FOR OFFICE USE ONLY

Application No:_____ Client ID_____ Prescreened by:_____

WASHOE COUNTY DEPARTMENT OF SOCIAL SERVICES
APPLICATION FOR ASSISTANCE - ADULT SERVICES
(PLEASE PRINT)

Today's Date:_____ Referred By:_____

IDENTIFICATION

List the Adult Male and the Adult Female whether you are married or not. Then list all other members under 18 years old in the household and explain the relationship, i.e. child, step child, grandchild, etc. Include sponsors and their family regardless of whether they live with the person requesting assistance. Attach additional sheet if necessary.

Name (Last, First, Middle) Include Jr., Sr., III if applicable	Marital Status	Relationship to You	Sex M/F	Date of Birth	City, State & Country of Birth	U.S. Citizen Y/N	Social Security Number
1.		Self					
2.							
3.							
4.							
5.							
6.							

Alien Registration number(s) for all non-citizen household members: _____

OTHER NAMES USED: (Maiden, previous marriage, AKA's, etc.) _____

Person(s) needing assistance? _____

Home Address	City	State	Zip	Telephone
Mailing Address	City	State	Zip	Msg Phone
Emergency Contact Name	Relationship		Telephone	
Nearest Relative Name and Phone Number				

List the name(s) of your spouse and/or minor children not living with you: _____
Date of Separation:_____

Are you registered under the Nevada Domestic Partnership Law? Yes No

Have you ever served in the military? Yes No

If yes, Branch , Dates of Service and type of discharge:_____

Are you a registered member of a Native American tribe? Yes No

If yes, which tribe:_____

MEDICAL

Have you incurred any hospital bills in the past three months that you would like assistance with?_____
If **yes**, what months are you requesting assistance for?_____
Have you or any member of your family been a patient in the last twelve months at any of the following hospitals or clinics? If yes, please **circle the facility.**

Renown Regional Medical Center Saint Mary's N Nevada Medical Center NV Mental Health
Healthcare Center St. Mary's Clinic HAWC VA Clinic Renown South Meadows

Date(s) of Service / Pt. ID : _____ _____
_____ _____
_____ _____

Have you been transported by Ambulance is the last three months? Yes No Date(s) of Service:_____

Are you pregnant? Yes No If yes, due date? _____

Do you have any major medical problems? Yes No
If yes, please describe: _____

RESIDENCE

Are you a resident of Nevada? Yes No How long have you resided in Washoe County?_____

Reason for moving to Washoe County? Employment Family Born Here Medical Reasons Court Ordered/Parole Liked the area Other:_____

What City and State did you move from? _____

Do you have a felony conviction? Yes No Do you have any outstanding warrants? Yes No
If yes, type and dates of conviction(s): _____

PRIOR RESOURCES

Have you or anyone listed on the application applied for or received any of the following? *(Circle all that apply)*

TANF/FMC MEDICAID MEDICARE MEDI-CAL INDIAN HEALTH

SOCIAL SECURITY PRIVATE INSURANCE WORKMANS' COMP VA MEDICAL

Has anyone listed on the application had medical insurance within the last 12 months? Yes No
If yes, Name of insurance Company and Date ended:_____

EMPLOYMENT INFORMATION

Please list employment history for the previous **twelve (12) months** beginning with current or last employer for yourself, spouse & minor children . Include information about self employment and odd jobs.

Name of Person Working	Employment Dates MM/YY	Employer's Name, Address & Phone Number	Job Title	Rate of pay & hours per wk
	Start: End:			
	Start: End:			
	Start: End:			
	Start: End:			
	Start: End:			
	Start: End:			

INCOME

Have you or anyone listed on this application applied for or received the following income in the previous six months?

Benefit	Name of Person Applying/Receiving Benefit	Date Applied /Received	Monthly Amount
Alimony			
Baby-sitting Income			
Benefits from another State			
Child Support			
Educational Financial Aid			
General Assistance			
Gifts/Gratuity			
Litigation/Settlement/Lump Sums			
Loans			
Military allotment			
Pan handling			
Pension			
Plasma sales / can recycling			
Railroad Retirement			
Social Security/SSI/SSD			
TANF/Food Stamps			
Tax Refunds			
Tips			
Unemployment benefits			
Veteran's Benefits/Widows			
Wages			
Worker's Compensation/EICON			
Other (Explain)			

RESOURCES

Please indicate which resources you or anyone listed on the application own or have in their name.

TYPE OF RESOURCE	Name of Owner	BANK/COMPANY NAME	ACCOUNT NUMBER	BALANCE / VALUE
Checking Account				
Savings/Credit Union				
Stocks/Bonds/CD's				
IRA/401K/Trust Accounts				
Investment Accounts				
Automobile(s) Make & Year		1.	Registered? Y N	
		2.	Registered? Y N	
Recreational Vehicle(s)				
Livestock (type)				
Own/Buying Residence				
Own/Buying Other Real Estate				
Life Insurance Policy				
Funeral Plan				

Do you currently have a home up for sale or in the foreclosure process? **YES** **NO**

If yes, when & where _____

Have you or anyone listed on the application sold, transferred or given away property in the last 60 months? **YES** **NO**

If yes, what _____ Value $_____ Date_____

Do you currently own a vehicle that has been repossessed? **YES** **NO**

Are you currently enrolled in or attending college? **YES** **NO**

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Client
Name:_____
SSN: _____
DOB: _____

Spouse
Name:_____
SSN: _____
DOB: _____

STATEMENT OF APPLICANT

To the best of my knowledge, and under the penalties of perjury, I declare that all information provided by me is true and correct. I will not sell, trade, willfully misuse or destroy any supplies / services given to me. I will notify Washoe County Department Social Services (WCDSS) whenever there is any change in my circumstances that might affect my eligibility for assistance or my eligibility for services may terminate. I understand that I am responsible to reapply for assistance when my eligibility expires if I require medical assistance.

I hereby authorize WCDSS to make any investigation concerning me or other members of my household / service unit which is necessary to determine eligibility for any benefits I have or will receive under programs administered by WCDSS.

RELEASE OF INFORMATION

I hereby authorize and consent to the release of any and all information concerning me and my household/service unit members to WCDSS by the holder of the information, regardless of the manner or form held, including, without limitation, information considered to be confidential by law or otherwise. I also authorize WCDSS to give any other governmental agency (local, state, or federal) information necessary to determine my/our eligibility for assistance from either WCDSS or the other governmental agency. I hereby release the holder of such information from liability, if any, resulting from the disclosure of the required information. A REPRODUCED COPY OF THIS AUTHORIZATION LEGALLY CONSTITUTES AN ORIGINAL COPY.

Applicant / Guardian Signature _____ Date _____

Co-Applicant / Spouse / Guardian Signature _____ Date _____

FOR HOSPITAL USE ONLY:	Date	Form completed by:
	Telephone #	
Comments:		