OHIO **HOUSING** FINANCE AGENCY

Social Security/Supplemental Security Income Verification

To: Name ____________________
Address ____________________
____
Email ____________________
Phone ____________________
Fax ____________________

From: Name ____________________
Address ____________________
____
Email ____________________
Phone ____________________
Fax ____________________

Re: Name ____________________
Last 4 Digits of SS # ____________________
Address ____________________
____

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:

1. Gross Monthly Social Security Benefit: $ ____________________ Effective: ____________________
   Date Benefits Began: ____________________
   Deduction for Medicare Premiums: $ ____________________ Net Amount Monthly Payment: $ ____________________
   Deduction for Medical Insurance Premiums: $ ____________________
2. Gross Monthly Supplemental Security Income: $ ____________________ Effective: ____________________
3. Overpayment Being Withheld: $ ____________________ Effective from: ____________________ to ____________________
4. Type of Benefits: ☐ Social Security ☐ Retirement ☐ Disability ☐ Widow(er) ☐ Child(ren) ☐ Supplemental Security Income ☐ SSI Age ☐ Disability / Blind ☐ Other
5. We are unable at this time to verify information requested: ☐ Claim Pending ☐ No record based on identifying information
   ☐ Other, please describe: ____________________

____________________ Name / Title of Person Supplying Information

____________________ Organization

____________________ Signature

____________________ Date

____________________ 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.