GAINESVILLE HOUSING AUTHORITY
Where Housing Matters

1900 SE. 4th St., Gainesville, FL 32641
Telephone (352) 872-5500 ~ Fax (352) 872-5501
www.gainesvillehousingauthority.org

EXECUTIVE DIRECTOR
PAMELA E. DAVIS

Request for Verification of Employment Income

ATTN: Personnel Department (**This Form Must Be Faxed, E-mailed, or Mailed Back!)**

Employee:	SS#	
Address:	Occupation	
	Employee #	

The above-named person is applying for, or participating in, a federally-assisted housing program operated by the Gainesville Housing Authority. Written verification of income is required in order to determine eligibility and the amount of rent that he/she is to pay. Your prompt return of this form will be appreciated. In no event should this form be filled out by the employee. Forms should be completed by the time-keeper, bookkeeper, or accountant.

Housing Coordinator: _____E-mail: _____ (352) 872-5500 Ext. _____

I do hereby authorize my employer to release all information requested below to the Gainesville Housing Authority for the purpose of determining my eligibility for housing assistance.

Employee Signature: Date:

Verification of Employment Income *(please complete whether employed or not)*

Date Employment began:	Occupation:
Date Employment terminated:	Re-employed:

Base Pay: $_____ per ☐hour ☐day ☐week ☐month ☐year

Date present rate effective _____

Average hours per week at base pay rate _____ Average weeks per year at base pay rate _____
Change in base rate anticipated in next 12 months to $_____ per _____
Overtime pay: $_____ per hour
Expected overtime during next 12 months: _____ hours per week

Earnings year to date: $_____

Total earnings in the past 12 months: $_____, consisting of,
Base Pay $_____ Bonus $_____ Overtime $_____

If employee is employee's landlord, is a rent reduction given? ☐ NO ☐ YES Amount $_____

Do federal funds pay for any part of salary? ☐ NO ☐ YES Amount $_____

Signature of Employer or
Authorized Representative _____ Phone #_____

Title:_____ Date _____

Company Name: _____

Company Address: _____

RETURN TO: Gainesville Housing Authority, Section 8
1900 SE 4th Street
Gainesville, FL 32641

ATTN: _____
Housing Coordinator
Fax: (352) 872-5501

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EXECUTIVE DIRECTOR
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VERIFICATION OF CHILD CARE OR ATTENDANT CARE COSTS
(PROVIDER)

Name of Head of Household: _____ Phone No. _____

Name of Child care Provider: _____

Address: _____ City _____ State _____ Zip _____

Telephone Number: _____

Name of Person Completing this Form: _____

I, _____, hereby certify that I provide care on the following days for the hours indicated for the following children or dependent persons:

Name	Age	Circle days cared for	Hours	
			To	From
		M T W Th F S Su	am/pm	am/pm
		M T W Th F S Su	am/pm	am/pm
		M T W Th F S Su	am/pm	am/pm
		M T W Th F S Su	am/pm	am/pm
		M T W Th F S Su	am/pm	am/pm
		M T W Th F S Su	am/pm	am/pm
		M T W Th F S Su	am/pm	am/pm

Total Hours: _____ per week _____ per month

Cost of care to the family: $_____ ( ) per week ( ) per month

Amount paid by the family: $_____ ( ) per week ( ) per month

(include full-time summer care of school children, if applicable)

Signed this _____ day of _____, 20_____

_____ _____
Signature of Care Provider Relationship to parent (if any)

FAX OR EMAIL: _____ **E-mail:** _____

Important: This form must be executed whenever a deduction from income is made

WARNING! Title 18, Section 1001 of the United States Code, states that a person who knowingly and willingly makes false or fraudulent statements to any department or agency of the United States is guilty of a felony. Also, amounts received from providing childcare and attendant care are reportable to the Internal Revenue Service (IRS).

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EXECUTIVE DIRECTOR
PAMELA E. DAVIS

Request for Termination of Employment Income

ATTN: Personnel Department (**This Form Must Be Faxed, E-mailed, or Mailed Back!)**

Employee:	SS#	
Address:	Occupation	
	Employee #	

We are required to verify, through the Employer, the termination of employment for all applicants and participants in the federally-assisted housing program operated by the Gainesville Housing Authority. We ask your cooperation in supplying this required information. In no event should this form be filled out by the employee. Forms should be completed by the time-keeper, bookkeeper, or accountant.

Housing Coordinator: _____E-mail: _____ (352) 872-5500 Ext. _____

I do hereby authorize my employer to release all information requested below to the Gainesville Housing Authority for the purpose of determining my eligibility for housing assistance.

Employee Signature: Date:

Employee's Name:	Social Security #:
Employee's Address:	Date Employed:
Date of Termination:	Last day employee actually worked:

Will employee receive additional pay unused annual or sick leave? Yes ____ No ____
If yes, amount employee will receive: $

Will employee receive additional pay checks for any workmen's compensation? Yes ____ No ____
If yes, give name & address of company through which this may be verified:

Name of Firm:

Street Address: City/State/Zip:

Reason for Termination: Employee quit ____ Terminated for cause _____ Lack of work ____
Other:
If terminated for lack of work or other, do you anticipate re-hiring this employee? Yes ___ No ___
If yes, when?

Signature of Employer or
Authorized Representative _____ Phone #_____

Title:_____ Date _____

Company Name: _____

Company Address: _____

RETURN TO: Gainesville Housing Authority, Section 8
1900 SE 4th Street
Gainesville, FL 32641

ATTN: _____
Housing Coordinator
Fax: (352) 872-5501