**Income and Employment Change Verification**

This form is to confirm income or employment change for applicants of Better Health Together COVID-19 housing assistance program. This form is to be completed by the applicant, and their employer, to verify applicant’s working hours or income has changed due to COVID-19.

Any questions about this program can be directed to hadley@betterhealthtogether.org

Employee Info:

|  |  |  |  |
| --- | --- | --- | --- |
| **Employee Name** |  | **Date** |  |

|  |  |
| --- | --- |
| **Employee Job Title** |  |
| **Average Hours/week** |  | **Rate of Pay or Salary** |  |
| **Gross income for last 3 months (or attached payroll printout)** |  | **Anticipated income for current and next 2 months**  |  |

[ ]  I authorize my employer to release information to Better Health Together

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Employer to continue on next page…*

To be filled out by Employer:

|  |  |  |  |
| --- | --- | --- | --- |
| **Employer Name** |  | **Phone** |  |
| **Address** |  |
| **Were employee’s hours or wages reduced due to COVID-19 Pandemic?** | [ ]  Yes [ ]  No |
| **If so, how?** |
| **When did this change begin?** |  **Date:**  |
| **Has employee returned to customary working hours / rate?**  | [ ]  Yes [ ]  No | **If yes, when? Date:**  |

[ ]  I confirm the above Employee Information is accurate to the best of my knowledge

Employer Representative’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Representative’s Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Representative’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_