SOUTH DAKOTA HOUSING DEVELOPMENT AUTHORITY

WORKMAN'S COMPENSATION VERIFICATION

TO: Name:_____	FROM: Name:_____
Address: _____	Address:_____
Phone: _____ Fax:_____	Phone: _____ Fax:_____
RE: Name:_____	

The person listed above has indicated that he/she is receiving Workman's Compensation. Information provided will remain confidential and will be used solely for the purpose of determining eligibility for occupancy.

Weekly Amount: $_____Monthly Amount: $_____

Total benefit amount that will be paid: $_____

Effective Date: _____ Ending Date if known:_____

Comments: _____

_____

_____

_____
Name and Title of Person Supplying Information

_____ _____
Signature Date

_____ _____ _____
Phone# Fax # E-mail