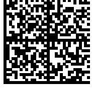
STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF WELFARE AND SUPPORTIVE SERVICES

JOE LOMBARDO
Governor

RICHARD WHITLEY, MS
Director

ROBERT THOMPSON
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

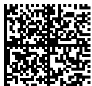
Employee's Address: ______________________

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): undefined

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