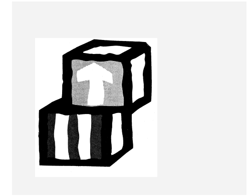
Please return to:

CAP AGENCY HEAD START

2496 145th St. West
Rosemount, MN 55068
PHONE 651-322-3500 FAX 651-322-3555



REQUEST FOR COUNTY ASSISTANCE VERIFICATION

To Whom It May Concern:

We are required to verify the income of all applicants who apply for our Head Start Program. The Applicant listed below has indicated that he/she is/was receiving income from your agency in the past 12 months. Please supply the information requested below as promptly as possible. All information is protected under the Minnesota Data Privacy Act in determining eligibility. Thank you.

Head Start Staff: __________

APPLICANT MUST COMPLETE THIS SECTION

Name:____ Birthdate:______________________________

Home Address: ____

City____ Social Security # :____________________________

Phone # _____________________________

County(s) Support received from: (please circle)

Dakota Ramsey Washington Hennepin Scott Carver Other____________________

Worker: _______________________________________ Worker Phone #: _________________________________

My signature authorizes verification of my information. You are hereby authorized to furnish all information requested on the inquiry. You may access any of my public assistance benefits through a computer system with this signature.

Signature: ____ Date: __________________________

COUNTY WORKER MUST COMPLETE THIS SECTION

Total gross income from this agency for ***any or all*** months benefits received: Maxis #:_______________

FOR **MFIP/GA/MSA/DWP** (Please Circle) Mo. ________/Yr._______ **THRU** Mo.________/Yr._______

January	February	March	April	May	June
$	$	$	$	$	$
July	**August**	**September**	**October**	**November**	**December**
$	$	$	$	$	$

Completed by: (print) ____ Phone Number: _________________

Signature: ____ Date: ________________________