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

1470 College Parkway Carson City, Nevada 89706-7924 (775) 684-0500

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Γ	٦	Date:		
		Case Name:		
		SSN:		
		Case Manager:		
L	_	Case Manager:	you to release to the requested informat	ne Division of ion.
BENEFIT VERIFICATION INQUIRY		(Client Signature)		(Date)
The individual referenced below has applied to this agbenefits that are being or have been received by our cl		We are requesting inform	ation concernin	g authorize
Please provide the information below and return this for and maintain accountability in the administration of conjunction with the official duties of this department	public funds in Neva	ada. The information pr		
If our identifying information (name and Social Secur	ity Number) does not	t agree with your records	, please indicate	the change
RE:				
		(Social Secur	rity Number)	
(Name) PLEASE SUPPLY THE FOLLOWING INFORMATION	ON:	(~~~~~	•	
PLEASE SUPPLY THE FOLLOWING INFORMATION				
PLEASE SUPPLY THE FOLLOWING INFORMATION Has a claim been filed? YES NO Claim N	No			
PLEASE SUPPLY THE FOLLOWING INFORMATION Has a claim been filed? ☐ YES ☐ NO Claim No Are benefits currently being paid? ☐ YES ☐ NO	No			
PLEASE SUPPLY THE FOLLOWING INFORMATION Has a claim been filed? YES NO Claim No Are benefits currently being paid? YES NO Date benefits began	No Type of benefit? Date benef	rits end(ed)		
PLEASE SUPPLY THE FOLLOWING INFORMATION Has a claim been filed? YES NO Claim Mare benefits currently being paid? YES NO Date benefits began Amount of benefits: Weekly	No Type of benefit? Date benef Semi-Monthly	its end(ed) Monthl	ly	
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PLEASE SUPPLY THE FOLLOWING INFORMATION Has a claim been filed? YES NO Claim No Are benefits currently being paid? YES NO Date benefits began Amount of benefits: Weekly	No Date benefit? Date benefitSemi-Monthly	its end(ed) Monthl Quarter Worked	Earnings fo	or Quarter
PLEASE SUPPLY THE FOLLOWING INFORMATION Has a claim been filed? YES NO Claim No Are benefits currently being paid? YES NO Date benefits began Amount of benefits: Weekly	No Date benefit? Date benefit Semi-Monthly Description over Address	Quarter Worked WRING THE FOLLOWING	Earnings for the second	or Quarter
PLEASE SUPPLY THE FOLLOWING INFORMATION Has a claim been filed? YES NO Claim No Are benefits currently being paid? YES NO Date benefits began Amount of benefits: Weekly Solution S	No Date benefit? Date benefit Semi-Monthly Description over Address	its end(ed) Monthl Quarter Worked CHAPTER FOLLOWING	Earnings for the second	or Quarter
PLEASE SUPPLY THE FOLLOWING INFORMATION Has a claim been filed? YES NO Claim No Are benefits currently being paid? YES NO Date benefits began Amount of benefits: Weekly Solution S	No Date benefit? Date benefits Semi-Monthly BENEFITS PAID DUCA Insurance	Cits end(ed) Monthl Quarter Worked VRING THE FOLLOWIN Overpayment T = = =	Earnings for the second	or Quarter

(Date)

(Authorized Signature of Benefit Agency)

(Case Manager's Signature)

(Telephone)