

VERIFICATION OF INCOME - ADFA DISASTER RECOVERY HOUSING ASSISTANCE LOAN PROGRAM

Employer/Payment Source Information

(APPLICANT – PLEASE COMPLETE HIGHLIGHTED\* SECTIONS ONLY):

Company/Agency\*: [redacted] Phone\*: [redacted]
Address\*: [redacted] Fax\*: [redacted]
City, ST, Zip Code\*: [redacted] Email\*: [redacted]

Applicant Release: I hereby authorize the release of the following employment/payment/benefit information.

Applicant Signature\*: [redacted] Date\*: [redacted]

Applicant Name (please print)\*: [redacted]

IF social security or other form of federal income are received, please obtain and provide a benefit statement.
Instructions for Employer/Payment Source Representative: This is to certify the income received by the above-named individual for purposes of participating in the Disaster Recovery Housing Assistance Loan Program. This information will be used only to determine the eligibility status and level of benefit. Complete only the section below that pertains to income/benefit provided to the subject applicant by your company/agency.

[ ] Employment Income

Employer representative to complete this section:

The person named above is employed by \_\_\_\_\_ since \_\_\_\_\_. He/she is paid \$\_\_\_\_\_ on a \_\_\_\_\_ basis and is currently working an average of \_\_\_\_\_ hours per \_\_\_\_\_.

Additional compensation please specify (if any): \_\_\_\_\_

Probability of continued employment: \_\_\_\_\_

Authorized Employer Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name, Title: \_\_\_\_\_

Address and Phone: \_\_\_\_\_

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

Payment source/benefit representative to complete this section:

- CIRCLE ONE: Social Security/SSI Pension/Retirement TANF
Public Assistance Unemployment Compensation Workers Compensation
Alimony Payments Foster Care Payments Child Support Payments
Armed Forces Income Other (please specify): \_\_\_\_\_

Payments or benefits in the amount of \$\_\_\_\_\_ are paid on a \_\_\_\_\_ basis. The expected duration of the payments or benefits is \_\_\_\_\_.

Authorized Payment Source Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name, Title: \_\_\_\_\_

Address and Phone: \_\_\_\_\_

Please return the completed form to:

DISASTER RECOVERY LOAN PROGRAM
P.O. BOX 8023
LITTLE ROCK, AR 72203

EMAIL: FloodProgram@arkansas.gov
PHONE: (501) 682-5993
FAX: (501) 682-5859