VERIFICATION OF PUBLIC ASSISTANCE

THIS SECTION TO BE COMPLETED BY MANAGEMENT AND EXECUTED BY TENANT

TO: (Name & address of public assistance office) Date: _____

_____

_____

_____

RE: _____ _____ _____
Applicant/Tenant Name | Social Security Number | Unit # (if assigned)

I hereby authorize release of my information.

_____ _____
Signature of Applicant/Tenant | Date

The individual named directly above is an applicant/tenant of a housing program that requires verification of income. The information provided will remain confidential to satisfaction of that stated purpose only. Your prompt response is crucial and greatly appreciated.

_____
Project Owner/Management Agent

MAIL OR FAX THIS FORM TO:

THIS SECTION TO BE COMPLETED BY CASEWORKER

Date of initial Assistance: _____

Gross Monthly Payment: $_____

(A) AFDC / ATAP / APA/ TANF $_____

(B) Other:
_____ $_____

Size of household: Adults: _____ Minors: _____

Date assistance will expire: _____

Is the client currently being penalized: Yes _____ No _____ If yes, by how much? $ _____

Are any changes expected in the next 12 months Yes _____ No _____

If yes, please explain: _____

_____

_____ _____ _____
Caseworker Signature | Caseworker Printed Name | Date

_____ _____ _____
Phone # | Fax # | E-mail

NOTE: Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction.

This institution is an equal opportunity provider.