E. Shoshone Dept. of Family Services
Foster Care Program
P.O Box #945 Ft. Washakie, WY 82514
Ph: (307) 332-6591/6592 or 856-7870
Fax: (307) 332-6593

INCOME VERIFICATION

Date: _____

Name of applicant(s): _____

Mailing address: _____

Contact phone numbers: _____

(Please fill out the following columns for the total of income you receive for one month, also the expenses you pay for one month)

INCOME SOURCES		**EXPENSES**	
Wages-self	$_____	Rent/Mortgage	$_____
Wages-other	$_____	Utilities	$_____
TANF benefits	$_____	Phone	$_____
Foodstamps	$_____	Food	$_____
SSI payments	$_____	Clothing	$_____
SSDI payments	$_____	Transportation/gas	$_____
Workers Comp	$_____	Child Care	$_____
Veteran's benefits	$_____	Tuition & Fee's	$_____
PELL	$_____	Books	$_____
Scholoarships/Grants	$_____	Insurance	$_____
Foster Care	$_____	Auto pymts.	$_____
Other:		Other:	
_____	$_____	_____	$_____
_____	$_____	_____	$_____
Total of Resources	$_____	Total of Expenses	$_____

_____

Signature & Date