

_____ _____

Signature Date

_____

Telephone

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MEDICAL/DENTAL EXPENSE VERIFICATION

Federal law and regulations require us to verify the sources and amounts of certain types of expenses of all applicants for admission as tenants to our federally assisted housing program and to re-examine periodically the expenses of existing tenant families. All information is confidential and will be used only in determining eligibility for rental assistance. **Medical expenses in excess of 3% of annual income can be deducted from and reduce overall annual gross income. This can potentially reduce the tenant portion of the rent**.

Household Name:	SSN:
Address:	Phone:

Provider: _____ Provider Address: _____

Phone: _____ _____

****

Please provide your best estimate of medical/dental expected over the next 12 months, based on experience/costs over the last 12 months and/or anticipated costs for applicant/family's current medical/dental condition. To the extent that you are aware that medical/dental insurance covers some/all of the charges, please answer accordingly. Your assistance and prompt response will be greatly appreciated.

Total medical/dental expense for the above named individual for the coming 12 month period: $_____

Amount individual is expected to pay out-of-pocket (amount not covered by insurance): $_____

If the individual has an outstanding account balance? ☐ Yes ☐ No
If yes, what is the balance? $_____

Is the individual making regular payments on the outstanding balance? ☐ Yes ☐ No

If yes: $ _____per ☐ Week ☐ Month

_____ _____
Signature/Title Date

_____
Phone

Please return this form to:
Name: _____ Phone: _____

Fax: _____

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PRESCRIPTION DRUG VERIFICATION

Federal law and regulations require us to verify the sources and amounts of income and allowable expenses of all applicants for admission as tenants to our federal assisted housing program and to reexamine periodically the incomes and allowable expenses of existing tenant families. All information is confidential and will be used only in determining eligibility for rental assistance. **Out of pocket, unreimbursed prescription drug costs can be deducted from and reduce overall annual gross income. This can potentially reduce the tenant portion of the rent**.

Household Name:	SSN:
Address:	Phone:
DOB:	

Pharmacy: _____ Address: _____

Phone: _____ _____

****

Please provide the anticipated amount paid by the customer (out of pocket) for prescription drugs for an ongoing basis. Your assistance and prompt response will be greatly appreciated:

$ _____ per ☐ month ☐ year

If the individual have an outstanding account balance? ☐ Yes ☐ No
If yes, what is the balance? $_____

Is the individual making regular payments on the outstanding balance? ☐ Yes ☐ No

If yes: $ _____per ☐ Week ☐ Month

Authorized Signature: _____ Date: _____

Please return this form to:
Name: _____ Phone: _____

Fax: _____

353 Water Street | Augusta, Maine 04330-4633 | 207.626.4600 | 800.452.4668 | Maine Relay 711 | Fax 207.626.4678 | mainehousing.org

To contact the Housing Choice Voucher Department: 207.624.5789 | 866.357.4853 | Fax 207.624.5713