PUBLIC ASSISTANCE VERIFICATION

The individual named below is an applicant/resident of a housing program that requires verification of income. The information provided will remain confidential and used only to determine eligibility. Please complete and return promptly.

DATE: _____

COMPANY NAME: _____ DEVELOPMENT NAME: _____

EMAIL: _____ EMAIL: _____

PHONE: _____ FAX: _____ PHONE: _____ FAX: _____

RELEASE STATEMENT FOR APPLICANT/RESIDENT I hereby authorize the above-named management agent to make inquiries regarding release of information for the purpose of determining my eligibility for occupancy.

PRINTED NAME: _____ **SIGNATURE:** _____

The following is to be completed by company representative

Please fill in ALL blanks. Enter N/A if an item is not applicable to the above individual.
(Note: Information provided may require additional documentation)

Name of Recipient: _____

Please list all household members receiving any type of assistance through this agency.

HOUSEHOLD MEMBER	ADULT/MINOR	TYPE OF ASSISTANCE	GROSS MONTHLY PAYMENT
	❑ Adult ❑ Minor		$
	❑ Adult ❑ Minor		$
	❑ Adult ❑ Minor		$
	❑ Adult ❑ Minor		$
	❑ Adult ❑ Minor		$
	❑ Adult ❑ Minor		$

Please indicate any anticipated changes (within the next 12 months):

Monthly Payment: _____ Effective Date of Change: _____

Assistance Type: _____ Effective Date of Change: _____

AUTHORIZED REPRESENTATIVE:

I certify that the above information is true and correct to the best of my knowledge.

Signature/Title: _____ Date: _____

Printed Name: _____ Direct Phone: _____

Company Name: _____ Email: _____