STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF WELFARE AND SUPPORTIVE SERVICES

JOE LOMBARDO
Governor

RICHARD WHITLEY, MS
Director

ROBERT THOMPSON
Administrator

☐ TANF ☐ MEDICAID ☐ SNAP

Date: ______________________
Case Name: ______________________
Case ID: ______________________

CHILD CARE EXPENSE VERIFICATION FORM

The Nevada State Division of Welfare and Supportive Services needs the following information completed and returned to correctly determine eligibility, benefit levels or other services for: ______________________

Name of babysitter or child care provider: ______________________

Street ______________________ City ______________________ State ______________________

Zip ______________________ Telephone Number: ( ) -

Name of person paying for child care costs: ______________________

Telephone Number: ( ) -

Are any portion of child care costs paid or subsidized by an outside agency or individual? ☐ YES ☐ NO

If YES, list who subsidizes and the amount of child care costs paid by the agency or individual:

Name: ______________________

Telephone Number: ( ) - Amount: $

When is child care paid and what is the amount? (*enter amount or amounts in column 1, 2, 3 or 4*):

	(1) Weekly ***(once per week)***	**(2) Bi-Weekly** ***(every other week)***	**(3) Monthly** ***(once per month)***	**(4) Twice Monthly** ***(twice (2) per month)***
Client Pays	$	$	$	$
Other Agency or Individual Pays	$	$	$	$

Who is child care paid for?

Child's Name	Age	# of hours	Days	Child's Name	Age	# of hours	Days
	/	/	/		/	/	/
	/	/	/		/	/	/
	/	/	/		/	/	/

Signature ______ Print Name ______ Title/Relationship ______ Date ______ Telephone Number