



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 _____

CASH CONTRIBUTION VERIFICATION

_____ has applied for assistance. In order to process the application, all income and insurance coverage must be verified. Please complete and return the information requested below to the address above. Your cooperation is appreciated.

1. Did you, or do you plan to, contribute any money directly to the above person during the months listed below?

YES NO

A. Please specify how much you gave, or plan to give, this person during the following months. **(Please provide receipts. They will be copied and returned to you.)**

	Actual Amount Paid	Expect to Pay
MM/YYYY _____	\$ _____	\$ _____
MM/YYYY _____	\$ _____	\$ _____
MM/YYYY _____	\$ _____	\$ _____

B. Does this person have to pay the money back to you? YES NO

C. Do you plan to continue giving this person money? YES NO

2. Do you supply medical and/or dental insurance for _____ ?

YES NO If YES, please complete the following information and furnish this Agency with a signed insurance claim form.

Name, address and phone number of insurance company _____

Policy Number _____ Date Issued _____

Policy Holder _____ Social Security Number _____

Signature _____ Print Name _____ Title/Relationship _____ Date _____ Telephone Number _____

Address _____

