

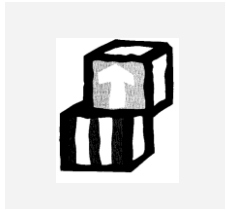


Please return to:  
**CAP AGENCY HEAD START**

2496 145<sup>th</sup> 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:

<u>MONTH(S)</u>	<u>SSI</u>	<u>SOCIAL SECURITY</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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: \_\_\_\_\_