# HOUSEHOLD SEWAGE TREATMENT SYSTEM
# REPAIR/REPLACEMENT PROGRAM

## Proof of Income

**Name:** _____ **Date:** _____

**Telephone:** _____ **Cell/Other:** _____

**Address:** _____ **Social Security Number:** _____

**City:** _____ **State:** _____ **Zip:** _____

**TOTAL HOUSEHOLD GROSS INCOME (before deductions).** List all income on the same line as the person who receives it. ***INCLUDE INCOME VERIFICATION WITH APPLICATION.***

| **1. NAME** (List all household members with income) | **2. GROSS INCOME AND HOW OFTEN IT WAS RECEIVED** | | |
|---|---|---|---|
| | Earnings from work before deductions | Monthly | All Other Income (indicate frequency, such as "weekly" "monthly" "quarterly" "annually") |
| | $ | ☐ | $_____/_____ |
| | $ | ☐ | $_____/_____ |
| | $ | ☐ | $_____/_____ |
| | $ | ☐ | $_____/_____ |
| | $ | ☐ | $_____/_____ |

**Must Provide Proof of income by all household members. Provide ALL of the following documents to be considered for the grant:**

- ☐ **2020 W-2 or 1099-R**
- ☐ **Four (4) consecutive weeks of pay stubs, stub must reflect year-to-date earnings.**
- ☐ **Monthly Social Security, Disability, Pension, and/or Unemployment if applicable. (2020 Benefit Statement)**

**Office Use Only**

Total Income: _____ Per: ☐ Month ☐ Year Denied: _____ Approved: _____

Reason: _____ Approval Level: _____

Manager/Supervisor Signature: _____ Date: _____