

ESG/ESG-CV/NDHG VERIFICATION OF INCOME

NORTH DAKOTA DEPARTMENT OF COMMERCE
 DIVISION OF COMMUNITY SERVICES
 SFN 59246 (06/21)

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/ESG-CV/NDHG 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	
Address		City	State ZIP Code
Email		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			
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
Additional Compensation Please Specify (if any)		Probability of Continued Employment	
Authorized Employer Representative Signature		Date	Phone
Name		Title	
Address		City	State ZIP Code

Payments and/or Benefit Income (complete one form for each distinct source of income for person named above)

Check one:			
<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 (please 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			
Amount of Payment/Benefit	Payment Frequency	Expected Duration of Payments/Benefits	
Authorized Payment Source Representative Signature			Date:
Name		Title	
Address		City	State ZIP Code