



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

BANKING/LOAN ACTIVITY — REQUEST FOR INFORMATION

It is necessary to determine the value and availability of this individual's resources for public assistance and/or SNAP. Please complete the information requested below. **If our information is incorrect or incomplete, please furnish the correct information and return to this office.** Your answers will be treated confidentially.

RE: _____
Name Social Security Number

1. LIST ALL ACTIVE AND INACTIVE ACCOUNTS (including accounts shown on your records that are not listed below):

ACCOUNT NUMBER	TYPE OF ACCOUNT	INDIVIDUAL OR JOINT? IF JOINT, WITH WHOM?	DATE OPENED	LOW BALANCE FOR: USE DOLLAR AMOUNTS ONLY			DATE CLOSED/ AMOUNT WITHDRAWN
				MM/YY	MM/YY	MM/YY	
							\$
							\$
							\$
							\$

2. ARE THE ABOVE FUNDS AVAILABLE TO THIS PERSON FOR WITHDRAWAL? ☐ YES ☐ NO

3. ARE ANY ACCOUNTS INTEREST BEARING OR DIVIDEND PAYING? YES NO

Please list account numbers: _____

4. DOES ACCOUNT REQUIRE MORE THAN ONE SIGNATURE TO WITHDRAW FUNDS: ☐ YES NO

If so, whose? _____
Name(s)

5. DOES THIS PERSON HAVE ANY LOANS? YES NO

Type: _____
Auto, Boat, RV, Signature, etc.

Date of Loan: _____ Current balance owing? \$ _____

List collateral: _____ Are payments current? _____



6. DOES THIS PERSON HAVE A SAFE DEPOSIT BOX? ☐ YES ☐ NO

If any accounts are trust accounts, please return a copy of the trust instrument with this completed form.

Signature	Print Name	Title	Date	Telephone Number
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