



*Please return to:*  
**CAP AGENCY ENERGY ASSISTANCE**  
**2496 145<sup>th</sup> St. West**  
**Rosemount, MN 55068**  
 PHONE 651-322-3550 FAX 651-322-3557

For office use only  
 HH# \_\_\_\_\_  
 STAFF: ONLINE  
 PRIMARY: \_\_\_\_\_

## REQUEST FOR COUNTY ASSISTANCE VERIFICATION

*To Whom It May Concern:*

We are required to verify the income of all applicants who apply for our Energy Assistance 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.

### 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 monthly gross income from this agency for the months of:

<u>MONTH</u>	<u>MFIP/GA/MSA/DWP</u>
_____	_____
_____	_____
_____	_____

Completed by: (print) \_\_\_\_\_ Phone Number: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_