

**VERIFICATION OF DISABILITY BENEFITS
(OTHER THAN SOCIAL SECURITY BENEFITS)**

THIS SECTION TO BE COMPLETED BY MANAGEMENT AND EXECUTED BY TENANT

TO: (Name & address of company) _____ Date: _____

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

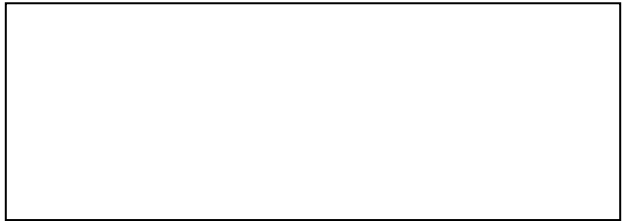
I hereby authorize release of my information.

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 AGENCY

Are benefits ongoing or limited in nature? _____

Weekly benefits: _____ Maximum potential benefits: _____

Initial benefit date: _____ Benefit expiration date: _____

Potential lump-sum settlement (s)? Yes No If yes how much? \$ _____

Additional comments: _____

Signature Printed Name/ Title 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.

