Clark County Social Service Senior Services Referral

Office Use Only
Date Received:
Received By:
Assigned Worker:
Application #:
Reference #:
IC Case #:

O Adult Daycare

O Homemaker Home Health Aide Services (HHHA)

O Alternative Health Care Program (AHC) – **ONLY** if applicant had in-patient stay within the last 30 days.

* If AHC - Please attach **DISCHARGE SUMMARY** & provide the following details:

Name of Institution/Hospital:	Admission Date:	Discharge Date:

Incomplete Information will delay processing

NAME:	SS#	D.O.B
SPOUSE:	SS#Able & willing to receive texts?	D.O.B.

CELL PHONE: ______ ALTERNATE PHONE: _____

ADDRESS, CITY, STATE, ZIP_____

EMAIL ADDRESS:

GROSS INCOME			ASSETS
INCOME SOURCE:	APPLICANT	SPOUSE	(Bank account balances, Life insurance cash surrender value, etc)
	\$	\$	
	\$	\$	
TOTAL HOUSEHOLD	\$	•	\$

INSURANCE INFORMATION (mark all that apply): () Medicaid () Medicare () Other: _____

MEDICAL/HEALTH CONCERNS:

ASSISTANCE REQUESTED:	O Personal Care	O Medication Pick up	() Meal Prep		
	◯ Laundry	O Grocery Shopping	O Light Cleaning		
ADDITIONAL INFORMATION:					
REFERRED BY:	PHONE:				
RELATIONSHIP TO APPLICANT:					