Training Office
7109 West Saginaw Hwy
Lansing, MI 48917

Case Name: Susan Sharp
Case Number: see your Case Data Sheet
Date: Last Month
DHS Office:
Specialist: A. Specialist
Phone: 517-222-3456
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 ústed 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، فأتصل بمكتب DHS الموجود في منطقتك.
يحرّم القانون على موظفي DHS إعطاء النصيحة القانونية.

Fifth Third

(EASTERN MICHIGAN)
P.O. BOX 630900 CINCINNATI OH 45263-0900

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: Susan Sharp Date: **Last Month**

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

Name (Type or Print)	Social Security Number
Susan Sharp	XXX-XX-XXXX

THIS SECTION IS TO BE COMPLETED BY FINANCIAL INSTITUTION

NOTE: Please Report on Closed Accounts if Closed Within Past 36 Months	Savings/Share Account	Certificate of Deposit	Checking/Draft Account	Long-Term Care Patient Trust Fund	Prepaid Burial Account	Other (Explain)
1. Account Number(s):	7007942					
2. Date Last Withdrawal	MM/DD/YY					
3. Amount Last Withdrawal	$910.00					
4. Current Balance	$50.00					
5. Highest Balance For Month of ______________	$960.00					
6. Lowest Balance For Month of	$50.00					

7. Is There a Safety Deposit Box? ☐ Yes ☒ No   8. Is There a Trust Fund? ☐ Yes ☒ No   If Yes, Attach 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 Months List:
Account Number: Account Members:	Account Number: Account Members:	Account Number ___________/______________ Type (e.g., Auto, Home) ___________/ ____________ Current Balance ____________/_ ____________ If collateral was used attach a copy of the loan application

12. Remarks:

13. Signature	14. Title	15. Telephone No.	16. Date
Teller	Teller, Fifth Third	( )	LAST MONTH