



JOE LOMBARDO
Governor

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: _____



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 Less than Half-time

PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT FINANCIAL AID THE ABOVE-NAMED STUDENT RECEIVED/WILL BE RECEIVING

(1) Gross Grant Amount _____ Time Period Covered: From _____ To _____
Source: _____ Date Received/Will Receive: _____

Funding (Check One): TITLE IV OTHER FEDERAL NON-FEDERAL

(2) Gross Grant Amount _____ Time Period Covered: From _____ To _____
Source: _____ Date Received/Will Receive: _____

Funding (Check One): TITLE IV OTHER FEDERAL NON-FEDERAL

(3) Gross Grant Amount _____ Time Period Covered: From _____ To _____
Source: _____ Date Received/Will Receive: _____

Funding (Check One): TITLE IV OTHER FEDERAL NON-FEDERAL

(4) Gross Grant Amount _____ Time Period Covered: From _____ To _____
Source: _____ Date Received/Will Receive: _____

Funding (Check One): TITLE IV OTHER FEDERAL NON-FEDERAL



