U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT
c/o ICF International
Attn: HUDQC
530 Gaither Road, Suite 500
Rockville, MD 20850

Boxes for Official use Only

C/P/C	Macro Link

TPVR-1
Periodic Payment Verification

To: _____ Re: _____
_____ ID: _____
_____ _____

Please Provide Periodic Payment Verification Information for the Person Named Above.

1. If you have no record of the person named above, please check the box and return the form. ❑
2. Please provide benefit history from [17 or 5 months prior to the QCM] through [QCM] by attaching documents containing the following information clearly labeled:
   - Type of payment
   - Gross benefit amount
   - Medical/other insurance
   - Other deductions
3. Were any of the benefits described above funded by any of the sources listed below? ❑ Yes ❑ No

   IF YES, circle which type:

01 = Payments for care of foster children/adult	13 = Nazi era reparation payments paid by a foreign government
02 = Student financial assistance	14 = Adoption assistance payments
03 = Refunds/rebates for property taxes	15 = Income from sub marginal land
04 = Disposition of funds of the Grand River band of Ottawa Indians	16 = Alaska Native Claims Settlement Act
05 = Shares received from judgment funds by Indian claims or U.S. claims court	17 = Agent orange settlement
06 = Maine Indian claims act	18 = Allowances paid to a child suffering from spina bifida who is a child of Vietnam veteran
07 = Amounts paid by a state agency to a family member who has a developmental disability	19 = Payments to Yakima or Apache Indians by Indian Claims Commission
08 = Bureau of Indian Affairs student assistance programs	20 = Earned income tax credit
09 = Child care under Child Care and Development Block Grant Act of 1990	21 = Food stamps
10 = Any amount of crime compensation under the Victims of Crime Act	22 = Payments set aside under a Plan to Attain Self Sufficiency (PASS)
11 = LIEAP (Low Income Energy Assistance Program)	23 = Monetary value of groceries by person not in living in the household
12 = Reimbursement for medical expenses	24 = Transitional assistance subsidy
	25 = 2012 Tax Rebates provided by the IRS

If you are unable to provide the requested information for the entire time period, provide as much information during that time period as available and an explanation below.

Explanation: _____

_____

Return the completed form in the self-addressed, stamped envelope provided by ____/___/____ <u>OR</u> fax the completed form toll free to: 800-823-0127. If you have any questions, call toll free: 877-392-9776.

Name and title of person completing the form: _____

Signature: _____ Phone Number: _____ Date: ____/_____/_____

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TPVR-2
Asset Verification

C/P/C	Macro Link

To: _____

_____

_____

Re: _____

ID: _____

_____

Please Provide Asset Verification Information for the Person Named Above for All Accounts Held at Your Institution.

1. If you have no record of the person named above, please check the box and return the form. ❑
2. Please provide account history for each account held by the person named above from [17 or 5 months prior to QCM] through [QCM] by attaching documents that contain the following information clearly labeled:
   - Average monthly value of the asset
   - Annual income (from interest, dividends, etc.,)
   - Interest rate
   - Cost to dispose of the asset
   - Name of co-owner (if jointly owned)

If you are unable to provide the requested information for the entire time period, provide as much information during that time period as available and an explanation below.

Explanation: _____

_____

Return the completed form in the self-addressed, stamped envelope provided by ____/___/____ <u>OR</u> fax the completed form toll free to: 800-823-0127. If you have any questions, call toll free: 877-392-9776.

Name and title of person completing the form: _____

Signature: _____ Phone Number: _____ Date: ____/_____/_____

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TPVR-3
Employment Income Verification

To: _____ Re: _____
_____ ID: _____
_____ _____

Please Provide Employment Information for the Person Named Above

1. If you have no record of the person named above, please check the box and return the form. ❑
2. Please provide employment start date and employment end date (if no longer employed):
   a. Employment Start Date (MM/DD/YYYY): _ _ / _ _ / _ _ _ _
   b. Employment End Date (MM/DD/YYYY): _ _ / _ _ / _ _ _ _
3. Please provide pay history from [17 or 11 months prior to the QCM] through [QCM] by attaching documents that contain the following information clearly labeled:

   - Gross Pay
   - Over-time Pay
   - Bonus
   - Medical Insurance/Other Insurance Deductions
   - Tips
   - Commissions
   - Other Pay
   - Other Allowances

   For **Active Military**: include all allowances including in addition to base pay. For e.g., housing allowance, food allowance, uniform allowance.

   For **National Guard/Reserve**: include drill pay, reserve pay and active duty pay

4. Was any of the pay described above funded by any of the sources listed below? ❑ Yes ❑ No

   IF YES, circle which type:

01 = Federal Work Study Program	**07** = RSVP (Retired Senior Volunteer Program)
02 = AmeriCorps participants	**08** = Foster Grandparents
03 = JTPA (Job Training Partnership Act)	**09** = Senior Companions
04 = Workforce Investment Act of 1998	**10** = Program Bureau of Indian Affairs Student Assistance Programs
05 = VISTA volunteers	**11** = Resident service stipend
06 = Payments funded through the Older Americans Act, including: • Green Thumb • AARP • Natl. Council on Aging (NCOA) • Natl. Council of Senior Citizens • U.S. Forest Services • Natl. Caucus of Black Aged (NCBA) • Natl. Assoc. for the Spanish Elderly • Urban League	**17 =** Agent Orange Settlement (Active Military or National Guard/Reserve) **18 =** Allowances paid to a child of a Vietnam veteran who suffers from spina bifida (Active Military or National Guard/Reserve) **26** = Hostile fire pay (Active Military or National Guard/Reserve)

If you are unable to provide the requested information for the entire time period, provide as much information during that time period as available and an explanation below.

Explanation: _____

_____

Return the completed form in the self-addressed, stamped envelope provided by ____/___/____ <u>OR</u> fax the completed form toll free to: 800-823-0127. If you have any questions, call toll free: 877-392-9776.

Name and title of person completing the form: _____

Signature: _____ Phone Number: _____ Date: ____/_____/_____

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TPVR-4
Training Program Verification

To: _____ Re: _____
_____ ID: _____
_____ _____

Please Provide Training Program Information for the Person Named Above

1. If you have no record of the person named above, please check the box and return the form. ❑
2. Date of enrollment in the training program named above (MM/DD/YYYY): _ _ / _ _ / _ _ _
3. Date of completion or anticipated date of completion (MM/DD/YYYY): _ _ / _ _ / _ _ _
4. Please indicate who funded/sponsored the training program (check all that apply).
   - ❑ U.S. Department of Housing and Urban Development (HUD)
   - ❑ Another Federal agency
   - ❑ State government
   - ❑ Local government
   - ❑ Other local entity
   - ❑ Other: _____
5. Does the program have clearly defined goals and objectives?
   - ❑ Yes ❑ No

   IF YES, briefly list or attach a description of those goals and objectives:

   _____
   _____
6. What is/was the monthly amount of earnings or other income received because of participation in the training program? $ _____
7. Specify the dates when income was received:
   a. From Date (MM/DD/YYYY): _ _ / _ _ / _ _ _ _
   b. Through Date (MM/DD/YYYY): _ _ / _ _ / _ _ _ _

Return the completed form in the self-addressed, stamped envelope provided by ____/___/____ <u>OR</u> fax the completed form toll free to: 800-823-0127. If you have any questions, call toll free: 877-392-9776.

Name and title of person completing the form: _____

Signature: _____ Phone Number: _____ Date: ____/_____/_____

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TPVR-5
Alimony Verification

C/P/C	Macro Link

To: _____ Re: _____
_____ ID: _____
_____ _____

Please Provide Alimony Verification Information for the Person Named Above

1. If you have no record of the person named above, please check the box and return the form. ❑
2. Please provide alimony payment history for the person named above from [17 or 5 months prior to the QCM] through [QCM] by attaching documents that contain the requested information
3. Please provide the monthly court ordered alimony amount the person is entitled to: $_____
4. If you are unable to provide documents to support the requested information, please list the amount of alimony provided below.

	Alimony Amount
[QCM-5]	**$**
[QCM-4]	**$**
[QCM-3]	**$**
[QCM-2]	**$**
[QCM-1]	**$**
[QCM]	**$**

If you are unable to provide the requested information for the entire time period, provide as much information during that time period as available and an explanation below.

Explanation: _____

_____

Return the completed form in the self-addressed, stamped envelope provided by ____/___/____ <u>OR</u> fax the completed form toll free to: 800-823-0127. If you have any questions, call toll free: 877-392-9776.

Name and title of person completing the form: _____

Signature: _____ Phone Number: _____ Date: ____/_____/_____

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TPVR-6
Child Support Verification

C/P/C	Macro Link

To: _____ Re: _____
_____ ID: _____
_____

Please Provide Child Support Verification Information for the Person Named Above

1. If you have no record of the person named above, please check the box and return the form. ❑
2. Please list the **names of the children** on whose behalf support payments were made to the person named above.

   Child's name

   1._____
   2._____
   3._____
   4._____
3. Please provide benefit history for all the children listed above from [17 or 5 months prior to the QCM] through [QCM] by attaching documents that contain the following information clearly labeled:
   - Financial Support
   - Medical
   - Child Care
   - Other (list): _____
4. Please provide the monthly court ordered Child Support amount: $_____
5. If you are unable to provide documents to support the requested information, please list the amount of child support provided below.

	Financial Support	**Medical**	**Child Care**	**Other: _____**
[QCM-5]	**$**	**$**	**$**	**$**
[QCM-4]	**$**	**$**	**$**	**$**
[QCM-3]	**$**	**$**	**$**	**$**
[QCM-2]	**$**	**$**	**$**	**$**
[QCM-1]	**$**	**$**	**$**	**$**
[QCM]	**$**	**$**	**$**	**$**

If you are unable to provide the requested information for the entire time period, provide as much information during that time period as available and an explanation below.

Explanation: _____
_____

Return the completed form in the self-addressed, stamped envelope provided by ____/___/____ <u>OR</u> fax the completed form toll free to: 800-823-0127. If you have any questions, call toll free: 877-392-9776.

Name and title of person completing the form: _____

Signature: _____ Phone Number: _____ Date: ____/_____/_____

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TPVR-7
TANF & Other Welfare Verification

To: _____ Re: _____
_____ ID: _____
_____ _____

Please Provide TANF and Welfare Verification Information for the Person Named Above

1. If you have no record of the person named above, please check the box and return the form. ❑
2. Please provide benefit history from [17 or 5 months prior to the QCM] through [QCM] by attaching documents that contain the following information clearly labeled:
   - Type of benefit (include child support if being paid through the agency)
   - Gross benefit amount
   - Medical/other insurance
   - Other deductions
3. Was this person (or other household member) paid for participation in a self-sufficiency or on-the-job training program?
   ❑ Yes ❑ No
   IF YES, provide:
   - Job Start Date: (MM/DD/YYYY): ___/___/_____ Job End Date: (MM/DD/YYYY): ___/___/_____
   - Monthly amount paid during [QCM] ____/_____? $ _____
4. Were TANF benefits ever reduced because of fraud or failure of any member to participate in an economic self- sufficiency program or work activity?
   ❑ Yes ❑ No
   IF YES:
   - What was the date the reduced monthly benefit amount became effective:(MM/DD/YYYY) __/__/____
   - What was the amount of the benefit prior to the reduction? $ _____
5. If the person was not receiving benefits as of [QCM] __/___, did the person ever receive TANF benefits?
   ❑ Yes ❑ No
   IF YES:
   - What was the date the monthly benefit amount was stopped: ____/____/___
   - What was the amount of the benefit prior to the stoppage? $ _____
   - List names of persons included in benefit payment: _____
   - Indicate why the benefits stopped: _____

If you are unable to provide the requested information for the entire time period, provide as much information during that time period as available and an explanation below.

Explanation: _____

_____

Return the completed form in the self-addressed, stamped envelope provided by ____/___/____ <u>OR</u> fax the completed form toll free to: 800-823-0127. If you have any questions, call toll free: 877-392-9776.

Name and title of person completing the form: _____

Signature: _____ Phone Number: _____ Date: ____/_____/_____

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TPVR-8
Medical & Disability Expenses Verification

To: _____ Re: _____
_____ ID: _____
_____ _____

Please Provide Medical and Disability Expense Information for the Person Named Above

1. If you have no record of the person named above, please check the box and return the form. ❑
2. Please provide a document that lists the monthly out-of-pocket cost of healthcare services or items you provided the person named above. Please include information for the following 12 months: [11 months prior to QCM] through [QCM].
   Note: ***Out-of-pocket expenses*** *should only include expenses not covered by health insurance.*

   The list below includes some common medical and disability expense items. Please provide information about all the services and items that was rendered by you or your institution to the person named above.

   List of healthcare services
   - Health insurance premiums
   - Services of doctor, nurses, dentists, other healthcare professionals
   - Services of health care facility (e.g., hospitals, clinics, labs)
   - Medical care of permanently institutionalized individuals
   - Care providers (live-in-aides)
   - Medical transportation
   - Animal services

   List of healthcare items
   - Prescription medications
   - Non-prescription drugs and medical supplies
   - Physical impairment assistive devices (hearing aids, eyeglasses)
   - Mobility assistance devices, such as wheel chairs
   - Special equipment

3. If in addition to the expenses listed above, there was an outstanding balance with incremental payments being made as of [QCM], please provide the following information.
   1. Type of Expense: _____
   2. Amount of Outstanding Balance: $ _____
   3. Amount Paid per month: $ _____
   4. Expected number of payments for the next 12 months: $_____

If you are unable to provide the requested information for the entire time period, provide as much information during that time period as available and an explanation below.

Explanation: _____

_____

Return the completed form in the self-addressed, stamped envelope provided by ____/___/____ <u>OR</u> fax the completed form toll free to: 800-823-0127. If you have any questions, call toll free: 877-392-9776.

Name and title of person completing the form: _____

Signature: _____ Phone Number: _____ Date: ____/_____/_____

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TPVR-9
Child Care Expense Verification

To: _____ Re: _____
_____ ID: _____
_____ _____

Please Provide Child Care Information for the Person Named Above

1. If you have no record of the person named above, please check the box and return the form. ❑
2. Please list the **names of the children** of the person named above for whom you provide child care services for

Child's name	Name of person who paid for the child's care
1._____	_____
2._____	_____
3._____	_____
4._____	_____

3. Please provide a history of all child care expenses for the children listed above from [12 month prior to QCM] through [QCM] by attaching documents that contain only the amounts paid by the person. Include any amounts paid for each child and the name of the person who paid.
4. If you are unable to provide documents to support the requested information, please list the amount of child support provided below.

	Child 1	**Child 2**	**Child 3**	**Child 4**
[QCM-11]	**$**	**$**	**$**	**$**
[QCM-10]	**$**	**$**	**$**	**$**
[QCM-9]	**$**	**$**	**$**	**$**
[QCM-8]	**$**	**$**	**$**	**$**
[QCM-7]	**$**	**$**	**$**	**$**
[QCM-6]	**$**	**$**	**$**	**$**
[QCM-5]	**$**	**$**	**$**	**$**
[QCM-4]	**$**	**$**	**$**	**$**
[QCM-3]	**$**	**$**	**$**	**$**
[QCM-2]	**$**	**$**	**$**	**$**
[QCM-1]	**$**	**$**	**$**	**$**
[QCM]	**$**	**$**	**$**	**$**

If you are unable to provide the requested information for the entire time period, provide as much information during that time period as available and an explanation below.

Explanation: _____

_____

Return the completed form in the self-addressed, stamped envelope provided by ____/___/____ OR fax the completed form toll free to: 800-823-0127. If you have any questions, call toll free: 877-392-9776.

Name and title of person completing the form: _____

Signature: _____ Phone Number: _____ Date: ____/_____/_____

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TPVR-10
Student Gift & Contribution Verification

To: _____ Re: _____
_____ ID: _____
_____ _____

Please Provide Information about Gifts and Contribution you have made to the Person Named Above

1. The person named above has stated that you provided financial contributions or paid bills for him/her on a regular basis. Please provide the amount of money you paid to or for the person named above for the following 6 month period. If your contribution was something other than money provide the value of the gift or contribution (how much you paid).

List the Type of Gift or Contribution below (e.g. money, phone, groceries, clothes, insurance, car payment, school tuition, rent)	**[QCM-5]**	**[QCM-4]**	**[QCM-3]**	**[QCM-2]**	**[QCM-1]**	**[QCM]**
	$	**$**	**$**	**$**	**$**	**$**
	$	**$**	**$**	**$**	**$**	**$**
	$	**$**	**$**	**$**	**$**	**$**
Total	**$**	**$**	**$**	**$**	**$**	**$**

2. The rules for receiving housing assistance from the Department of Housing and Urban Development require that the parent's income of all students be taken into consideration unless that student is legally emancipated from their parents. To determine the amount of housing assistance the person named above should receive we need the following information:
   a. When did the person named above stop living with you? (MM/DD/YYYY): _ _ / _ _ / _ _ _ _
   b. Are you claiming the person named above as a dependent on your income tax forms?
      ❑ Yes ❑ No
      IF NO, when did you stop claiming the person named above as a dependent? (MM/DD/YYYY): _ _ /_ _ / _ _ _ _

3. Please provide the following information regarding your household's income during _____/_____ [QCM]:

Name (List the full name of each parent or guardian)	**Employer Name (list all employers of parent/guardian**	**Annual Amount received from the employer**	**Source of Income other than Employment (list each source)**	**Annual Amount received from that source**
		$		**$**
		$		**$**
		$		**$**
		$		**$**

If you are unable to provide the requested information for the entire time period, provide as much information during that time period as available and an explanation below.

Explanation: _____

_____

Return the completed form in the self-addressed, stamped envelope provided by ____/___/____ <u>OR</u> fax the completed form toll free to: 800-823-0127. If you have any questions, call toll free: 877-392-9776.

Name and title of person completing the form: _____

Signature: _____ Phone Number: _____ Date: ____/_____/_____

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TPVR-11
Student Verification

To: _____ Re: _____
_____ ID: _____
_____ _____

Please Provide Student Status and Financial Assistance Information for the Person Named Above.

1. If you have no record of the person named above, please check the box and return the form. ❑
2. As of [QCM] ____/____was the person named above a student or planning to be a student at your institution?

   ❑ Yes ❑ No

   IF YES: Please provide the following information

   a. Dates the semester/session **immediately prior** to or including [QCM] ____/_____ began and ended:

      From ____/_____ Thru: ____/_____

      - The person's student status during that semester/session. ❑ Full Time ❑ Part Time ❑ Not a student
      - The cost of tuition and fees for the person named above during that semester/session: $_____

   b. Dates the semester/session **immediately after** or including [QCM] ____/_____ began and ended:

      From ____/_____ Thru: ____/_____

      - The person's student status during that semester/session. ❑ Full Time ❑ Part Time ❑ Not a student
      - The cost of tuition and fees for the person named above during that semester/session: $_____

3. According to your records is the person named above a veteran of the U.S. Military? ❑ Yes ❑ No
4. Did the person named above receive financial assistance while attending your institution during the period specified above? ❑ Yes ❑ No

   IF YES: Please provide information about that assistance below. (Attach additional documents, if needed)

Received Date	Type of Assistance	Amount	Period of Time it Was Intended to Cover	Explain Stipulations or Restrictions?
___/___/____ MM DD YYYY		$	From: ___/____ Thru: ___/____ MM YYYY MM YYYY	
___/___/____ MM DD YYYY		$	From: ___/____ Thru: ___/____ MM YYYY MM YYYY	
___/___/____ MM DD YYYY		$	From: ___/____ Thru: ___/____ MM YYYY MM YYYY	

Return the completed form in the self-addressed, stamped envelope provided by ____/___/____ <u>OR</u> fax the completed form toll free to: 800-823-0127. If you have any questions, call toll free: 877-392-9776.

Name and title of person completing the form: _____

Signature: _____ Phone Number: _____ Date: ____/_____/_____

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TPVR-12
Trust Fund Verification

To: _____ Re: _____
_____ ID: _____
_____ _____

Please Provide Verification of Trust Fund Information for the Person Named Above.

If you have no record of the person named above, please check the box and return the form. ❑

Please provide the following information about the trust fund indicated below or any other trust connected with the person named above.

		Trust Identified by Person Named Above	Any Other Trust
1.	ID # of Trust Fund:		
2.	Is the person named above the **creator** (grantor) or **beneficiary**?		
3.	What is the date the trust was established? (mm/dd/yyyy)	/ /	/ /
4.	Is the trust fund **revocable** or **irrevocable**?		

5. If the person named above is the **creator** of the trust, the trust is **irrevocable** and was **established prior to** (2 yrs prior to QCM) _____/_____, ***stop here.*** *Sign below and return this form in the enclosed envelope.*

6. If the person named above is the **beneficiary**, please complete the table below, providing the information for the one-year period between [QCM] _____/_____ and _____/_____ :

Macro Link	Trust Fund ID#	Amount Paid*	How Often Was/Is That Amount Paid?
		$	
		$	

* If rate of pay changed during the one-year period indicated above, record each rate of pay and corresponding dates in a separate row

7. If the person named above is the **creator** of the trust and the trust is **revocable** please complete the table below, providing the information as of [QCM] _____/_____.

Macro Link	Trust Fund ID #	Cash Value	Amount of any Payments Made to any Beneficiaries (annual amount, starting with date above)	Growth Rate Expected (annual amount, starting with date above)	Cost to Dissolve	Fund Jointly Held? Yes/No	Fund Jointly Held? If Yes, Held Jointly Name of Co-holder
		$	$	%	$		
		$	$	%	$		

8. If the person named above is the **creator** of the trust and the trust is **irrevocable but was established between** (2 yrs prior to QCM) **_____/_____ and** [QCM] **_____/_____,** please provide the following information as of [QCM] _____/_____:

Macro Link	Trust Fund ID #	Cash Value	Name of Beneficiaries	Amount of any Payments Made to any Beneficiaries (annual amount, starting with date above)	Growth Rate Expected (annual amount, starting with date above)	Cost to Dissolve	Fund Jointly Held? Yes/No	Fund Jointly Held? If Yes, Held Jointly Name of Co-holder
		$		$	%	$		
		$		$	%	$		

9. Does the person named above have access to any funds in the trust that have **not** been revealed in the questions/tables above? If **yes**, what is that amount? $ _____ (lump sum or annual figure, if applicable).
Explain:_____

Return the completed form in the self-addressed, stamped envelope provided by ____/___/____ <u>OR</u> fax the completed form toll free to: 800-823-0127. If you have any questions, call toll free: 877-392-9776.

Name and title of person completing the form: _____

Signature: _____ Phone Number: _____ Date: ____/_____/_____

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C/P/C	Macro Link

TPVR-13
Life Insurance Verification

To: _____ Re: _____
_____ ID: _____
_____ _____

Please Provide Life Insurance Verification Information for the Person Named Above for All Accounts Held at Your Institution.

1. If you have no record of the person named above, please check the box and return the form. ❑
2. Please provide information for each account held by the person named above by attaching documents that contain the following information clearly labeled:
   - Life Insurance ID number
   - Face Value as of the [QCM]
   - Cash Value as of the [QCM]
   - Penalty/Fee for Borrowing the Full Cash Value
   - Annual Income (Interest, Dividends, etc.)
   - Name of co-owner (if jointly owned)

Return the completed form in the self-addressed, stamped envelope provided by ____/___/____ <u>OR</u> fax the completed form toll free to: 800-823-0127. If you have any questions, call toll free: 877-392-9776.

Name and title of person completing the form: _____

Signature: _____ Phone Number: _____ Date: ____/_____/_____

U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT
c/o ICF International
Attn: HUDQC
530 Gaither Road, Suite 500
Rockville, MD 20850

Boxes for Official use Only

C/P/C	Macro Link

TPVR-14
Real Estate & Personal Property Verification

To: _____ Re: _____
_____ ID: _____
_____ _____

Please Provide Information for All Properties Owned by the Person Named Above

1. If you have no record of the person named above, please check the box and return the form. ❑

2. Please provide the following information for the property indicated below and any other property owned by the person named above. Provide the information for the month of ____/_____ [QCM].

Address	**Value of Property As of** ____/_____[QCM]	**Cost to Dispose** (if applicable) **As of** ____/_____[QCM]	**Asset Held Jointly As of** ____/____[QCM]	
			Yes/No	**If Asset Held Jointly, enter Co-Owner Name**
	$	$		
	$	$		
	$	$		
	$	$		

Return the completed form in the self-addressed, stamped envelope provided by ____/___/____ OR fax the completed form toll free to: 800-823-0127. If you have any questions, call toll free: 877-392-9776.

Name and title of person completing the form: _____

Signature: _____ Phone Number: _____ Date: ____/_____/_____

U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT
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Rockville, MD 20850

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C/P/C	Macro Link

TPVR-15
Gift & Contribution Verification

To: _____ Re: _____
_____ ID: _____
_____ _____

Please Provide Information about Gifts and Contribution you have made to the Person Named Above

The person named above has stated that you provided financial contributions or paid bills for him/her on a regular basis. Please provide the amount of money you paid to or for the person named above for the following 6 month period. If your contribution was something other than money provide the value of the gift or contribution (how much you paid).

List the Type of Gift or Contribution below (e.g. money, phone, groceries, clothes, insurance, car payment, school tuition, rent)	**[QCM-5]**	**[QCM-4]**	**[QCM-3]**	**[QCM-2]**	**[QCM-1]**	**[QCM]**
	$	**$**	**$**	**$**	**$**	**$**
	$	**$**	**$**	**$**	**$**	**$**
	$	**$**	**$**	**$**	**$**	**$**
	$	**$**	**$**	**$**	**$**	**$**
Total	**$**	**$**	**$**	**$**	**$**	**$**

If you are unable to provide the requested information for the entire time period, provide as much information during that time period as available and an explanation below.

Explanation: _____

_____

Return the completed form in the self-addressed, stamped envelope provided by ____/___/____ <u>OR</u> fax the completed form toll free to: 800-823-0127. If you have any questions, call toll free: 877-392-9776.

Name and title of person completing the form: _____

Signature: _____ Phone Number: _____ Date: ____/_____/_____

U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT
c/o ICF International
Attn: HUDQC
530 Gaither Road, Suite 500
Rockville, MD 20850

Boxes for Official use Only

C/P/C	Macro Link

TPVR-16
Disability Status Verification

To: _____ Re: _____
_____ ID: _____
_____ _____

Please Provide Disability Status Verification for the Person Named Above.

Please check the box that applied to the person named above, as of _____/_____ [QCM] and complete and sign the certification of disability**.**

Certification of Disability

In my professional opinion, _____ (the person named above)

- ❑ DID NOT meet the definition of a person with a disability
- ❑ DID meet the definition of a person with a disability because he/she (check all definitions of persons with disability listed below that apply):
  - ❑ Was receiving SSI or SSA disability
  - ❑ Was considered to have a disability as defined in Sec. 223 of the Social Security Act (42 U.S.C. 423): "Inability to engage in any substantial, gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months, or in the case of an individual who has attained the age of 55 and is blind and unable by reason of such blindness to engage in substantial, gainful activity requiring skills or ability comparable to those of any gainful activity to which he/she has previously engaged with some regularity and over substantial periods of time."
  - ❑ Had a developmental disability as defined in Section 102(7) of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6001(7)):"Severe chronic disability that: (a) is attributable to a mental or physical impairment or combination of mental and physical impairments; (b) is manifested before the person attains age 22; (c) is likely to continue indefinitely; (d) results in substantial functional limitation in three or more of the following areas of major life activity: (1) self-care,(2) receptive and responsive language, (3) learning, (4) mobility, (5) self-direction, (6) capacity for independent living, (7) economic self-sufficiency; and (e) reflects the person's needs for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated."
  - ❑ Had a physical, mental or emotional impairment that:
    - Was expected to be of long continued and indefinite duration,
    - Substantially impeded his or her ability to live independently, and;
    - Was of such a nature that the ability to live independently could be improved by more suitable housing conditions.

    NOTE: The definition of a person with a disability **DOES NOT EXCLUDE** persons who have the disease of acquired immunodeficiency syndrome (AIDS) or any condition arising from the etiologic agent for AIDS. For purposes of qualifying for low-income housing, these definitions **DO NOT INCLUDE** a person whose disability is based solely on any drug or alcohol dependence.

If you are unable to provide the requested information for the entire time period, provide as much information during that time period as available and an explanation below.

Explanation: _____

_____

Return the completed form in the self-addressed, stamped envelope provided by ____/___/____ <u>OR</u> fax the completed form toll free to: 800-823-0127. If you have any questions, call toll free: 877-392-9776.

Name and title of person completing the form: _____

Signature: _____ Phone Number: _____ Date: ____/_____/_____