BRIAN SANDOVAL
Governor

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

MIKE WILLDEN
Director

☐ CARSON CITY OFFICE
2533N.Carson St .Ste., #200
Carson City, NV 89706-0240
(775) 684-0800
FAX (775) 684-0844

☐ YERINGTON OFFICE
215 W. Bridge St., #6
Yerington, NV 89447-2544
(775) 463-3028
FAX (775) 463-7735

☐ RENO OFFICE
3697 Kings Row
Reno, NV 89503-1963
(775) 448-5000
FAX (775) 448-5094

☐ PROFESSIONAL DEV. CTR.
680-690 S. Rock Blvd.
Reno, NV 89502-4113
(775) 448-5238
FAX (775) 448-5246

☐ WINNEMUCCA OFFICE
475 W. Haskell St., #6
Winnemucca, NV 89445-6702
(775) 623-6557
FAX (775) 623-6566

☐ **TANF** ☐ **MEDICAID** ☐ **FOOD STAMPS**

Date: _____

Case Name: _____

SSN: _____

Case Manager:_____

AUTHORIZATION: I authorize you to release to the Division of Welfare and Supportive Services the requested information regarding my insurance policy activity.

_____
(Client Signature) (Date)

INSURANCE POLICY INFORMATION

RE: Client's Name: _____ Birthdate: _____ SS No.: _____

Policy in Name of: _____ Relationship to Client: _____

Other information which may help identify policy: _____

It is necessary to determine the value and availability of this person's resources for public assistance. Our records indicate this person may be insured under a policy with your company. Please provide the information 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 and birthdate) does not agree with your records, please indicate the change.

☐ This company has no record of the above-named person.

☐ This person is no longer insured. Termination date of coverage: _____ Were funds paid directly to the client as a result of the termination? ☐ YES ☐ NO If YES, amount $_____, date paid _____

☐ This person is currently insured.

Dependents covered by this insurance: _____

Date Insured: _____ Policy No.: _____ Type of Insurance: _____

Face Value: $_____ Actual cash value (after loan or lien amounts have been deducted): $ _____

Dividends Received: $_____ Date Received: _____

Due date for next payment: _____ Date of last payment: _____

Who is the owner of this policy? _____

Who would receive the money should this policy be surrendered? _____

Are claims for medical insurance ever paid directly to our client? ☐ YES ☐ NO If YES, dates and amounts of payments made to our client during the month(s) of: _____

Is this a Qualified Long Term Care Partnership Policy? ☐ YES ☐ NO

If yes, what is the total amount of LTC benefits paid as of: _____ $_____

_____ _____ _____
(Signature of Representative) (Title) (Date)

DISTRIBUTION: WHITE - Insurance Company; CANARY - Suspense File