Clark County Social Service
Long Term Care Placement Request

Please completely fill out the attached application, including the first section. If a section does not apply, please mark N/A.

Gather and copy all verifications that apply as listed on Page 6 of the application.

Return application and verifications to:

Clark County Social Service
Long Term Care/Homemaker Services
1600 Pinto Lane
Las Vegas, NV 89106
Fax: 702-455-8682

You may mail the application and verifications, or bring them in person and leave them with the receptionist. A social worker ***will not*** be available at this time to go through the application or answer your questions. Bringing the paperwork in person only saves the time in mailing.

If you have ***any*** questions while you are filling out the application, please call 455-8687.

Clark County Social Service
Long Term Care Placement Request

OFFICE USE ONLY
Date Received: _____/____/___
Assigned Worker:_____
PIN:_____
Case #:_____

Please complete the entire application. Leave no space blank; if a section does not apply, please mark N/A.

Date of Request: ___/___/_____
Submitted By: _____
Relationship/Agency:_____
Phone: (_____) _____-_____ Fax #: (_____) _____ - _____
Date Patient Admitted to Hospital or Long Term Care Facility: ___/___/_____
Date Acute Care No Longer Required: ___/___/____
Potential Discharge Date: ___/___/_____
Nevada State Welfare Level of Care Assessment_____
Medical Problems/Reason for Placement: _____
Person to Contact for Appointment:_____
Address: _____ Phone: (_____) - _____ - _____

PLEASE SELECT ONE:
Nursing Home ☐
Adult Group Care ☐

Date:____/____/____

Long Term Care Patient Information M☐ F☐

Name: _____ Maiden Name/AKA's:_____

SSN: _____-_____-_____ DOB: _____/_____/_____ Ethnicity: ☐Hispanic ☐Non – Hispanic ☐Not - Chosen

Race: ☐American Indian / Alaskan Native ☐Asian ☐Black / African American
☐Observed Hispanic or Latino ☐White ☐Native Hawaiian / Other Pac. Islander

Medicare #: _____ Part A Effective Date: ___/___/___ Part B Effective Date: ___/___/____

Birthplace: _____ If Foreign Born, Alien Status:_____ _____Marital

Status: Date: ___/___/___ Single☐ Married☐ Separated☐ Divorced☐ Widowed☐

Military Branch: _____ Serial #: _____ From: ___/___/___ To ___/___/____

Service Connected Disability: Yes☐ No☐ _____% Disability

Current Address: _____ Zip Code:_____

Mailing Address: _____ Zip Code:_____

Telephone #: (_____) _____-_____ Message #: (_____) _____-_____

Spouse Information (Complete whether person is living, divorce, or deceased) M☐ F☐

Name: _____ Maiden Name/AKA's: _____

SSN: _____-_____-_____ DOB: _____/_____/_____ Ethnicity: ☐Hispanic ☐Non – Hispanic ☐Not - Chosen

Race: ☐American Indian / Alaskan Native ☐Asian ☐Black / African American
☐Observed Hispanic or Latino ☐White ☐Native Hawaiian / Other Pac. Islander

Medicare #: _____ Part A Effective Date: ___/___/___ Part B Effective Date: ___/___/____

Birthplace: _____ If Foreign Born, Alien Status:_____

Military Branch: _____ Serial #: _____ From: ___/___/___ To ___/___/____

Service Connected Disability: Yes☐ No☐ _____% Disability

Current Address: _____ Zip Code: _____

Mailing Address: _____ Zip Code: _____

Telephone #: (_____) _____-_____ Message #: (_____) _____-_____

Others Residing in Household (Be Specific: Son, Daughter, Cousin, Ex-Wife, Friend, Etc.)

Name	Sex	DOB	SSN	Relationship to HH

Household Income (List **All** Monies Received by **Long Term Care Patient, Spouse, and Any Dependent Minor Children,** Such as Employment, Unemployment Benefits, Pension, Social Security, VA, ADC, SIIS, Child Support, Etc.)

Household Member	Source	Amount	Award Date/ Per Week/Mo.	Claim #

Total Household Income:$ _____

Household Expenses Actually Paid per Month

Expense	Amount	Expense	Amount
Rent ☐ Mortgage ☐		Child Support	
Prescriptions, RX Med Supplies		Child Care to Non-Relative	
Medical Insurance		IRS, Court Fines, Retribution	
Doctor/Dentist/Med Bill Payment		Other:	

Total Household Actual Monthly Expenses: $ _____

PRIOR RESOURCES

Medical Insurance Co: _____Payment per Month: $_____

If None, Reason: _____

Other Resources: I/We Have Applied for the Following Resource _____(SSI, SSA, VA, ADC, SIIS, Other) on ____/____/____ (Date). I/We Plan to Apply on ____/____/____ (Date).

Lawsuits: Specify Any Currently Pending Suits for Automobile or Other Accidents, Business, Etc.:

_____

Attorney's Name and Address: _____

I/We Have Filed for Bankruptcy: No ☐ Yes ☐ I/We Plan to File ☐ Date: ____/____/____

Attorney's Name and Address: _____

Assets	Yes	No	Cash & Face Value/Balance	Company/ Location	Account/ Policy No.
Cash on Hand	☐	☐	$		
LTC Client Trust Acct.	☐	☐	$		
Checking Account	☐	☐	$		
Savings Account	☐	☐	$		
Savings Certificate	☐	☐	$		
Safe deposit box contents	☐	☐	$		
Life Insurance(s)	☐	☐	$		
Burial Insurance	☐	☐	$		
Stocks/Bonds	☐	☐	$		
Residential Real Estate	☐	☐	$		
Non-Residential Real Estate	☐	☐	$		
Trusts/Deeds/Notes Payable	☐	☐	$		
Trust Fund/IRA/Keough/Other	☐	☐	$		
Vehicle(s)	☐	☐	$		
Livestock	☐	☐	$		
Machinery/Equipment	☐	☐	$		

Beneficiary: _____

I/We Have Sold, Given Away or Transferred Ownership in Land, Money, Deeds of Trust, Other Assets to Someone in the Last 36 Months. No ☐ Yes ☐ If Yes, Provide Details:

Item: _____ Transferred to: _____

Relationship to Me/Us: _____

On Open Market? No ☐ Yes ☐ Date: ____/____/____ Real Value: $ _____

I/We Have Received a Lump Sum of Money Within the Last 36 Months: No ☐ Yes ☐

Amount: $_____ Date: ____/____/____ Source: _____

FAMILY HISTORY

Residence Last 3 Years

Street Address	City/State/Zip	Dates From	To

How Long Has Patient Been a Resident of Clark County? _____

Employment --- Long Term Care Patient, Last 3 Years

Employer & Address	Position	From	To	Reason for Leaving

Union Membership, Past or Present. Local: _____

Employment --- Spouse, Last 3 Years

Employer & Address	Position	From	To	Reason for Leaving

Union Membership, Past or Present. Local: _____

Relatives (List Parents, Brothers, Sisters, Adult Children)

Name	Relationship	Address	Telephone

Statement of Patient and Spouse:

I/We Hereby Declare That I/We Do ☐ Do Not ☐ Have Any Relatives Who Can Provide Financial Aid.

If Yes, Please Name: _____

I/We do hereby expressly and forever waive and release, indemnify and hold harmless, Clark County and all of their respective officers, employees, agents, or representatives from any and all claims, demands, rights, damages, actions, attorneys' fees, costs, expenses, and compensation, known or unforeseen, for personal injuries or damages sustained, incurred, arising from, or connected in any way, with my/our placement in a long-term care facility (nursing home, adult group care, or adult day care) by Clark County Social Service.

To the best of my/our knowledge and under penalty of perjury, I/we declare that all information supplied in this application is true and correct. Clark County Social Service is hereby authorized to make any reasonable inquiries in order to establish my/our eligibility.

NOTE: Both patient and spouse or representative must sign. Application not valid without signature.

X_____ _____

Patient/Parent/Guardian/Representative Date

X_____ _____

Spouse Date

X_____

Institution Worker

Person Completing Application: Relationship to Patient:

_____ _____

Please list reason placement is necessary (include mental health and/or behavioral concerns, social support availability, specific equipment/assistance needed, etc.):

Name of person completing form | Name of Agency (if applicable) | Date

Notice to Patient or Representative: This packet is a request by the patient and institution to determine the patient's household eligibility for medical institutional care. It must be completed accurately and in specific detail as well as signed by the **patient and spouse or representative** and the institution worker. The family is required to attest to the truthfulness of its contents.

In order to determine eligibility, the following information must be provided with referral. It will help the application process if **copies** of the following items are submitted with the completed packet:

1. Identification for patient (or parent/guardian) and spouse. Must include a Social Security Number, and proof of citizenship or alien status if foreign born.

2. Identification for all related household members. Proof of citizenship or alien status if foreign born.

3. Verification of shelter expense (rent receipt, house payment coupons, etc.).

4. Verification of **all** sources of monies received by household (copies of checks or award letters are acceptable).

5. Copies of medical insurance policies, and proof of cash/loan amount for life and burial policies.

6. Bank accounts: Last **three** monthly activity statements. For ongoing Long Term Care patients, a copy of bank statement is required for **each month** County assistance is required.

7. Verification of application to other resources: Pending slips, denial notices and documents from all sources, such as AFDC, SSI/SSD.

8. Copies of registrations and verification of ownership of all vehicles, including autos, trucks, trailers, campers, motor homes, motorcycles, dune buggies, boats, etc., licensed or unlicensed, regardless of location (not necessary if household has only one vehicle declared to be their essential vehicle).

9. Written documents pertaining to sale or transfer of assets, money or other property which occurred within the last 36 months.

10. Safe deposit box(es): provide location(s), signatories and list of contents.

11. Level of Care Assessment (NSW PASARR).

12. History and Physical (H&P)

13. All applicants are required to have a Chest X-Ray prior to admission.

A letter may be sent to advise the patient, institution or representative to contact a designated County caseworker to provide further information, if required. **It may be necessary for the patient, spouse or representative to be interviewed by Clark County Social Service.**

Failure to cooperate or provide information may result in denial of assistance.

A notice of decision of the patient's eligibility will be provided to the institution and the patient or representative.

SIGNED: _____ _____

Patient or Representative Witness (Institution Worker)

Department of Social Service

1600 Pinto Lane • Las Vegas NV 89106-4309
(702) 455-4270 • Fax (702) 455-5950

Jamie Sorenson, Director

Margaret LeBlanc, Deputy Director, Randy Reinoso, Deputy Director• Teresa Etcheberry Deputy Director

AUTHORIZATION FOR LEVEL OF CARE ASSESSMENT

I, _____, hereby authorize Clark County Social Service to obtain medical, social and/or psychiatric information concerning me.

I hereby authorize Clark County Social Service to obtain information as needed regarding my daily physical functioning ability and physical condition. I understand this information will be used to determine the level of care required prior to/and during admission to an adult group care or long term care facility through on-going audit procedure.

This authorization is valid for the period I am eligible to receive Clark County assistance. A photocopy of this authorization is considered the same as the original.

_____ ___/____/_____
Signature of Applicant/Recipient Date

_____ _____
Legal Guardian Witness

_____
Witness

Department of Social Service

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RELEASE OF INFORMATION

To the best of my knowledge and under penalty of perjury, I declare that all information provided by me is true and correct. I will not sell, trade, or willfully destroy any supplies or services given to me. I will notify Clark County Social Service (CCSS) whenever there is any change in my circumstances that might affect my eligibility for assistance.

I hereby authorize Clark County Social Service 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 Clark County Social Service. I hereby authorize and consent to the release of any and all information concerning me and my household/service unit members to Clark County Social Service by the holder of the information, regardless of the manner or form held, including, without limitation, information made confidential by law or otherwise and patient information privileged under N.R.S. 49.225 or any other provision of the law or otherwise. I also authorize CCSS to give any other governmental agency (local, state, or federal) information necessary to determine my (our) eligibility for your program or the other agency's program. 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.**

_____ _____

Signature/Date Signature/Date

_____ _____

Signature/Date Signature/Date

SS-9105 Release of Information

Department of Social Service

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Authorization for Release of Information To Other Agencies/Resources

I hereby authorize Clark County Social Service to disclose information regarding my physical, psychological, social, financial circumstances and/or any other necessary information to any agencies, organization or facility in order to determine the need and eligibility for appropriate long term care services and payment sources.

This authorization is valid for the period my case is active for CCSS services. A photocopy of this authorization is considered the same as the original.

_____ ____/____/____
Name Date

____/____/____ _____
Date of Birth Signature of Applicant or Recipient

_____-_____-_____ _____
SSN Signature of Applicant or Recipient

_____
Clark County Social Service Worker

SS-6113

Department of Social Service

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Jamie Sorenson, Director

Margaret LeBlanc, Deputy Director, Randy Reinoso, Deputy Director• Teresa Etcheberry Deputy Director

Authorization for Release of Information

I, _____, give full authorization to:

Name: _____

Address: _____

Telephone:_____

to provide verbal and/or written information regarding my physical, psychological, social and/or financial status to:

Clark County Social Service

1600 Pinto Lane

Las Vegas, NV 89106

for the purpose of_____. This consent is valid for one year from the date of signature unless otherwise stated. I understand that I may revoke this consent, in writing, at any time, except to the extent that action has been taken in reliance on the consent.

A photocopy of this authorization is considered the same as the original.

Client Name: _____

Address: _____

Telephone: _____

_____
Client Signature

_____
Date