



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: _____

CHILD CARE EXPENSE VERIFICATION FORM

The Nevada State Division of Welfare and Supportive Services needs the following information completed and returned to correctly determine eligibility, benefit levels or other services for: _____

Name of babysitter or child care provider: _____

Street _____ City _____ State _____

Zip _____ Telephone Number: (____) _____ - _____

Name of person paying for child care costs: _____

Telephone Number: (____) _____ - _____

Are any portion of child care costs paid or subsidized by an outside agency or individual? ☐ YES ☐ NO

If YES, list who subsidizes and the amount of child care costs paid by the agency or individual:

Name: _____

Telephone Number: (____) _____ - _____ Amount: \$ _____

When is child care paid and what is the amount? (enter amount or amounts in column 1, 2, 3 or 4):

	(1) Weekly (once per week)	(2) Bi-Weekly (every other week)	(3) Monthly (once per month)	(4) Twice Monthly (twice (2) per month)
Client Pays	\$ _____	\$ _____	\$ _____	\$ _____
Other Agency or Individual Pays	\$ _____	\$ _____	\$ _____	\$ _____

Who is child care paid for?

Child's Name	Age	# of hours	Days	Child's Name	Age	# of hours	Days
Child's Name	Age	# of hours	Days	Child's Name	Age	# of hours	Days
Child's Name	Age	# of hours	Days	Child's Name	Age	# of hours	Days

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

