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.

_____
Development Owner/Management Agent

EMAIL, 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.

This institution is an equal opportunity provider.