Advomas 1607 E BIG BEAVER Ste 350 Troy MI 48083

Case Name:	
Case Number:	
Date:	
DHS Office: Advomas	
Specialist / ID:	/
Phone:	
Fax:	
Individual 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 ústed no entiende esto, llame a una oficina de DHS en su área.
La ley prohíbe a los empleados de DHS proporcionar asesoria legal.
إذا و اجهت صعوبة في فهم هذا الطلب، فأتصل بمكتب DHS الموجود في منطقتك.
يحرّم القانون على موظفي DHS إعطاء النصيحة القانونية.

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.

AUTHORITY: P.A., 280 of 1939 **COMPLETION:** Required

PENALTY: Inability to determine eligibility for public assistance

VERIFICATION OF ASSETS

AUTHORIZATION: You are hereby authorized to release the information requested below to the Department of Human Services.	تفويض: إنك مفوّض بموجب هذا المستند أن تصرّح عن المعلومات المطلوبة أدناه إلى إدارة الخدمات الإنسانية.				
AUTORIZACION: Usted está autorizado a dar la información pedida más abajo a Department of Human Services.	Signature of Client or Client's Representative Date				

To determine eligibility for assistance it is necessary to verify assets owned by the person named below, either alone or jointly with other persons. If the account is joint, please list the names of the account members.

Please provide current information on the person indicated below. Also, please report on accounts closed within the past 36 months. A stamped, addressed envelope is enclosed for return of the completed form. Thank you.

THIS SECTION IS TO BE COMPLETED BY THE SPECIALIST

THIS SECTION IS TO BE COMPLETED BY THE SPECIALIST											
Name (Type or Print)						Social Security Number					
THIS SECTION IS TO BE COMPLETED BY FINANCIAL INSTITUTION											
NOTE: Please Report on Closed Accounts if Closed Within Past 36 Months	Savings/Share	Certificate of Deposit	Checking/Draft Account	Patie	Term Care nt Trust und	Prepaid Burial Account		Other (Explain)			
1. Account Number(s):											
2. Date Last Withdrawal											
3. Amount Last Withdrawal											
4. Current Balance											
5. Highest Balance For Month of											
6. Lowest Balance For Month of											
7. Is There a Safety Deposit Bo	ox? 🗌 Yes	□ No 8.	Is There a Trus	t Fund?	Yes	s □ No	lf Yes, Att	tach a Copy of the Trust.			
9. For Each Joint Account List 10. For Each Joint Account List 11. For Each Loan Application Within Past 36 Mo							ithin Past 36 Months List:				
Account Number:	Account Number: Acc				Type (e.	ccount Number // ype (e.g., Auto, Home)//					
Account Members:	Ac	Account Members:			Current Balance /_ If collateral was used attach a copy of the loan application						
12. Remarks:											
13. Signature		14. Title			15. Telephone No.		16. Date				