



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")
	\$ _____	<input type="checkbox"/>	\$ _____ / _____
	\$ _____	<input type="checkbox"/>	\$ _____ / _____
	\$ _____	<input type="checkbox"/>	\$ _____ / _____
	\$ _____	<input type="checkbox"/>	\$ _____ / _____
	\$ _____	<input type="checkbox"/>	\$ _____ / _____

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

- 2024 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. (2024 Benefit Statement)**

Office Use Only

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

Reason: _____ Approval Level: _____

Manager/Supervisor Signature: _____ Date: _____