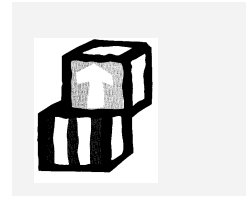




Please return to:
CAP AGENCY HEAD START
 2496 145th St. West
 Rosemount, MN 55068
 PHONE 651-322-3500 FAX 651-322-3555



REQUEST FOR COUNTY ASSISTANCE VERIFICATION

To Whom It May Concern:

We are required to verify the income of all applicants who apply for our Head Start 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.

Head Start Staff: _____

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 gross income from this agency for **any or all** months benefits received: _____ Maxis #: _____

FOR **MFIP/GA/MSA/DWP** (Please Circle) Mo. _____/Yr. _____ THRU Mo. _____/Yr. _____

January	February	March	April	May	June
\$	\$	\$	\$	\$	\$
July	August	September	October	November	December
\$	\$	\$	\$	\$	\$

Completed by: (print) _____ Phone Number: _____

Signature: _____ Date: _____