

Income Verification Request

***Please complete one form per child**

Full Legal Name: _____

Social Security Number: _____

Address: _____

Phone Number: _____

E-Mail: _____

Full Legal Name of Child: _____ DOB: _____

Please send the income verification to:

Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

How to submit this information:

Mail

E-Mail

Fax

Other _____

I hereby authorize release of information from the Department of Human Services regarding my child's adoption assistance payment.

Parent Signature: _____ Date: _____

Send this to: Department of Human Services, Adoption Assistance Program
PO Box 64944
St. Paul, MN 55164-0944
Fax: 651 - 431-7627
Email: adoption.assistance@state.mn.us