STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPENDENT SUPPORT FORM

Date _____

Name of Applicant _____

Address of Applicant _____

Date of Birth: _____

If applicant has no means of support please indicate the current living arrangement:

- ☐ Permanent House Guest
- ☐ Temporary House Guest
- ☐ Guest in a Rental Home (no fee)
- ☐ Transitional Housing (no fee)
- ☐ Cash Assistance
- ☐ Other: _____

The person providing support for the above applicant certifies the following:

I, _____, hereby affirm, under penalty of perjury, that I have been the sole support of the person named above and to the best of my knowledge declare that his person has no other primary means of support.

I have provided support (cash or room and board) since: _____

Provider's name (please print): _____

Relation to applicant: _____

Address (if different than above): _____

Telephone number: _____

Provider's signature: _____