SALEM HOUSING AUTHORITY

The Salem Housing Authority is required by law to verify the Income, Medical and Dental Deductions for all persons applying for admission and re-certification for Federal Housing Assistance Program participation.

We kindly ask for your co-operation in supplying the information as indicated below. This information will be held in strict confidence as prescribed by both State and Federal laws and will be used only in determining eligibility for participation in these programs.

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

EMPLOYER TEL. #: _____

EMPLOYEE NAME: _____

EMPLOYEE SOCIAL SECURITY #: _____

DATE OF EMPLOYMENT: _____POSITION: _____

DATE OF TERMINATION: _____

DATE RETURNED TO WORK (IF APPLICABLE): _____

GROSS WAGES: $_____PER HOUR $_____PER WEEK $_____

YEAR-TO-DATE EARNINGS $_____ THROUGH (DATE): _____

DATE OF INCREASE IN WAGES (IF ANY): _____

HOURS WORKED PER WEEK: _____ OVERTIME HOURS: _____

AMOUNT DEDUCTED FOR MEDICAL AND DENTAL PLAN: $_____

AMOUNT DEDUCTED FOR SAVINGS PLAN (CREDIT UNION, 401K, ETC.): $_____

WARNING: Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction. This is signed under the penalties of perjury.

SIGNED: _____ DATE: _____
Company Representative

SIGNED: _____ DATE: _____
Applicant Signature

S8wages