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

VA BENEFIT 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 to the address above. 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:

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

   Status: ☐ Pending ☐ Approval ☐ Denial ☐ Termination ☐ Reinstatement ☐ Appeal

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

   Date benefits began: _____ Date benefits end: _____

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

Month	Base Amount	Amount of Housebound or Aid and Attendance	Amount of Spouse's Benefit (if included in total paid amount)	Total Paid (Sum of previous 3 columns)	Date Paid

3.	Has the client reported or claimed medical expenses?	☐ YES ☐ NO
4.	In computing the VA benefit payment, was the client's countable income reduced by medical expenses reported?	☐ YES ☐ NO
5.	Has the client applied for Aid and Attendance or Housebound benefits:	☐ YES ☐ NO

COMMENTS:

Signature	Print Name	Title	Date	Telephone Number