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

STEVE SISOLAK
Governor

RICHARD WHITLEY, MS
Director

STEVE H. FISHER
Administrator

☐ TANF ☐ MEDICAID ☐ SNAP

ATTENTION: Payroll Department

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

EARNINGS VERIFICATION

Please provide the information for each of the items 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, Social Security number or address) does not agree with your records, please indicate the change.

RE: _____ _____
Name Social Security Number

Employee's Address: _____

1. Date work Began: _____ Number of Hours employee is scheduled to work per week: _____
2. Hourly rate of pay $_____ Average hours worked per week: _____ Date of first paycheck: _____
3. How often are paychecks issued: ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly

   When are regularly scheduled paydays? _____
4. Will "tips" be received? ☐ YES ☐ NO If YES: Estimated amount: $_____ per _____
5. Is this employment Contractual? ☐ YES ☐ NO If YES: Contracted wage amount: $_____ per _____

   Maximum Earnings provided in contract: $_____ Number of months covered by this contract: _____
6. Are/Were wages funded in whole or in part by Workforce Incentive (formerly JTPA?) Programs? ☐ YES ☐ NO

   If YES, through: ☐ Work experience OR ☐ On-the-job training

7. Please list below all monies (earnings, sick pay, vacation pay, disability, etc.) PAID or ANTICIPATED TO BE PAID (regardless of when earned to the employee in the month of):

PAY PERIOD ENDING	HOURS WORKED PER PAY PERIOD	ACTUAL DATES PAID	GROSS WAGES PAID (Include special allowances such as meals, uniforms, etc., and show a break-out of such amounts)	PRE-TAX DEDUCTIONS (Source/Type)

8. Do you anticipate any change in the number of hours, rate of pay or paydays next month: ☐ YES ☐ NO

   If YES, please explain the change. _____

9. Is Medical Insurance available to the employee? ☐ YES ☐ NO If YES, is the employee enrolled? ☐ YES ☐ NO

   If YES, provide the policy # _____ Effective Date: _____ End Date: _____

   Names of dependents covered: _____

10. If this person is **NOT** working for you at this time, complete the following information:

	DATE				
Quit:	_____				
Fired:	_____	Reason for leaving:	_____		
Leave of absence:	_____	Expected date of return:	_____		
Applied Workers Comp.:	_____	Date of final check:	_____	Gross amount:	$ _____

_____

Signature of Employer | Print Name | Title | Date | Telephone Number