

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

RICHARD WHITLEY, MS Director

ROBERT THOMPSON Administrator

	☐TANF ☐ MEDICAID ☐ SNAP
	Date: Case Name: Case ID:
<u>POQ 28.298:</u>	AUTHORIZATION: I authorize you to release to the Division of Welfare and Supportive Services the requested information.
	Client Signature Date
FINANCIAL AID	
Student Name:	SSN:
Student's Status: ☐ Full-time ☐ Half-time or More ☐ L	
PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT FIBE RECEIVING	NANCIAL AID THE ABOVE-NAMED STUDENT RECEIVED/WILL
(1) Gross Grant Amount Time Period C	Covered: From To
Source:	Date Received/Will Receive:
Funding (Check One): TITLE IV OTHER FEDE	RAL NON-FEDERAL
(2) Gross Grant Amount Time Period C	Covered: From To
Source:	Date Received/Will Receive:
Funding (Check One): TITLE IV OTHER FEDE	RAL □NON-FEDERAL
(3) Gross Grant Amount Time Period C	Covered: From To
Source:	Date Received/Will Receive:
Funding (Check One): TITLE IV OTHER FEDE	RAL NON-FEDERAL
(4) Gross Grant Amount Time Period C	Covered: From To
Source:	Date Received/Will Receive:
Funding (Check One):	



EXPENSES "EARMARKED" BY INSTITUTION/GRANTOR TO BE PAID WITH FINANCIAL AID

Tuition/Mandatory Fees \$		Fees Charged to All Students		\$
Origination Fees	\$	Dependent Care		\$
Loan Insurance Premium	\$	Transportation		\$
Books/Supplies	\$	Miscellaneous Personal Expenses		\$
Is this student enrolled in a work study program?		□YES	□no	
Is a high school diploma/GED or equivalency test required?		□YES	\square NO	
Is medical coverage provided by the institution?		□YES	\square NO	
Signature	Print Name	Title	Date	Telephone Number

