



Collateral Verification Letter
 Department of Social Services
 B-3112 (10/2019)

| | | |
|----------------------------------|----------|------|
| Date Sent | Examiner | Team |
| Please return completed form by: | | |

Must be completed by a non-household member.

Please list all persons living at the address below.

| | | |
|--|------------------------|------------------------|
| Client Name | | Date Client Moved In |
| Address (Street, Apt#) | | |
| City | State NY | Zip |
| Number of Apartments in the Building | | |
| Persons living at the specific address above | | |
| Name | Relationship to Client | |
| 1. _____ | | |
| 2. _____ | | |
| 3. _____ | | |
| 4. _____ | | |
| 5. _____ | | |
| 6. _____ | | |
| 7. _____ | | |
| 8. _____ | | |
| I the undersigned, certify that the above information is true to the best of my knowledge. | | |
| Signature | | Date |
| Address | | Relationship to Client |
| Phone Number | | How long known client |

| | |
|---|----------|
| Verified per TC <input type="checkbox"/> Yes <input type="checkbox"/> No | Comments |
| | |
| | |

Please return completed form to:
 Erie County Department of Social Services
 158 Pearl Street
 Buffalo NY 14202