CAP
COMMUNITY ACTION PARTNERSHIP
OF SCOTT CARVER & DAKOTA COUNTIES

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

REQUEST FOR SOCIAL SECURITY BENEFITS 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 RECEIVING SOCIAL SECURITY MUST COMPLETE THIS SECTION

Name of Recipient:_____ Birthdate of Recipient:_____

Social Security # of Recipient: _____

Address:_____

City:_____ State:_____ ZIP: _____

Phone # : _____

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

Signature:_____ **Date:** _____

SOCIAL SECURITY ADMINISTRATION OFFICE MUST COMPLETE THIS SECTION

The gross amount of the monthly **Social Security (SS)/SSI** benefits for:

MONTH(S)	**SSI**	**SOCIAL SECURITY**
_____	_____	_____
_____	_____	_____
_____	_____	_____

We are unable at this time to verify information requested:

_____ Claim still pending
_____ No record based on identifying information
_____ Other - see reverse form

Completed by: (print)_____ Phone Number: _____

Signature:_____ Date: _____