STEVE SISOLAK
Governor

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

RICHARD WHITLEY, MS
Director

STEVE H. FISHER
Administrator

☐ TANF ☐ MEDICAID ☐ SNAP

Date: _____
Case Name: _____
Case ID: _____

AUTHORIZATION: I authorize you to release to the Division of Welfare and Supportive Services the requested information.

Client Signature | Date

INSURANCE POLICY INFORMATION

It is necessary to determine the value and availability of _____ *resources for public assistance. Our records indicate* _____ *may be insured under a policy with your company. Please provide the information below and return to the above address. Your cooperation will help insure integrity and maintain accountability in the administration of public funds in Nevada. The information provided us will be used only in conjunction with the official duties of this department and will be considered confidential. If our identifying information (name and birthdate) does not agree with your records, please indicate the change.*

Client's Name: _____ DOB: _____ SSN: _____

Policy Holder: _____ Relationship to Client: _____

Policy Number: _____

☐ This company has no record of the above-named person.

☐ This person is no longer insured. Termination date of coverage: _____

Were the funds paid directly to the client as a result of termination? ☐ YES ☐ NO

If YES, Amount $ _____ Date Paid _____

☐ This person is currently insured.

Dependents covered by this insurance: _____

Date Insured: _____ Policy No.: _____ Type of Insurance: _____

Face Value: $ _____ Actual cash value (after loan or lien amounts have been deducted): $ _____

Dividends Received: $ _____ Date Received: _____

Due date for next payment: _____ Date of last payment: _____

Who is the owner of this policy? _____

Who would receive the money should this policy be surrendered? _____

Are claims for medical insurance ever paid directly to our client? ☐ YES ☐ NO

If YES, dates and amounts of payments made to our client during the month(s) of: _____

Is this a Qualified Long Term Care Partnership Policy? ☐ YES ☐ NO

If YES, what is the total amount of LTC benefits paid as of: _____

Signature	Print Name	Title	Date	Telephone Number