

Case Name:  
 Case Number:  
 Date:  
 MDHHS Office:  
 Specialist / ID: /  
 Phone:  
 Fax:  
 Individual ID:

**STATE OF MICHIGAN**  
 Department of Health and Human Services

If you do not understand this, call an MDHHS office in your area. MDHHS employees are prohibited by law from providing legal advice.

Si usted no entiende esto, llame a una oficina de MDHHS en su área. La ley prohíbe a los empleados de MDHHS proporcionar asesoría legal.

NAME:  
 ADDRESS:

إذا واجهت صعوبة في فهم هذا الطلب، فاتصل بمكتب MDHHS الموجود في منطقتك. إعطاء النصيحة القانونية MDHHS يحرم القانون على موظفي

**SHELTER VERIFICATION**

Verification Due Date
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**All pages need to be completed and returned.**

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) \$	Is the rent reduced because of Section 8 or subsidized housing, etc? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how much does the client pay?
Address of Shelter Unit  _____  _____	<input type="checkbox"/> Renting      If buying, client <b>PAYS</b> (NOT escrowed) <input type="checkbox"/> Buying Date moved in? <input type="checkbox"/> Property Taxes (mm/dd/yy) <input type="checkbox"/> Homeowners Insurance <input type="checkbox"/> Special Assessments <input type="checkbox"/> Condo Fees _____ per month <input type="checkbox"/> Other _____

Case Name	Case Number	Specialist
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Type of Shelter Unit <input 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 type="checkbox"/> Yes <input type="checkbox"/> No
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Check each of the following that are **included** in rent:     Heating/Cooling (including room air conditioner)  
 Electric     Water/Sewer     Cooking Fuel     Trash Removal     Telephone     None

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

Property Owner/Contract Holder/Landlord Name Address _____	Tax ID# of Property Owner (required for direct payment by MDHHS)	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 _____	MDHHS Provider ID #, if any		
Signature of Landlord/Mortgagor/Land Contract Holder	Title	Telephone #	Date

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

Is your home a DMH/CMH contract home?     Yes     No    Facility License Number \_\_\_\_\_  
Does DMH or CMH pay a subsidy on behalf of the client?     Yes     No  
Client's monthly shelter responsibility    \$ \_\_\_\_\_  
Client is responsible to pay:     Heating     Cooling (including room air conditioner)  
 Trash Removal     Electric     Water/Sewer     Cooking Fuel  
 Telephone     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?     Yes     No    Facility License Number \_\_\_\_\_  
\_\_\_\_\_  
AFC Home/Supported Independent Living Facility Name

Signature of AFC/Supported Independent Living Facility/Representative	Title	Telephone #	Date
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The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

**AUTHORITY:** Federal 7 CFR, Food and Nutrition Act of 2008, as amended, 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.

This institution is an equal opportunity provider.