

VERIFICATION OF EARNINGS

Issued under P.A. 346 of 1966, as amended, and Section 8 of the U.S. Housing Act of 1937.

Section A	
County:	Name of person holding the job:
Name of Head of Household:	Social Security Number of person holding the job:
Address:	Do you receive tips? <input type="checkbox"/> Yes <input type="checkbox"/> No
City, State, ZIP Code:	If so, how much per week? \$
NOTE: If tips are received directly, a notarized statement must be provided.	
You are authorized to release information requested by MSHDA.	
_____	_____
Signature of person holding the job	Date
STOP HERE Please complete Section A and return to address below.	

Section B - To be completed by Employer:					
<i>Please provide the information requested so we can quickly determine eligibility.</i>					
Please complete and return as soon as possible or within 14 days.					
Employee's name as it appears on your records:	Employee's title, position or work:				
Are earnings from a Title IV work-study program? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are earnings from a Title IV or Title V Program? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Are earnings from an economic or self-sufficiency job training program? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Original date of employment:	Date rehired or recalled to work:	Termination date:			
Current average number of hours per week:	Straight time hours:	Overtime hours (if applicable):	Overtime is paid at the rate of: \$		
If seasonal or occasional employment, give lay-off periods:					
Current rate of pay: \$	Per:	Effective date:	New rate of pay: \$	Per:	Effective date:
Amount of <input type="checkbox"/> tips, <input type="checkbox"/> incentive pay, <input type="checkbox"/> bonus, or <input type="checkbox"/> commissions: \$	Per (weekly, bi-monthly):		Retirement benefits available? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Health benefits available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Amount deducted for medical/hospital insurance: \$		Per (weekly, bi-monthly):		
Firm or employer name:		Telephone number: ()		Fax number: ()	
Business address:		City, State, ZIP:		E-mail address:	
I understand that any false pretense, including any false statement or representation, or the fraudulent obtaining of money, real or personal property, or the fraudulent use of an instrument, facility, article or other valuable thing or service used to assist a participant in any MSHDA program, is punishable by imprisonment for up to 10 years or by a fine up to \$5,000.					
_____				_____	
Signature of employer or authorized representative				Date	
_____			_____		
Typed or printed name of person filling out this form			Typed or printed title of person filling out this form		

Please return completed form to:

Schoolcraft County EDC
321 Deer Street
Manistique, Michigan 49854
Phone (906) 341-5126 Fax (906) 341-5555

MSHDA USE ONLY					
\$ _____	X _____	(hrs) X _____	(wks) = _____	(Total)	
\$ _____	X _____	(hrs) X _____	(wks) = _____	(Total)	
\$ _____	X _____	(wks) = _____	(Total)		
\$ _____	X _____	(wks) = _____	(Total)		
\$ _____	X _____	(months) = _____	(Total)		
\$ _____	X _____	(months) = _____	(Total)		

Penalties which may be imposed for intentionally submitting false or misleading information in obtaining Authority financing are set forth in the Michigan State Housing Development Authority Act of 1966 (MCLA 125.1447).