



INCOME VERIFICATION REQUEST

Date: _____

To: _____

RE: Name: _____

SSN: _____

ID Number: _____

Section I: AGENCY REQUEST

The above named individual has applied for assistance from the State of Florida. In order to determine eligibility, the department must have verification of all income and resources.

Please complete Section II. Attached is a signed authorization for the release of this information. In order to establish the individual's eligibility as quickly as possible, we are requesting your response by _____ (10 days). Enclosed is an envelope for mailing the completed form to us.

Thank you very much for your prompt attention.

Sincerely,

Name (print) Telephone Number

Address

Section II: RESPONSE

Gross Income Amount: \$ _____

Deduction Type and Amount: Type: _____ Amount: \$ _____

Deduction Type and Amount: Type: _____ Amount: \$ _____

Deduction Type and Amount: Type: _____ Amount: \$ _____

Net Amount: \$ _____

Frequency of Income: Weekly Biweekly Monthly Other (specify): _____

Are any changes anticipated in the above income information? Yes No

If so, when and amount: _____

Comments: _____

Signature/Title of Employer's Representative	Date Signed	Representative's Telephone Number
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