

**Social Services Verification**

TO: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (City/County) Dept. of Social Services

Applicant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize the Department of Social Services to release information about my entitlements and the amounts that I receive to Virginia Career Works. This information is needed to determine eligibility for Career Services under the Workforce Innovation and Opportunity Act (WIOA).

Applicant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian (if applicant under 18 yrs.):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Client Name: | |  | | | | | | |  | SS#: | |  | | | |
| Date of Birth: | |  | | | | | |  | | | | | |  | |
| Address: | |  | | | | | | | | | | | | | |
|  | | | Street/PO Box | | City | | | State | | | | | | Zip | |
|  | | |  | |  | | |  | | | | | |  | |
| Case Number: | | |  | |  | | | Family Size: | | |  | | | | |
| Date Benefits Started: | | | |  | | |  | Termination Date: | | | | |  | | |
| **PLEASE CHECK ALL APPLICABLE ITEMS** | | | | | | | | | | | | | | | |
| [ ] | TANF $\_\_\_\_\_\_ | | | | [ ] | SSI $\_\_\_\_\_\_\_ | | | | | | | | |  |
| [ } | Food Stamps $ \_\_\_\_\_\_\_ | | | | [ ] | Foster Child $\_\_\_\_\_ | | | | | | | | |  |

**NAMES OF ALL FAMILY MEMBERS LISTED ON:**

TANF: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food Stamps:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Social Service Rep. Printed Name Date

Please Return This Form To: