

**To:** Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 Email \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Fax \_\_\_\_\_

**From:** Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 Email \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Fax \_\_\_\_\_

**Re:** Name \_\_\_\_\_ Address \_\_\_\_\_  
 Last 4 Digits of SS # \_\_\_\_\_

**Release:** I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is no older than 12 months. There are circumstances that would require the owner to verify information that is up to 5 years old, which would be authorized by me on a separate consent attached to a copy of this consent.

Applicant/Tenant \_\_\_\_\_

Date \_\_\_\_\_

**You do not have to sign this form if either the requesting organization or the organization supplying the information is left blank.**

The individual named above has applied for tenancy or is currently residing in a community that was developed under the U.S. Department of Housing and Urban Development, U.S. Department of Agriculture (Rural Housing) or Section 42 of the IRS code which is administered by the State. Federal regulations require the housing owner to annually verify the household's income and other information related to eligibility. The information you provide will be used only for the purpose of determining the household's eligibility for the program and will be kept in strict confidence. We are required to complete our verification process in a short time period and would appreciate your prompt response. Return this form via email or fax number as it appears above. If you have any questions, please feel free to contact our office. Thank you for your cooperation.

**Information Being Requested:**

Name of Annuitant: \_\_\_\_\_  
 Current Interest Rate:  Fixed  Variable (please list average rate for last 6 months) \_\_\_\_\_%  
 Current monthly gross amount of annuity payment: \$ \_\_\_\_\_  
 Deduction from gross amount for medical insurance premiums: \$ \_\_\_\_\_  
 Reimbursement for medical insurance premiums: \$ \_\_\_\_\_  
 Effective date of current amount: \_\_\_\_\_  
 Is there a known increase in monthly payment in the next 12 months?  Yes  No  
 If 'yes,' amount of increase: \$ \_\_\_\_\_

Current value of annuity: \$ \_\_\_\_\_  
 Date of initial award: \_\_\_\_\_  
 Effective date: \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Name / Title of Person Supplying Information \_\_\_\_\_

Organization \_\_\_\_\_

Phone # \_\_\_\_\_

Fax # \_\_\_\_\_

Email Address \_\_\_\_\_

*Under penalties of perjury, I certify that the information provided herein is true and accurate to the best of my knowledge. The undersigned further understands that providing false representation herein constitutes fraud.*