

**Veterans Administration Benefits/Disability Benefits/  
Workers' Compensation/Unemployment Compensation**

Applicant/Resident: \_\_\_\_\_ Social Security No.: \_\_\_\_\_  
Unit No.: \_\_\_\_\_

To Whom It May Concern:

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. By signing below I authorize the release of this information.

\_\_\_\_\_  
Participant's Signature Date

**THIS SECTION TO BE COMPLETED BY PROVIDING ADMINISTRATION**

<b>Benefit Amount</b>	
Amount of <b>Monthly</b> Payments to Participant:	\$ _____
<b>OR</b>	
Amount of <b>Weekly</b> Payments to Participant:	\$ _____
Date Payments Began: _____	Date Payments Ended: _____
<b>Type of Benefit (check one):</b>	
<input type="radio"/> Workers' Compensation	<input type="radio"/> Unemployment Compensation (Maximum benefit that could be drawn during the next (12) month period: \$ _____)
<input type="radio"/> Disability Benefits	<input type="radio"/> Veterans Administration Benefits
<input type="radio"/> Other (please list): _____	

I certify that this information is accurate.

\_\_\_\_\_  
Signature Name (print)

\_\_\_\_\_  
Title Date

\_\_\_\_\_  
Agency/Company Telephone Number

\_\_\_\_\_  
Address City State Zip