M-19L 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.