

To: _____

From: _____

Phone: _____ Fax: _____

Email: _____

RE: _____
Applicant's Name

I hereby authorize release of my information.

Signature of Applicant _____ Date _____

OR copy of the attached executed release form which authorizes the information to be requested.

State regulations require verification of income from all members of the household applying for participation in the assistance program which we operate. This information will be used only to determine the eligibility status and level of benefit for the household. Your prompt response is greatly appreciated.

THIS SECTION TO BE COMPLETED BY PROVIDER

1. Type of Benefit: _____ Claim Number _____

2. Date benefit began: _____

3. Payment:

Gross Monthly Pension or Annuity \$ _____

Deduction for Medical Insurance \$ _____
(Enter as negative number) (-100.00)

Net Monthly Pension or Annuity \$ _____

Authorized Signature

Printed Name

Date

Title

Address

Phone #

Fax #

Email

Note: Section 101 of Title 18 of the US Code states that a person is guilty of a felony for knowingly and willingly making false or fraudulent statements to any department of the United States Government.