

EMPLOYMENT VERIFICATION OF INCOME

517-3

This will authorize _____
(**employer's name /address**) to release the information requested below regarding my employment compensation.

_____	_____
Full Name (Please Print or Type)	Social Security Number
_____	_____
Signature	Street Address
_____	_____
Date	City/State/Zip

TO WHOM IT MAY CONCERN: The individual named above is a participant/applicant for housing, which has rents that are subsidized through the U.S. Department of Housing and Urban Development's housing assistance payment program. Federal regulations require that in order for a family to be eligible for this form of assistance, the income of the family expenses, and other information related to eligibility must be verified. The information requested below will be held in strict confidence as is required under the provisions of the Government Data Collection and Dissemination Practices Act, and will be used only to determine the eligibility of the family for the housing subsidy. Thank you for your cooperation in completing those applicable portions of this inquiry and returning it.

_____	Manassas Department of Social Services
Administrative Agent	9324 West Street
_____	Manassas, VA 20110
Position/Title	703-361-8277 ext. 2327
_____	571-921-8806 fax
Date	

TO BE COMPLETED BY THE EMPLOYER

1. Date of Employment: _____ Position/Occupation: _____
2. Current Rate of Regular Pay: \$ _____ per _____ (hour/week/month/etc.)
3. Current Rate of Overtime Pay: \$ _____ per _____ (hour/week/month/etc.)
4. Number of hours/weeks employee normally works: _____
5. Anticipated average amount of overtime per week: _____
6. Gross **annual** earnings you anticipate for this employee for the next 12 months: _____
(Gross amount including all tips, bonuses, overtime, commissions)
7. Anticipated Tips, Commissions, Bonuses: \$ _____
8. Do you anticipate any change in the employee's rate of pay in the near future?
YES / NO (Please circle one) If yes, Revised Rate _____ Effec. Date _____
9. Does this employee receive vacation with pay? YES / NO (Please circle one)
10. Does this employee receive sick leave with pay? YES /NO (Please circle one)
11. Amount deducted for medical coverage: \$ _____
12. Amount deducted for savings plan: \$ _____
13. If the employee's work is seasonal or sporadic, indicate lay-off period(s): _____
14. Additional Comments: _____

I certify that the above information is true and correct to the best of my knowledge.

_____	_____
Print Name	Name of Employer
_____	_____
Signature	Mailing Address
_____	_____
Title	City/State/Zip
_____	_____
Date	Telephone Number

WARNING: Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction.