Tri-CAP INC.
TRI-COUNTY ACTION PROGRAM
Helping People. Changing Lives.

Authorization for Release of Employment Information

Employee Name: _____ HH# _____

Employer: _____

Requested: Gross income received for the month of: _____

PERMISSION: I give permission to the employer named on this form to give information about the questions asked. I give permission to Tri-CAP to contact the employer about the information asked on this form. Tri-CAP will use the information to decide if I am eligible for assistance.

RIGHTS & UNDERSTANDING: I know that I must give my written consent before anyone can share this information. I understand Tri-CAP needs this information to decide if I am eligible for assistance and the amount. I know that I do not have to consent to this release. I understand that if I don't give my consent, I may not get the assistance I am applying for. My consent ends one year from the date I sign this form, but I may stop this consent at any time.

Client Signature: _____ SS# _____ Date: _____

Dear Employer,

We understand that was employed with you. It is necessary that we verify employment information. Will you please provide us with the requested information below and return it to Tri-CAP via fax or mail? Thank you.

Employment period:	Date Employment started	Date Employment ended	Reason Ended ☐ Voluntary ☐ Involuntary

Attach a printout of gross income received in the following time period or complete the table below:
Gross income received from: _____

	Income received						
Date received							
Gross earnings							
Advances/Tips/Bonuses							

Employer completing this form:

Signature	Title	Date

Address		

Please print your name	Phone	Fax