



A Community Partner,  
Helping People to Help Themselves

# Walla Walla Housing Authority

501 Cayuse Street  
Walla Walla WA 99362  
509-527-4542 \* Fax 509-527-4574  
Hearing-impaired, please use relay service  
www.wallawallaha.org \* wwha@wallawallaha.org



## VERIFICATION OF VETERAN BENEFITS

RE: \_\_\_\_\_ Agency: \_\_\_\_\_  
SS#: \_\_\_\_\_ Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Dear Sir or Madam:

The above named applicant/participant has authorized Walla Walla Housing Authority to obtain verification of benefits for the purpose of determining eligibility for occupancy in our housing assistance program. Your verification is for the confidential use of this Agency and the US Department of Housing and Urban Development (HUD). Please furnish the information requested below and return this form to Walla Walla Housing Authority at the above listed address.

I hereby authorize the release of this information.

Applicant/Participant Signature

Date

- COMPENSATION (SERVICE CONNECTED):  Disability  Death  
 Dependency and Indemnity  
 PENSION (Non-Service Connected):  Disability  Death  
 Effective Date of Current Award: \_\_\_\_\_  
 Monthly Amount \$ \_\_\_\_\_
- ALLOWANCES for Education or Training:  School  On-the-Job  
 Monthly Amount: \$ \_\_\_\_\_ Award date from \_\_\_\_\_ to \_\_\_\_\_  
 Employer: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_
- OTHER PAYMENTS (Insurance, etc.): \_\_\_\_\_  
 Monthly Amount: \$ \_\_\_\_\_
- CHANGES EXPECTED, Please explain:  
 \_\_\_\_\_

Signature/Title

Date

Your prompt return of this letter will be appreciated. If you have any questions, please call our office.

WARNING! TITLE 18, SECTION 1001 OF THE U.S. CODE, STATES THAT A PERSON IS GUILTY OF A FELONY FOR KNOWINGLY AND WILLINGLY MAKING FALSE OR FRAUDULENT STATEMENTS TO ANY DEPARTMENT OR AGENCY OF THE UNITED STATES.