



3-1L Verification of Pension or Annuity

SCSHFDA, 300-C Outlet Pointe Blvd., Columbia, SC 29210, (803) 896-9001 www.schousing.com

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.
Federal 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 \$ _____

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 willing making false or fraudulent statements to any department of the United States Government.