Joe Lombardo
*Governor*

Laura Rich
*Interim Director*

# DEPARTMENT OF HUMAN SERVICES

DIVISION OF SOCIAL SERVICES

*Helping people. It's who we are and what we do.*

Robert H. Thompson
*Administrator*

☐ TANF ☐ MEDICAID ☐ SNAP

Date: _____

Case Name: _____

Case ID: _____

## CHILD CARE EXPENSE VERIFICATION FORM

The Nevada State Division of Social 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 |
|---|---|---|---|---|---|---|---|
| | / / | / | | | / / | / | |
| | / / | / | | | / / | / | |
| | / / | / | | | / / | / | |

Signature Print Name Title/Relationship Date Telephone Number