

## Documentation of Telephone Verification

Applicant/Resident: \_\_\_\_\_

Unit #: \_\_\_\_\_

1. Oral (telephone) verifications may be used when other methods are not feasible. Describe the reasons(s) that third-party written or first hand verifications are not feasible in this instance:

\_\_\_\_\_  
\_\_\_\_\_

2. In lieu of third-party written or first hand verification, on \_\_\_\_\_, at \_\_\_\_\_ (Date) \_\_\_\_\_ (Time)

I spoke with \_\_\_\_\_, \_\_\_\_\_, at \_\_\_\_\_.  
(Contact Person) (Title) (Name of Employer)

3. Gross Pay Before Deductions (select one):

Hourly \$\_\_\_\_\_ x \_\_\_\_\_  Monthly \$\_\_\_\_\_

Weekly \$\_\_\_\_\_  Bi-Weekly \$\_\_\_\_\_

4. Is the employee compensated for overtime?  Yes  No

Average OT hours worked per week/month/year: \_\_\_\_\_ Rate: \$\_\_\_\_\_/hour  
(Circle one)

5. Does the employee receive other compensation?  Yes  No

bonus \$\_\_\_\_\_ per week/month/year  tips \$\_\_\_\_\_ per week/month  
(avg) (circle one) (avg) (circle one)

commission \$\_\_\_\_\_ per week/month/year  other \$\_\_\_\_\_ per week/month  
(avg) (circle one) (avg) (circle one)

6. Other remarks regarding employee's income: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Signature of Owner or Agent for Owner**

\_\_\_\_\_  
**Date**

**WARNING:** Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to willfully falsify a material fact or make a false statement in any matter within the jurisdiction of a federal agency.



**CERTIFICATE OF DEPOSIT**

<u>Account Number(s)</u>	<u>Current Account Balance(s)</u>	<u>Annual Interest Rate</u>	<u>Withdrawal Penalty</u>
_____	\$ _____	_____ %	_____
_____	\$ _____	_____ %	_____
_____	\$ _____	_____ %	_____

**TRUST**

Value of Trust Fund Administered: \$ \_\_\_\_\_

Anticipated Amount of Income to be earned by: \_\_\_\_\_

Trust over next 12 months: \$ \_\_\_\_\_

**PROPERTY**

Value of Equity in Real Property \$ \_\_\_\_\_

I certify that the above information is true and correct.

\_\_\_\_\_  
Signature of Official

\_\_\_\_\_  
Title of Official

\_\_\_\_\_  
Printed Name of Official

\_\_\_\_\_  
Name of Institution (Bank)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
City, State      Zip Code

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**INCOME VERIFICATION FOR HOUSEHOLDS WITH SECTION 8 CERTIFICATES**

Unit #: \_\_\_\_\_

To: Section 8 Program Administrator

Housing Authority: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

\_\_\_\_\_ has applied for residency/is a resident of \_\_\_\_\_,  
Applicant / Resident Name Property Name

a Low Income Housing Tax Credit property. In the case of a tenant receiving housing assistance payments under HUD's Section 8 Existing Housing Program, IRS regulations allow that if the PHA provides a statement to the building owner declaring that the tenant's income does not exceed the applicable limit under the LIHTC program, then the owner is not required to further verify the tenant's income.

Number of Household Members: \_\_\_\_\_  Move-In  Recertification

Permission by: \_\_\_\_\_  
Applicant / Resident Signature Date

**Under the Low Income Housing Tax Credit Program, the combined annual income of the household before any adjustments, cannot exceed \$ \_\_\_\_\_.**  
**Income Limit**

Please complete the section below and return this form in the enclosed self-addressed, stamped envelope. Thank you in advance for your prompt attention.

Sincerely,

\_\_\_\_\_  
Apartment Manager

**THE FOLLOWING TO BE COMPLETED BY THE PUBLIC HOUSING AUTHORITY:**

Based on the last income certification/recertification effective on \_\_\_\_\_, the household consists of \_\_\_\_\_  
Date

\_\_\_\_\_ members whose combined annual income **before any adjustments**, does not  
# of HH Members

exceed the income limit shown above.

\_\_\_\_\_  
Signature Date Phone #

\_\_\_\_\_  
Printed Name Title

The Low Income Housing Tax Credit Program is a federal low-income rental housing program governed by the Internal Revenue Service. Section 42 of Internal Revenue Code requires owners to determine the income eligibility of all tenants occupying tax credit units. (Owners should be aware that although the verifications requirements of Section 1.42-5(b)(1)(vii) may be met through the use of this form, a Tenant Income Certification (TIC) must still be completed annually.)

**MONETARY CONTRIBUTION VERIFICATION**

Date: \_\_\_\_\_

RE: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

I, \_\_\_\_\_, am receiving, on a regular basis, a monetary

contribution in the amount of \$ \_\_\_\_\_ from

\_\_\_\_\_, Social Security # \_\_\_\_\_

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

\_\_\_\_\_  
Signature of Recipient

\_\_\_\_\_  
Printed Name of Recipient

\_\_\_\_\_  
Date

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**DEPARTMENT OF HUMAN SERVICES VERIFICATION**

Name and Address of DHS

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_

Re \_\_\_\_\_

SSN \_\_\_\_\_

Claim Number \_\_\_\_\_

The above referenced person has applied for residency/is a resident at \_\_\_\_\_.  
As part of our processing, it is necessary that we obtain verification of his/her benefits.

I hereby authorize and request the following information be released to \_\_\_\_\_.

\_\_\_\_\_  
Signature of Applicant / Resident

Please complete the section below and return it via mail or fax. Thank you for your prompt attention.

\_\_\_\_\_  
Apartment Manager Signature

Type of Assistance: \_\_\_\_\_

Monthly Amount of Assistance: \$ \_\_\_\_\_

Effective Date: \_\_\_\_\_

Number of Adults: \_\_\_\_\_ Number of Children: \_\_\_\_\_

Does this recipient receive Child Support or Child Support Rebate? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, please give amount and if Child Support is paid through Child Support Agency or paid directly to recipient.

\$ \_\_\_\_\_ is being paid to Child Support Agency.

\$ \_\_\_\_\_ is being paid directly to recipient.

Is this family receiving any other type of income from any other source? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, please give sources and amounts.

\$ \_\_\_\_\_ is from \_\_\_\_\_.

\$ \_\_\_\_\_ is from \_\_\_\_\_.

If any changes are contemplated, please explain: \_\_\_\_\_

\_\_\_\_\_  
Name and Title of Official

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone Number

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## WORKER'S COMPENSATION VERIFICATION

Name and Address of Insurance Company

\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_

Re: \_\_\_\_\_

SSN \_\_\_\_\_

The above referenced person has applied for residency / is a resident at \_\_\_\_\_

As part of our processing, it is necessary that we obtain verification of his/her benefits.

I hereby authorize and request the following information be released to \_\_\_\_\_

\_\_\_\_\_  
Applicant / Resident Signature

Please complete the section below and return it via mail or fax. Thank you for your prompt attention.

\_\_\_\_\_  
Apartment Manager Signature

Name of Insurance Company:

\_\_\_\_\_

Please check appropriate items:

1. Permanent Disability ( )

a. Monthly Benefits: \$ \_\_\_\_\_

b. Lump Sum Settlement: \$ \_\_\_\_\_

2. Partial/Permanent Disability ( )

a. Monthly Benefits: \$ \_\_\_\_\_

b. Lump Sum Settlement: \$ \_\_\_\_\_

3. Temporary Disability ( )

a. Weekly Benefits: \$ \_\_\_\_\_

b. Number of weeks for which  
benefit will be paid: \_\_\_\_\_

c. Lump Sum Settlement: \$ \_\_\_\_\_

\_\_\_\_\_  
Signature of Official

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title of Official

\_\_\_\_\_  
Telephone

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## SELF EMPLOYMENT VERIFICATION

Date: \_\_\_\_\_

RE: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

I, \_\_\_\_\_, Apartment Manager of \_\_\_\_\_, do hereby certify that the above referenced person stated in my presence that this information is true and correct to the best of his/her knowledge.

\_\_\_\_\_  
Apartment Manager's Signature

\_\_\_\_\_  
Date

I, \_\_\_\_\_, do hereby certify that I am self-employed as \_\_\_\_\_.  
Itemized herein are my approximate monthly earnings beginning \_\_\_\_\_, 19 \_\_\_\_.

January	\$ _____	May	\$ _____	September	\$ _____
February	\$ _____	June	\$ _____	October	\$ _____
March	\$ _____	July	\$ _____	November	\$ _____
April	\$ _____	August	\$ _____	December	\$ _____

Monthly Average: \$ \_\_\_\_\_ Yearly Total: \$ \_\_\_\_\_

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

**NOTE: Please attach a copy of current income tax return form.**

\_\_\_\_\_  
Signature of Applicant/Tenant

\_\_\_\_\_  
Date

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**REAL ESTATE PROPERTY VERIFICATION**

Name and Address of Real Estate Company

Date \_\_\_\_\_

\_\_\_\_\_

Re: \_\_\_\_\_

\_\_\_\_\_

SSN \_\_\_\_\_

The above referenced person has applied for residency / is a resident at \_\_\_\_\_

As part of our processing, it is necessary that we obtain verification of the source/amounts of income/assets of each family member.

I hereby authorize and request the following information be released to \_\_\_\_\_

\_\_\_\_\_  
Applicant / Resident Signature

Please complete the section below and return it via mail or fax. Thank you for your prompt attention.

\_\_\_\_\_  
Apartment Manager Signature

**TO BE COMPLETED BY AUTHORIZED OFFICIAL**

Description of Property: \_\_\_\_\_

Type of Property (i.e., Single Family, Detached Dwelling, Raw Land, etc.): \_\_\_\_\_

Address or Location (Street Address or Legal Description): \_\_\_\_\_

Market Value: \$ \_\_\_\_\_

If this property is being/ will be / was sold, estimate expenses below:

Broker's Fee: \$ \_\_\_\_\_

Settlement Costs: \$ \_\_\_\_\_

Legal Fees: \$ \_\_\_\_\_

Other (Specify): \$ \_\_\_\_\_

\_\_\_\_\_  
Signature of Authorized Official

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Authorized Official

\_\_\_\_\_  
Telephone Number

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**UNEMPLOYMENT BENEFITS VERIFICATION**

Oklahoma Employment Security Commission

Date \_\_\_\_\_

\_\_\_\_\_

Re: \_\_\_\_\_

\_\_\_\_\_

SSN \_\_\_\_\_

The above referenced person has applied for residency / is a resident at \_\_\_\_\_

As part of our processing, it is necessary that we obtain unemployment benefits on the above referenced person.

I hereby authorize and request the following information be released to \_\_\_\_\_

\_\_\_\_\_  
Applicant / Resident Signature

Please complete the section below and return it via mail or fax. Thank you for your prompt attention.

\_\_\_\_\_  
Apartment Manager Signature

**TO BE COMPLETED BY AUTHORIZED OFFICIAL**

Is this individual qualified to receive unemployment benefits?     YES             NO

Weekly Benefit Amount:            \$ \_\_\_\_\_

Beginning Date of Benefits:        \_\_\_\_\_

Ending Date of Benefits:            \_\_\_\_\_

Remarks (if any): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Official

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title of Official

\_\_\_\_\_  
Telephone Number

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**MILITARY EMPLOYMENT VERIFICATION**

Name and Address of Commander

\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_

Re: \_\_\_\_\_

SSN \_\_\_\_\_

The above referenced person has applied for residency / is a resident at \_\_\_\_\_

I hereby authorize and request the following information be released to \_\_\_\_\_

\_\_\_\_\_  
Applicant / Resident Signature

Please complete the section below and return it via mail or fax. Thank you for your prompt attention.

\_\_\_\_\_  
Apartment Manager Signature

- 1. Base pay and longevity pay: \_\_\_\_\_
- 2. Proficiency pay: \_\_\_\_\_
- 3. Sea and foreign duty pay: \$ \_\_\_\_\_
- 4. Hazardous duty pay: \$ \_\_\_\_\_
- 5. Imminent danger pay: \$ \_\_\_\_\_
- 6. Subsistence allowance: \$ \_\_\_\_\_
- 7. Quarters Allowance: \$ \_\_\_\_\_
- 8. Other additional pay benefits: \$ \_\_\_\_\_

\_\_\_\_\_  
Signature of Commander or his Adjutant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title and Grade

\_\_\_\_\_  
Telephone Number

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**SOCIAL SECURITY VERIFICATION**

Social Security Administration

Date \_\_\_\_\_

\_\_\_\_\_

Re: \_\_\_\_\_

\_\_\_\_\_

SSN \_\_\_\_\_

\_\_\_\_\_ County

The above referenced person has applied for residency / is a resident at \_\_\_\_\_

As part of our processing, it is necessary that we obtain verification of his/her benefits and anticipated GROSS income.

I hereby authorize and request the following information be released to \_\_\_\_\_

\_\_\_\_\_  
Applicant / Resident Signature

Please complete the section below and return it via mail or fax. Thank you for your prompt attention.

\_\_\_\_\_  
Apartment Manager Signature

Name of Beneficiary: \_\_\_\_\_

Type of Benefit:

SSI: \_\_\_\_\_ SSA: \_\_\_\_\_

Total of Amount of Monthly Benefit:

\$ \_\_\_\_\_

Amount Deducted for Medical:

\$ \_\_\_\_\_

\_\_\_\_\_  
Signature of Social Security Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

\_\_\_\_\_  
Telephone Number

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**VETERANS ADMINISTRATION INCOME VERIFICATION**

Veterans Administration Office

Date: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

RE: Veteran's Full Name

\_\_\_\_\_  
Veteran's Social Security Number

\_\_\_\_\_  
Veteran's Claim Number

\_\_\_\_\_  
Relationship to Recipient

The above referenced person has applied for residency / is a resident at \_\_\_\_\_

As part of our processing, it is necessary that we obtain verification of his/her benefits and anticipated GROSS income.

I hereby authorize and request the following information be released to \_\_\_\_\_

\_\_\_\_\_  
Applicant / Resident Signature

Please complete the section below and return it via mail or fax. Thank you for your prompt attention.

\_\_\_\_\_  
Apartment Manager Signature

Veteran's Compensation:      Disability    ( )      Death    ( )      Dependents    ( )

Retirement    ( )      Widow's Benefits    ( )

Monthly Amount: \$ \_\_\_\_\_

Allowance for Education or Training    ( )

\_\_\_\_\_  
Name of Official

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title of Official

\_\_\_\_\_  
Telephone Number

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**RETIREMENT (PENSION) VERIFICATION**

Name and Address of Company

\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_

Re: \_\_\_\_\_

SSN \_\_\_\_\_

The above referenced person has applied for residency / is a resident at \_\_\_\_\_

As part of our processing, it is necessary that we obtain verification of the source/amounts of income of each family member.

I hereby authorize and request the following information be released to \_\_\_\_\_

\_\_\_\_\_  
Applicant / Resident Signature

Please complete the section below and return it via mail or fax. Thank you for your prompt attention.

\_\_\_\_\_  
Apartment Manager Signature

**TO BE COMPLETED BY AUTHORIZED OFFICIAL**

Claim Number: \_\_\_\_\_

Amount of Monthly Benefit: \$ \_\_\_\_\_

Company's Name and Address from who benefits are being received: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Official

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title of Official

\_\_\_\_\_  
Telephone Number

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