PUBLIC HOUSING AGENCY
SAINT PAUL

555 North Wabasha Street, Suite 300
Saint Paul, Minnesota 55102
651-298-5158 • Fax 651-292-7917
Hearing Impaired-Minnesota Relay: 711

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____
Resident/Applicant Name

____
Address

____
Resident/Applicant Unit I.D. **Resident Soc. Security #**

Employment Verification

The person identified above is an applicant for, or a resident of, a federally assisted rental program administered by the Public Housing Agency (PHA). We are required to verify the income of all residents/applicants for admission to, or continuance in, the Rental Assistance Program. Please supply the information requested below as soon as possible. A self-addressed, stamped envelope has been enclosed for your convenience.

PHA Representative______________________ Date______________ Phone (651)__________

I authorize the company identified above to provide to the PHA information concerning my employment and wages, as specified on this form. This information will only be used to determine my eligibility for admission to, or continuance in The Rental Assistance Program. I understand that this information will be kept confidential.

______ : **I am also aware that the PHA may access The Work Number (Equifax) to obtain my employment and wage information, along with any other employment and wages reported by employer(s) other than the company identified above, for which the PHA has the right to review, question, and use.**
(Initials)

Resident/Applicant Signature:______________________________ Date______________

Name of Employee:______________________________ SS#______________________

Address of Employee: ____

GROSS EARNINGS during the past 12 months from__________ to__________ were $______________

If employed less than 12 months, earnings from date of employment through______________ were $__________

Average Number of Hours Per Week: **Straight Time:** ______________ **Hourly Wage $** __________

Overtime__________ Hourly Overtime Wage $______ Overtime is: Regular________ Sporadic______

Amount of bonus, incentive pay, commission and/or tips: $________ Effective____________________

Previous Base Pay Rates: **$**__________ **per** ________ **Effective Date**____________________

$__________ **per** ________ **Effective Date**____________________

$__________ **per** ________ **Effective Date**____________________

If known, expected change of rate of pay: $____________ Effective Date______________________

Is this position funded by TITLE V FUNDS? ☐ **Yes** ☐ **No** **Is this position funded through a school work-study program?** ☐ **Yes** ☐ **No**

Original Date of Hire:__________________ Re-hired:______________________________

TERMINATION DATE:__________ Employee's Title/Occupation______________________________

Do you anticipate that this employee will remain with your firm for the next 12 months? ☐ **YES** ☐ **NO**

If seasonal or sporadic employment, give usual lay-off periods______________________________

PAYROLL DEDUCTIONS:

Health Care: $______________ Per Month Dental $__________ Per Month: Other____________________

COMPLETED BY______________________________ **TITLE**______________ **DATE**__________

EMPLOYER'S PHONE #________________________ **FAX #**______________________________

RETURN TO: PHA Management Office______________________ **PHA Rental Office** ____________

White: Employer **Yellow**: Tracer
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