

Joe Lombardo  
Governor

Laura Rich  
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: \_\_\_\_\_

**AUTHORIZATION:** I authorize you to release to the Division of Welfare and Supportive Services the requested information.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

### CASH CONTRIBUTION VERIFICATION

\_\_\_\_\_ has applied for assistance. In order to process the application, all income and insurance coverage must be verified. Please complete and return the information requested below to the address above. Your cooperation is appreciated.

1. Did you, or do you plan to, contribute any money directly to the above person during the months listed below?

YES  NO

A. Please specify how much you gave, or plan to give, this person during the following months. **(Please provide receipts. They will be copied and returned to you.)**

	Actual Amount Paid	Expect to Pay
MM/YYYY _____	\$ _____	\$ _____
MM/YYYY _____	\$ _____	\$ _____
MM/YYYY _____	\$ _____	\$ _____

B. Does this person have to pay the money back to you?  YES  NO

C. Do you plan to continue giving this person money?  YES  NO

2. Do you supply medical and/or dental insurance for \_\_\_\_\_ ?

YES  NO If YES, please complete the following information and furnish this Agency with a signed insurance claim form.

Name, address and phone number of insurance company \_\_\_\_\_

Policy Number \_\_\_\_\_ Date Issued \_\_\_\_\_

Policy Holder \_\_\_\_\_ Social Security Number \_\_\_\_\_

Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Title/Relationship \_\_\_\_\_ Date \_\_\_\_\_ Telephone Number \_\_\_\_\_

Address \_\_\_\_\_

