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

Date: _____

Case Name: _____

SSN: _____

Case Manager: _____

AUTHORIZATION: I authorize you to release to the Division of Welfare and Supportive Services the requested information.

_____
(Client Signature) (Date)

BENEFIT VERIFICATION INQUIRY

The individual referenced below has applied to this agency for assistance. We are requesting information concerning authorized benefits that are being or have been received by our client.

Please provide the information below and return this form in the enclosed envelope. Your cooperation will help insure integrity and maintain accountability in the administration of public funds in Nevada. The information provided will be used only in conjunction with the official duties of this department and will be considered confidential.

If our identifying information (name and Social Security Number) does not agree with your records, please indicate the change.

RE: _____ _____
(Name) (Social Security Number)

PLEASE SUPPLY THE FOLLOWING INFORMATION:

Has a claim been filed? ☐ YES ☐ NO Claim No. _____

Are benefits currently being paid? ☐ YES ☐ NO Type of benefit? _____

Date benefits began _____ Date benefits end(ed) _____

Amount of benefits: Weekly _____ Semi-Monthly _____ Monthly _____

Do you show any work history in the month(s) of _____

If so, please complete the following:

Employer Name	Employer Address	Quarter Worked	Earnings for Quarter
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE FURNISH INFORMATION REGARDING BENEFITS PAID DURING THE FOLLOWING PERIOD(S):

Month of	Gross Amount		FIT		FICA		Insurance		Overpayment		Total Net Paid	Date Paid
_____	_____	–	_____	–	_____	–	_____	–	_____	=	_____	_____
_____	_____	–	_____	–	_____	–	_____	–	_____	=	_____	_____
_____	_____	–	_____	–	_____	–	_____	–	_____	=	_____	_____

Will benefit decrease or increase? ☐ YES ☐ NO When? _____
(Month) (Year)

MEDICAL COVERAGE: _____

_____

_____ _____
(Case Manager's Signature) (Date) (Authorized Signature of Benefit Agency) (Telephone)

DISTRIBUTION: WHITE - Benefit Agency; CANARY - Casefile

2339 - EG (1/93)