



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

For office use only
 HH# _____
 STAFF: ONLINE
 PRIMARY: _____

REQUEST FOR DISABILITY 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.

EMPLOYEE MUST COMPLETE THIS SECTION

Name: _____ Social Security #: _____
 Home Address: _____ Phone #: _____
 City: _____ State: _____ ZIP: _____

(Please fill in below the company information PAYING disability)

Company Name: _____
 Work Address: _____
 City, State, ZIP: _____
 Phone: _____ FAX #: _____

My signature authorizes verification of my disability. You are hereby authorized to furnish all information requested on the inquiry.

Employee's Signature: _____ Date: _____

COMPANY PAYING DISABILITY MUST COMPLETE THIS SECTION

Employee's Title: _____ Date of Hire: _____

Total monthly gross income from this company for the months of:

<u>MONTH(S)</u>	<u>Reimbursed Wages Only</u> (No Medical, Mileage, etc.....)
_____	_____
_____	_____
_____	_____

Completed by: (print) _____ Phone Number: _____
 Signature: _____ Date: _____