

PUBLIC ASSISTANCE VERIFICATION

TO: _____

TEL.#: _____

DATE: _____ APT. #: _____
DEVELOPMENT NAME: Port Terrace Apartments
APPLICANT/RESIDENT: _____

FROM: Port Terrace Apartments
1587 W. Port View Drive.
Port Washington, WI 53074
TEL.#: 262-284-4477
FAX.#: 262-284-4476

In order to comply with federal regulations requesting verification on all income, assets and allowances for residents of tax credit housing, please complete the following information and return it as soon as possible to the above address.

I hereby authorize release of any information requested regarding my income, assets, and allowances.

Applicant/Resident Signature

Social Security Number(s)

TO BE COMPLETED BY PUBLIC ASSISTANCE OFFICE

AMOUNT PER MONTH

- | | | |
|-----------------------------|-------------------------------|----------|
| 1. | Number of Persons in Family | \$ _____ |
| 2. | General Assistance | \$ _____ |
| 3. | Child Support | \$ _____ |
| 4. | Other Assistance - Type _____ | \$ _____ |
| TOTAL MONTHLY GRANT: | | \$ _____ |
| 5. | Other Income - Source _____ | \$ _____ |

Please comment on any changes in assistance expected in the next 12 months.

COMMENTS: _____

Signature of Person Verifying Information: _____ Telephone Number: _____

Title: _____ Date: _____

FORM # 5

OFFICE USE ONLY:

