

BANK VERIFICATION FORM

Control Number _____

Please complete Section I and have a bank official complete Section II of this form. We will deny, stop or change your benefits if you do not return this form within 10 days.

Section I (to be completed by client):

I, _____ of _____
Name Address

authorize _____
Name of Bank

to release information concerning bank accounts to the Department of Social Services.

Signature: _____ Date: _____

Section II (To be completed by bank):

Please provide the following information for the above client and family members:

Checking Accounts

Account Number _____
Account Name _____
Balance \$ _____

Account Number _____
Account Name _____
Balance \$ _____

Savings Accounts

Account Number _____
Account Name _____
Balance \$ _____

Account Number _____
Account Name _____
Balance \$ _____

Other Accounts

Type of Account _____
Account Name _____
Account Number _____
Balance \$ _____

Type of Account _____
Account Name _____
Account Number _____
Balance \$ _____

Signature: _____
Bank Official

Date: _____

Telephone Number: _____