

VERIFICATION OF SOCIAL SERVICES

CLIENT: _____
ADDRESS: _____

DATE: _____
S.S. #: _____

TO WHOM IT MAY CONCERN:

The client listed above has indicated that he or she is receiving income from your agency. Information provided will remain confidential and will be used solely for the purpose of determining eligibility for occupancy.

Sincerely,

Project Management Agent

I hereby authorize the above named management agent to make inquiries regarding my income for the purpose of determining my eligibility for occupancy.

Signature: _____ Date: _____

Monthly payment from this agency:

AFDC _____

General Relief/Assistance _____

Child Support Pass Through _____

Other _____

Other Known Income _____

Remarks- Please indicate any anticipated changes in:

(1) The monthly payment: _____

(2) The family status of the Applicant: _____

Social Services Worker: _____

(Signature)

(Title)

(Date)

(Phone)

Please Return To:

DOGWOOD TERRACE APARTMENTS
P.O. Box 536
Big Stone Gap, VA 24219
Phone: 276-523-4788
Fax: 276-523-5141