# *State of Nevada*
# *Victims of Crime Program*

*Use this form to authorize the Employer to verify wage loss information when applicant is requesting lost wage reimbursement.*

| Victim/Applicant Name: | VOCP Claim # |
|---|---|
| | |

## Employer Information:

| Employers Name: | Phone # | Fax # |
|---|---|---|
| | | |

| Employers Mailing Address: | City, State, Zip: |
|---|---|
| | |

## Applicants Statement of Hours and Wage Loss Information:

| Number of Hours Worked: | Amount Paid Per Pay Period: | Amount of work lost due to crime: |
|---|---|---|
| ☐ Full Time<br>☐ Part Time<br>☐ Piece Work<br>☐ Other: | $ _____<br>☐ Hourly<br>☐ Weekly<br>☐ Bi-Weekly<br>☐ Monthly<br>☐ Other: | _____<br>Total Lost Wages Sought from VOCP:<br>$ _____ |

## Authorization for Release of Employment and Wage Information

I have applied for reimbursement of lost wages from the Nevada Victim of Crime Program (VOCP). In order to assist the VOCP to determine my eligibility for assistance I hereby consent to and authorize the release of information to the VOCP.

**Employment Information: I hereby authorize my current or former employer to release any and all information concerning my employment status, including my wages, benefits, insurance, lost time or other information to the VOCP. (NRS 217.200).**

*Penalties for Providing False Information: It is a violation of Nevada law to provide false or misleading, or intentionally incomplete information to the VOCP. (NRS 217.270)*

| Applicant Signature: | Print Name: | Date: |
|---|---|---|
| | | |
| Telephone # | Email address: | |

| *Mail to:* | *Fax to:* | *Scan and email to:* |
|---|---|---|
| VOCP<br>6171 W. Charleston Blvd., Bldg. 9<br>Las Vegas, NV 86146 | (702) 486-2825 | vocp@dcfs.nv.gov |