

Case Name: **SUSAN SHARP**
 Case Number: **XXXXXXXXXX**
 Date: **MMDDYYYY**
 DHS Office:
 Co: District: Section: Unit: Worker:
 Specialist:
 Phone:
 Fax:
 Specialist ID:

STATE OF MICHIGAN
Department of Human Services

If you do not understand this, call a DHS office in your area.
 DHS employees are prohibited by law from providing legal advice.
 Si usted no entiende esto, llame a una oficina de DHS en su área.
 La ley prohíbe a los empleados de DHS proporcionar asesoría legal.
 إذا واجهت صعوبة في فهم هذا الطلب، فاتصل بمكتب DHS الموجود في منطقتك.
 يحرم القانون على موظفي DHS إعطاء النصيحة القانونية.

Mary Martin

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.
 "This institution is an equal opportunity provider."
AUTHORITY: Federal
 7 CFR Food Stamp Act of 1977, Special Security Privacy Act, 454 PA 2004, MCL 445.81 et seq., 1939 PA 280, as amended and MAC 400.7001 – 400.7049
COMPLETION: Required for SER Relocation Services. Optional for other programs.
PENALTY: Decrease or loss of benefits.

SHELTER VERIFICATION

Your shelter obligation must be verified by the verification due date in the box above. You may give this form to your landlord, mortgage company or land contract holder for completion, or you may provide other proofs, such as:

- Rental or mortgage contracts, a signed and dated statement from your landlord, mortgage company or land contract holder, that includes the name and address of the client, amount paid and period covered.
- Current copies of your property taxes, homeowner's insurance, assessment, telephone, heat and utility bills.

Contact our office if you have any questions or need additional forms.

To Be Completed by LANDLORD/MORTGAGE CO./LAND CONTRACT HOLDER about Client's Obligation

Total Monthly Shelter Obligation (Excluding Additional Fees) \$150		Is the rent reduced because of Section 8 or subsidized housing, etc? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, how much does the client pay?	
Address of Shelter Unit 901 N. Larch Lansing MI 48906		<input checked="" type="checkbox"/> Renting <input type="checkbox"/> Buying	If buying, client PAYS (NOT escrowed) <input type="checkbox"/> Property Taxes <input type="checkbox"/> Homeowners Insurance <input type="checkbox"/> Special Assessments <input type="checkbox"/> Condo Fees \$ _____ per month <input type="checkbox"/> Other
Date moved in? (mm/dd/yy) 10/12/2007			
Type of Shelter Unit: <input checked="" type="checkbox"/> Apartment <input type="checkbox"/> House <input type="checkbox"/> Condo <input type="checkbox"/> Mobile Home <input type="checkbox"/> Lot Rent <input type="checkbox"/> Room <input type="checkbox"/> Room and Board (food is provided by the landlord)			Is the home free of lead paint or certified lead safe? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Check each of the following that are included in rent: <input type="checkbox"/> Heat <input type="checkbox"/> Electric <input checked="" type="checkbox"/> Water/Sewer <input checked="" type="checkbox"/> Cooking Fuel <input checked="" type="checkbox"/> Trash Removal <input type="checkbox"/> Telephone <input type="checkbox"/> None			
Property Owner/Contract Holder/Landlord Name Mary Martin Address 901 N. Larch Lansing MI 48906		Tax ID# of Property Owner	Type of ID (Check one) <input type="checkbox"/> MI ID <input type="checkbox"/> MI Temporary ID <input type="checkbox"/> Federal ID
Mailing Address for Shelter Payment (if different) Name _____ Address _____		MDHS Provider ID #, if any	
Signature of Landlord/Mortgagor/Land Contract Holder <i>Mary Martin</i>		Title Landlord	Telephone No. 517-241-0719 Date Today

Case Name SUSAN SHARP	Case Number XXXXXXXXXX	Specialist
---------------------------------	----------------------------------	------------

To be Completed by AFC/Supported Independent Living Facilities Only:

Is your home a DMH/CMH contract home? <input type="checkbox"/> Yes <input type="checkbox"/> No		Facility License Number _____
Does DMH or CMH pay a subsidy on behalf of the client? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Client's monthly shelter responsibility \$ _____		
Client is responsible to pay: <input type="checkbox"/> Heating <input type="checkbox"/> Cooling (including room air conditioner) <input type="checkbox"/> Electric <input type="checkbox"/> Water/Sewer <input type="checkbox"/> Cooking Fuel		
<input type="checkbox"/> Trash Removal <input type="checkbox"/> Telephone <input type="checkbox"/> None		
Client's monthly uncovered medical expenses: \$ _____ per month, or \$ _____ per day.		
Medical services provided for this client: _____		
Is your home a non-profit home? <input type="checkbox"/> Yes <input type="checkbox"/> No		Facility License Number _____
AFC Home/Supported Independent Living Facility Name _____		
Signature of AFC/Supported Independent Living Facility/Representative	Title	Telephone No.
		Date