WALLA WALLA
HOUSING AUTHORITY

Verification of Pension & Annuity Benefits

TO: Name, Address & Telephone of Plan Administrator	FROM: Walla Walla Housing Authority 501 Cayuse Street Walla Walla Washington 99362 Phone 509-527-4542 | Fax 509-527-4574

Applicant Name:_____ Last 4 of SSN: XXX-XX-_____

By my signature below, please release the requested information to the Walla Walla Housing Authority for use to determine my eligibility for services.

_____

Signature Date

Please return form to the Walla Walla Housing Authority by fax to 509-527-4574
or US Postal Mail to 501 Cayuse Street, Walla Walla Washington 99362

Date of Initial Award $_____

Gross Monthly Amount of Pension or Annuity $_____

Medical Insurance Premiums Deducted from Gross Monthly Benefit Amount $_____

I hereby certify that the statements above are true and complete to the best of my knowledge.

_____

Print Name & Title Signature Date

If you or anyone in your family is a person with disabilities, and you require a specific accommodation in order to fully utilize our programs and services, please contact the housing authority.