

Pahrump Office
 Marilyn Gallivan Complex
 1981 E. Calvada Blvd. North
 Suite 120
 Pahrump, NV 89048
 Phone: (775) 751-7095
 Fax: (775) 751-4284



**Health and Human Services
 Director - Karyn Smith**

Tonopah Office
 Nye County Courthouse
 101 Radar Road
 Post Office Box 926
 Tonopah, NV 89049
 Phone: (775) 482-8125
 Fax: (775) 482-7261

APPLICATION FOR ASSISTANCE

A. TYPE OF ASSISTANCE REQUESTED:

| | | | | |
|---|---|---|---|-------------------|
| <input type="checkbox"/> Food | <input type="checkbox"/> Employment Incentive | <input type="checkbox"/> Dental | <input type="checkbox"/> Rent (first or last mo.) \$ _____ | # Bedrooms: _____ |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Child Care | <input type="checkbox"/> Prescriptions | <input type="checkbox"/> Deposit (Rent/Electric/Water/Propane) \$ _____ | |
| <input type="checkbox"/> Utilities \$ _____ | <input type="checkbox"/> Burial/Cremation | <input type="checkbox"/> Ryan White - EFA | <input type="checkbox"/> Other: _____ | |

B1. APPLICANT/HOUSEHOLD INFORMATION: (please print clearly)

| <i>For Office Use *Only*</i> | Household Member Name Last, First, Middle Initial | Relationship TO Head of Household | Marital Status *See Below* | Gender Identity *See Below* | Sexual Orient. *See Below* | Age | Date of Birth | Social Security Number | Disabled Y/N | Veteran Y/N | US Citizen Y/N | Ethnicity *See Below* | Race *See Below* |
|----------------------------------|--|---|-------------------------------------|--------------------------------------|-------------------------------------|-----|---------------|------------------------|-----------------|----------------|-------------------|-----------------------------|------------------------|
| | | SELF | | | | | | | | | | | |
| | | | | | | | | | | | | | |
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| | | | | | | | | | | | | | |

Are there additional people in your home not listed here? (check one) Yes No If "YES," please ask a staff member for an additional household member information sheet.

*Marital Status: S - Single M - Married D - Divorced IR - In Relationship CU - Civil Union CL - Common Law W - Widowed Sep - Separated
 *Gender Identity: F - Female M - Male MTF - Trans Female (Male to Female) FTM - Trans Male (Female to Male) GNC - Gender Non-Conforming O - Other X - Refused
 *Sexual Orientation: H - Heterosexual G - Gay L - Lesbian B - Bisexual Q - Questioning/Unsure O - Other X - Refused
 *Ethnicity: H - Hispanic N - Non-Hispanic O - Other/Unknown
 *Race: W - Caucasian/White AA - African American/Black A - Asian AI - American Indian/Alaska Native PI - Pacific Islander/Native Hawaiian MR - Multi Race (one or more) O - Other/Unknown

C. HOUSING INFORMATION:

| | | | | | | | | | |
|--|--|---|-------------------------|---|---|---|-------|--------|------|
| Home Address: | | City: | State: | Zip: | Mailing Address: | | City: | State: | Zip: |
| Primary Phone Number: | | | Secondary Phone Number: | | | Email Address: | | | |
| Length of time at <u>CURRENT</u> residence: Years: Months: Days: | | Have you been a Nevada resident for 2+ years? <input type="checkbox"/> Yes <input type="checkbox"/> No | | How long have you been a resident of Nye County? | | Are you currently homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where did you sleep last night? | | | |
| Have you ever applied for Section 8?: <input type="checkbox"/> Yes <input type="checkbox"/> No | | | If so, when?: | | What City/State?: | | | | |
| Have you/anyone in your household ever been evicted from subsidized housing?: <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | Have you been continually homeless for at least one year?: <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| How many times have you been homeless in the last 3 years?: | | | | | How many months continually homeless prior to today?: | | | | |

D1. ADULT INFORMATION: (Required for each person 18 years or older in household)

1st Adult Household Member's Name:

2nd Adult Household Member's Name:

What school grade did you last complete?

What school grade did you last complete?

Diploma? Yes No GED? Yes No

Diploma? Yes No GED? Yes No

Are you in school or working on a degree? Yes No If yes, what school?

Are you in school or working on a degree? Yes No If yes, what school?

Work Status: (check one) Employed Full-Time Employed Part-Time Migrant Seasonal Farm Worker
 Unemployed (Short-term) Unemployed (Long-term) Unemployed (Not in Labor Force)
 Retired Unknown/Not Reported

Work Status: (check one) Employed Full-Time Employed Part-Time Migrant Seasonal Farm Worker
 Unemployed (Short-term) Unemployed (Long-term) Unemployed (Not in Labor Force)
 Retired Unknown/Not Reported

Health Insurance: (check all that apply) Medicaid Medicare Private Health Insurance
 Nevada Check-Up Direct-Purchase State Children's Health Insurance Program
 State Health Insurance for Adults Military Healthcare (VA) Employment Based
 Tribal Insurance No Health Insurance Unknown/Not Reported

Health Insurance: (check all that apply) Medicaid Medicare Private Health Insurance
 Nevada Check-Up Direct-Purchase State Children's Health Insurance Program
 State Health Insurance for Adults Military Healthcare (VA) Employment Based
 Tribal Insurance No Health Insurance Unknown/Not Reported

Check ONE for each category:

Check ONE for each category:

Do you have a disabling condition? Yes No Client doesn't know Client refused
 Do you have a physical disability? Yes No Client doesn't know Client refused
 -Is it long term? Yes No Client doesn't know Client refused
 Do you have a developmental disability? Yes No Client doesn't know Client refused
 Do you have a chronic health condition? Yes No Client doesn't know Client refused
 Do you have HIV/AIDS? Yes No Client doesn't know Client refused
 Do you have a mental health problem? Yes No Client doesn't know Client refused
 Do you have a substance abuse problem? Yes No Client doesn't know Client refused
 Are you a domestic violence victim/survivor? Yes No Client doesn't know Client refused

Do you have a disabling condition? Yes No Client doesn't know Client refused
 Do you have a physical disability? Yes No Client doesn't know Client refused
 -Is it long term? Yes No Client doesn't know Client refused
 Do you have a developmental disability? Yes No Client doesn't know Client refused
 Do you have a chronic health condition? Yes No Client doesn't know Client refused
 Do you have HIV/AIDS? Yes No Client doesn't know Client refused
 Do you have a mental health problem? Yes No Client doesn't know Client refused
 Do you have a substance abuse problem? Yes No Client doesn't know Client refused
 Are you a domestic violence victim/survivor? Yes No Client doesn't know Client refused

Have you been convicted of a misdemeanor or felony? Yes No

Have you been convicted of a misdemeanor or felony? Yes No

Are you required to register? Yes No

Are you required to register? Yes No

Explain conviction and date:

Explain conviction and date:

List last 3 years arrests:

List last 3 years arrests:

* If you have more than 2 adults in household, please ask a staff member for an additional adult information sheet.

E1. CHILD INFORMATION: (Required for each person 17 years or younger in household)

| | |
|---|---|
| 1st Child's Name: | Grade: |
| Are they attending school? <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, what school? |
| If NOT enrolled, what was the last date he/she was enrolled? | |
| Health Insurance: (check all that apply) <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private Health Insurance <input type="checkbox"/> Nevada Check-Up <input type="checkbox"/> Direct-Purchase <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Military Healthcare (VA) <input type="checkbox"/> Employment Based <input type="checkbox"/> Tribal Insurance <input type="checkbox"/> No Health Insurance <input type="checkbox"/> Unknown/Not Reported | |
| Check ONE for each category: | |
| Do you have a disabling condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |
| Do you have a physical disability? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |
| -Is it long term? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |
| Do you have a developmental disability? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |
| Do you have a chronic health condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |
| Do you have HIV/AIDS? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |
| Do you have a mental health problem? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |
| Do you have a substance abuse problem? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |
| Are you a domestic violence victim/survivor? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |

| | |
|---|---|
| 2nd Child's Name: | Grade: |
| Are they attending school? <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, what school? |
| If NOT enrolled, what was the last date he/she was enrolled? | |
| Health Insurance: (check all that apply) <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private Health Insurance <input type="checkbox"/> Nevada Check-Up <input type="checkbox"/> Direct-Purchase <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Military Healthcare (VA) <input type="checkbox"/> Employment Based <input type="checkbox"/> Tribal Insurance <input type="checkbox"/> No Health Insurance <input type="checkbox"/> Unknown/Not Reported | |
| Check ONE for each category: | |
| Do you have a disabling condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |
| Do you have a physical disability? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |
| -Is it long term? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |
| Do you have a developmental disability? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |
| Do you have a chronic health condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |
| Do you have HIV/AIDS? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |
| Do you have a mental health problem? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |
| Do you have a substance abuse problem? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |
| Are you a domestic violence victim/survivor? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |

| | |
|---|---|
| 3rd Child's Name: | Grade: |
| Are they attending school? <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, what school? |
| If NOT enrolled, what was the last date he/she was enrolled? | |
| Health Insurance: (check all that apply) <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private Health Insurance <input type="checkbox"/> Nevada Check-Up <input type="checkbox"/> Direct-Purchase <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Military Healthcare (VA) <input type="checkbox"/> Employment Based <input type="checkbox"/> Tribal Insurance <input type="checkbox"/> No Health Insurance <input type="checkbox"/> Unknown/Not Reported | |
| Check ONE for each category: | |
| Do you have a disabling condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |
| Do you have a physical disability? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |
| -Is it long term? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |
| Do you have a developmental disability? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |
| Do you have a chronic health condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |
| Do you have HIV/AIDS? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |
| Do you have a mental health problem? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |
| Do you have a substance abuse problem? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |
| Are you a domestic violence victim/survivor? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |

| | |
|---|---|
| 4th Child's Name: | Grade: |
| Are they attending school? <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, what school? |
| If NOT enrolled, what was the last date he/she was enrolled? | |
| Health Insurance: (check all that apply) <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Private Health Insurance <input type="checkbox"/> Nevada Check-Up <input type="checkbox"/> Direct-Purchase <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Military Healthcare (VA) <input type="checkbox"/> Employment Based <input type="checkbox"/> Tribal Insurance <input type="checkbox"/> No Health Insurance <input type="checkbox"/> Unknown/Not Reported | |
| Check ONE for each category: | |
| Do you have a disabling condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |
| Do you have a physical disability? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |
| -Is it long term? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |
| Do you have a developmental disability? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |
| Do you have a chronic health condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |
| Do you have HIV/AIDS? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |
| Do you have a mental health problem? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |
| Do you have a substance abuse problem? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |
| Are you a domestic violence victim/survivor? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused |

* If you have more than 4 children in household, please ask a staff member for an additional child information sheet.

F. ASSETS AND RESOURCES:

Do you or anyone in your household have any of the following resources? (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Checking Account (Balance: \$_____) | <input type="checkbox"/> Vehicle(s): Year/Make/Model _____ |
| <input type="checkbox"/> Savings Account (Balance: \$_____) | <input type="checkbox"/> Individual Retirement Accounts (IRA) |
| <input type="checkbox"/> Cash on Hand (Amount: \$_____) | <input type="checkbox"/> Certificates of Deposit (CD) |
| <input type="checkbox"/> Credit Union Account (Balance: \$_____) | <input type="checkbox"/> Other Houses, Land or Buildings |
| <input type="checkbox"/> Savings Bonds | <input type="checkbox"/> Land/Mineral Rights |
| <input type="checkbox"/> Stocks/Bonds (Interest: _____) | <input type="checkbox"/> Burial Funds |
| <input type="checkbox"/> Individual Indian Money Accounts (IIMA) | <input type="checkbox"/> Life Insurance Policies |
| <input type="checkbox"/> Business Checking Account | <input type="checkbox"/> Keogh Accounts (401K) |
| <input type="checkbox"/> Trust Funds | <input type="checkbox"/> Mining Claims |

G. MONTHLY EXPENSES: (only fill out which expenses apply - leave blank if not applicable)

| Type | Monthly Amount | Your Share | Company Name (To Whom Expense is Paid) | Who Else Pays? | Current on Payments? |
|--------------------------|----------------|------------|--|----------------|--|
| Cable/Satellite | \$ | \$ | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Car Payment | \$ | \$ | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Credit Cards | \$ | \$ | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Electricity | \$ | \$ | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Food | \$ | \$ | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Garbage/Trash | \$ | \$ | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gas/Propane/Wood Heating | \$ | \$ | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gasoline Expense | \$ | \$ | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Insurance | \$ | \$ | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Internet Access | \$ | \$ | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Medical Expenses | \$ | \$ | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mortgage/Rent | \$ | \$ | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Space/Lot Rent | \$ | \$ | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Storage | \$ | \$ | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Telephone/Cell | \$ | \$ | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Water/Sewer | \$ | \$ | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other | \$ | \$ | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

H. EARNED INCOME:

Please complete the following for all members living in the home that generate income by employment/self-employment:

| Household Member | Employer | Employment Dates | | Rate of Pay/Frequency | Monthly Income (last 30 days) |
|------------------|----------|-------------------|-----------------|-----------------------|-------------------------------|
| | | Begin MM/DD/YY | End MM/DD/YY | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

I. UNEARNED INCOME: (only fill out which unearned income choices that apply - leave blank if not applicable)

Please complete each item for all members living in home:

| Unearned Income | Do you Receive? | Who Receives? | Who's Applied? | Amount | Frequency |
|--|--|---------------|----------------|--------|-----------|
| Alimony/Spousal Support | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Child Support | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Food Stamps | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Income Grants or Assistance (TANF or Foster Care, etc.) | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Indian General Assistance | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Military Allotment | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Money from Property Rentals/Leases | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Money or Loans from Relatives or Others | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Rent from Boarders/Roomers | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Retirement Pension | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Section 8/HUD Rental Assistance/USDA | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Social Security (Retirement/Survivors) | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Social Security Disability Insurance (SSDI) **See Below | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Supplemental Security Income (SSI) **See Below | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Unemployment Benefits | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Utility Allowance/EAP | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Veterans Benefits - Disability **See Below | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Veterans Benefits - Pension | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Workman's Comp | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Other (please list): | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Non-Banking Income (circle all that apply) | | | | | |
| Payday Loan, pawn, refund anticipation loan, online or yard sales, direct deposit advance, title loan, check-cashing loan, etc.) | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |

**** If you marked YES to receiving SSDI, SSI or Veterans Benefits - Disability, you MUST mark YES for that individual when it asks if they are disabled on pages 2 and 3.**

J1. VETERANS INFORMATION:

There are no Veterans in the household (If there are no Veterans in household, skip to next page)

1st Veteran's Name:

Branch of Service

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> Air Force | <input type="checkbox"/> Navy |
| <input type="checkbox"/> Army | <input type="checkbox"/> Other |
| <input type="checkbox"/> Coast Guard | <input type="checkbox"/> Unknown/Not Reported |
| <input type="checkbox"/> Marines | |

Duration of Active Duty (Months): _____

Served in War Zone:

- Yes
 No
 Unknown/Not Reported

Duration of War Zone Service (Months): _____

Theater/Wars Served In:

- | | |
|---|---|
| <input type="checkbox"/> World War II | <input type="checkbox"/> Afghanistan |
| <input type="checkbox"/> Korean War | <input type="checkbox"/> Iraq (Iraqi Freedom) |
| <input type="checkbox"/> Vietnam War | <input type="checkbox"/> Iraq (New Dawn) |
| <input type="checkbox"/> Persian Gulf War | <input type="checkbox"/> Other Operations |

Discharge Status

- Honorable
 General under Honorable Conditions
 Under other than Honorable Conditions (OTH)
 Bad Conduct
 Dishonorable
 Uncharacterized
 Client doesn't know
 Client refused

2nd Veteran's Name:

Branch of Service

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> Air Force | <input type="checkbox"/> Navy |
| <input type="checkbox"/> Army | <input type="checkbox"/> Other |
| <input type="checkbox"/> Coast Guard | <input type="checkbox"/> Unknown/Not Reported |
| <input type="checkbox"/> Marines | |

Duration of Active Duty (Months): _____

Served in War Zone:

- Yes
 No
 Unknown/Not Reported

Duration of War Zone Service (Months): _____

Theater/Wars Served In:

- | | |
|---|---|
| <input type="checkbox"/> World War II | <input type="checkbox"/> Afghanistan |
| <input type="checkbox"/> Korean War | <input type="checkbox"/> Iraq (Iraqi Freedom) |
| <input type="checkbox"/> Vietnam War | <input type="checkbox"/> Iraq (New Dawn) |
| <input type="checkbox"/> Persian Gulf War | <input type="checkbox"/> Other Operations |

Discharge Status

- Honorable
 General under Honorable Conditions
 Under other than Honorable Conditions (OTH)
 Bad Conduct
 Dishonorable
 Uncharacterized
 Client doesn't know
 Client refused

* If you have more than 2 Veterans in household, please ask a staff member for an additional Veterans information sheet.

Please use the space below to explain the reason why you are requesting services. Be specific as to the reasons and/or situation that caused you to be in a crisis situation:

Empty space for explaining the reason for requesting services.

If Nye County Health & Human Services is able to assist you, please use the space below to explain how you will be able to maintain self-sufficiency after assistance is rendered. Please be specific as to resources and steps you will take to avoid crisis in the future:

Empty space for explaining self-sufficiency after assistance.

**For Office Use ONLY* - RW EFA apps only - Please list programs you attempted to receive assistance for client and write in reason they were not eligible.*

WSA: AHTF: ESG: CSBG:

To the best of my knowledge and under penalty of perjury, I declare that all information provided herein and any other information requested and given is true and correct.

CLIENT'S NAME (please print)

CLIENT'S SIGNATURE

DATE

WORKER'S SIGNATURE

DATE

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 Marilyn Gallivan Complex
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Authorization for Release of Information

Consent - I authorize and direct any federal, state and/or local agency, organization, business and individuals to release to Nye County Health and Human Services or representatives any information or material to complete or verify my applications for participation, and or to maintain my continued assistance under any county program. I authorize Nye County Health and Human Services to communicate, obtain or release any information necessary from the agencies, business or individuals to continue my case. The purpose of the release is to verify the above information or enhance effective case management. This authorization constitutes a full and complete release from any liability.

Information Covered - I understand that, depending on the program and requirements, previous or requested, including but not limited to:

| | |
|---------------|------------------|
| Residency | Background |
| Income | Welfare Benefits |
| Family Status | Medical Records |

Groups and Individuals that May be Asked - The groups or individuals that may be asked to release the above information (depending on program requirements) includes, but not limit to:

| | | | |
|--|---------------------------------------|--|--|
| Previous/Current Landlords | Schools and Colleges | Law Enforcement | Alimony and Child Support Providers |
| Public Housing Authorities (Section 8, USDA, etc.) | Division of Child and Family Services | Utility Companies | Behavioral and Substance Abuse Treatment |
| Past and Present Employers | Courts and Post Offices | Medical and Prescription Providers | State Unemployment Agencies |
| NyE Communities Coalition | Child Care Providers | State/Federal Grant Providers | Other Social Service Providers |
| Family Resource Center/No to Abuse | Veterans Administration | Banks and Other Financial Institutions | Other: |
| Social Security Administration | Retirement Systems | Credit Providers | Other: |

Conditions - I agree that a photocopy of this authorization maybe used for the purpose stated above and will expire one year from the date of signature.

Signature:

| | | | |
|------------------------------|------------|-------------------|-------|
| _____ | _____ | _____ | _____ |
| Head of Household | Print Name | Social Security # | Date |
| _____ | _____ | _____ | _____ |
| Co-Head of Household | Print Name | Social Security # | Date |
| _____ | _____ | _____ | _____ |
| Other Adult Household Member | Print Name | Social Security # | Date |
| _____ | _____ | _____ | _____ |
| Other Adult Household Member | Print Name | Social Security # | Date |

Name: _____

Date: _____

| Assessment | |
|--|---|
| COVID-19 Affected (MARK 1 BOX FOR HOUSEHOLD) | |
| <input type="checkbox"/> | Individual or household member tested negative, recovered from COVID-19, <u>no longer needing services</u> |
| <input type="checkbox"/> | Individual or household member tested negative for COVID-19, <u>not in need of services related to COVID-19</u> |
| <input type="checkbox"/> | Individual or household members have not been impacted, exposed, or tested for COVID-19, are symptom free, <u>no COVID services needed</u> |
| <input type="checkbox"/> | Individual or household member tested positive for COVID-19. <u>Refused services related to COVID-19</u> |
| <input type="checkbox"/> | Individual or household member connected to services for COVID-19, pending approval |
| <input type="checkbox"/> | Individual or household member impacted by COVID-19. (Includes job loss and/or loss of childcare, etc.) |
| <input type="checkbox"/> | Individual or household member exposed to COVID-19. Quarantine required |
| <input type="checkbox"/> | Individual or household member tested positive for COVID-19 |
| Basic Needs - Other Than Rent/Mortgage/Utilities (MARK 1 BOX FOR HOUSEHOLD) | |
| <input type="checkbox"/> | Not in need of basic necessities |
| <input type="checkbox"/> | Situation resolved; no longer in need of basic necessities |
| <input type="checkbox"/> | Situation addressed; receives <u>most</u> basic necessities |
| <input type="checkbox"/> | Situation addressed; receives <u>some</u> basic necessities |
| <input type="checkbox"/> | Urgent situation; in need of basic necessities; can be scheduled |
| <input type="checkbox"/> | Emergent situation; immediate |
| Early Childhood Education (ECE) or Childcare (MARK 1 BOX FOR HOUSEHOLD) | |
| <input type="checkbox"/> | Enrolled in Head Start or ECE |
| <input type="checkbox"/> | Enrolled in unsubsidized licensed childcare of choice |
| <input type="checkbox"/> | Enrolled in licensed subsidized childcare of choice |
| <input type="checkbox"/> | Enrolled in subsidized afterschool program |
| <input type="checkbox"/> | Enrolled in licensed subsidized child care; limited choice |
| <input type="checkbox"/> | Childcare provided by a family member, friend or <u>unlicensed</u> facility |
| <input type="checkbox"/> | Enrolled in Head Start (limited hours/day), need for additional child care |
| <input type="checkbox"/> | <u>At risk of losing</u> childcare benefits. (Needs to reapply to continue benefits) |
| <input type="checkbox"/> | On waiting list for childcare |
| <input type="checkbox"/> | Not enrolled in childcare or in unsafe facility |
| <input type="checkbox"/> | Does not have minor children or grandchildren in need of ECE |

After School, Before School, or Summer Camp Programs (MARK & PUT INITIALS OF EACH CHILD NEXT TO APPROPRIATE BOX)

| | |
|--------------------------|--|
| <input type="checkbox"/> | Attends program on a <u>daily basis</u> |
| <input type="checkbox"/> | Attends program <u>4 days a week</u> |
| <input type="checkbox"/> | Attends program <u>3 days a week</u> |
| <input type="checkbox"/> | Attends program <u>less than 3 days a week</u> |
| <input type="checkbox"/> | At home or in street without adult supervision |
| <input type="checkbox"/> | N/A |

Education – Adults/Youth (MARK & PUT INITIALS OF EACH ADULT (18 YEARS AND OLDER) NEXT TO APPROPRIATE BOX)

| | |
|--------------------------|---|
| <input type="checkbox"/> | Certificate/license from technical/professional training |
| <input type="checkbox"/> | Post-Secondary degree: Associates, Bachelors, Masters or Doctorate degree |
| <input type="checkbox"/> | Post-Secondary degree: Associates, Bachelors, Masters or Doctorate degree and a certificate or license |
| <input type="checkbox"/> | Post high school vocational education, non-college business courses, technical/professional training or college credits |
| <input type="checkbox"/> | High school diploma/GED |
| <input type="checkbox"/> | ESL Certificate |
| <input type="checkbox"/> | Reading/writing/math skills present; possible TABE, <u>no GED/no High School Diploma</u> |
| <input type="checkbox"/> | Reading/writing/basic math skills absent; <u>illiterate</u> |

Employment (MARK & PUT INITIALS OF EACH ADULT (18 YEARS AND OLDER) NEXT TO APPROPRIATE BOX)

| | |
|--------------------------|--|
| <input type="checkbox"/> | FT work <u>above</u> minimum wage <u>with</u> employer provided benefits |
| <input type="checkbox"/> | PT employment (by choice) that supplements (adds to) income needs |
| <input type="checkbox"/> | Retired or Disabled; not in workforce or seeking employment; sufficient income |
| <input type="checkbox"/> | FT work <u>above</u> minimum wage <u>without</u> employer provided benefits |
| <input type="checkbox"/> | FT work <u>at</u> minimum wage <u>with or without</u> employer provided benefits |
| <input type="checkbox"/> | Receiving SSI or SSDI |
| <input type="checkbox"/> | Employed; Currently on FMLA (no pay) |
| <input type="checkbox"/> | PT employment <u>with or without</u> employer provided benefits |
| <input type="checkbox"/> | Unemployed <u>with</u> work history or skills |
| <input type="checkbox"/> | Retired or disabled; not in workforce or seeking employment; insufficient income |
| <input type="checkbox"/> | Unemployed <u>without</u> work history or skills |

| Energy (MARK 1 BOX FOR HOUSEHOLD) | |
|--|---|
| <input type="checkbox"/> | Pay all bills without subsidy |
| <input type="checkbox"/> | Utilities included in Rent |
| <input type="checkbox"/> | Pay all bills with established payment plan |
| <input type="checkbox"/> | Pays all or most bills with subsidy or utility payment made by agency on behalf of client |
| <input type="checkbox"/> | <u>At risk of loss</u> of energy benefits. (Needs to reapply to continue energy benefits) |
| <input type="checkbox"/> | At risk of energy shutoff (notice of shutoff); unable to pay bill(s), needs to apply to obtain benefit |
| <input type="checkbox"/> | Utility shutoff; unable to pay bill(s) |
| <input type="checkbox"/> | Homeless; utilities not applicable |
| Food and Nutrition (MARK 1 BOX FOR HOUSEHOLD) | |
| <input type="checkbox"/> | Able to afford <u>any</u> food without food programs |
| <input type="checkbox"/> | Able to afford <u>most</u> food without food programs |
| <input type="checkbox"/> | Able to afford food by participating in food programs such as SNAP, WIC or other public or private food programs, <u>received additional food support to address food insecurity, achieved stabilization</u> |
| <input type="checkbox"/> | Able to afford food by participating in food programs such as SNAP, WIC or other public or private food programs - <u>NOT experiencing food insecurity</u> |
| <input type="checkbox"/> | Uses food programs such as SNAP, WIC, etc.; <u>is in need of immediate food assistance, experiencing food insecurity</u> |
| <input type="checkbox"/> | <u>At risk of loss</u> of SNAP, WIC or other food programs; (Needs to reapply to continue food benefits) |
| <input type="checkbox"/> | Unable to afford food; uses a food bank, pantry or vouchers |
| <input type="checkbox"/> | Unable to afford or obtain sufficient food |
| Health Insurance – Adults - 18 YEARS AND OLDER (MARK 1 BOX FOR HOUSEHOLD) | |
| <input type="checkbox"/> | <u>All</u> adults have health insurance |
| <input type="checkbox"/> | <u>At risk of loss</u> of health insurance. (Needs to apply or reapply to continue or supplement health insurance) |
| <input type="checkbox"/> | <u>Some</u> adults have health insurance |
| <input type="checkbox"/> | <u>No</u> adults have health insurance |
| Health Insurance – Children - 17 YEARS AND YOUNGER (MARK 1 BOX FOR HOUSEHOLD) | |
| <input type="checkbox"/> | <u>All</u> children have health insurance |
| <input type="checkbox"/> | <u>At risk of loss</u> of health insurance. (Needs to apply or reapply to continue or supplement health insurance) |
| <input type="checkbox"/> | <u>Some</u> children have health insurance |
| <input type="checkbox"/> | <u>No</u> children have health insurance |
| <input type="checkbox"/> | Does not have minor children in home |

Household Budgeting (MARK 1 BOX FOR HOUSEHOLD)

| | |
|--------------------------|--|
| <input type="checkbox"/> | Able to pay all bills; expenses do not exceed income; discretionary funds for spending and savings |
| <input type="checkbox"/> | Able to pay all bills; expenses do not exceed income; discretionary funds for spending |
| <input type="checkbox"/> | Able to pay all bills; expenses do not exceed income |
| <input type="checkbox"/> | Unable to pay some bills; expenses exceed income |
| <input type="checkbox"/> | Unable to pay most bills; expenses exceed income |
| <input type="checkbox"/> | Unable to pay any bills; expenses exceed income |

Housing (MARK ONLY 1 BOX FOR HOUSEHOLD)

| | |
|--------------------------|--|
| <input type="checkbox"/> | Home ownership (includes condo or co-op) |
| <input type="checkbox"/> | Non-subsidized rental housing |
| <input type="checkbox"/> | Employer provided housing |
| <input type="checkbox"/> | Safe and secure subsidized rental apartment |
| <input type="checkbox"/> | Safe and secure subsidized Section 8 housing |
| <input type="checkbox"/> | Living with relatives or friends by choice |
| <input type="checkbox"/> | Safe and secure subsidized public housing |
| <input type="checkbox"/> | At risk of loss of housing. (Needs to reapply to continue housing benefits) |
| <input type="checkbox"/> | Safe and secure transitional housing |
| <input type="checkbox"/> | Safe and secure domestic violence shelter |
| <input type="checkbox"/> | Temporary shelter; hotel, motel or trailer |
| <input type="checkbox"/> | Unaffordable home, subsidized or non-subsidized rental |
| <input type="checkbox"/> | Cannot make rent or mortgage, unexpected situation |
| <input type="checkbox"/> | Home in foreclosure |
| <input type="checkbox"/> | Living with relatives or friends due to crisis |
| <input type="checkbox"/> | Substandard/unsafe housing |
| <input type="checkbox"/> | At risk of eviction |
| <input type="checkbox"/> | Homeless |

Primary Health Care (MARK ONLY 1 BOX FOR HOUSEHOLD)

| | |
|--------------------------|--|
| <input type="checkbox"/> | Access to same provider (medical home) as needed |
| <input type="checkbox"/> | Access to various providers as needed |
| <input type="checkbox"/> | Limited access to providers |
| <input type="checkbox"/> | Emergency Room use only |
| <input type="checkbox"/> | No access due to geographic, transportation or financial constraints |

Transportation (MARK ONLY 1 BOX FOR HOUSEHOLD)

| | |
|--------------------------|---|
| <input type="checkbox"/> | Reliable private transportation/vehicle that meets family needs |
| <input type="checkbox"/> | Public transportation that meets family needs, no assistance needed |
| <input type="checkbox"/> | Private transportation/vehicle available, assistance needed |
| <input type="checkbox"/> | Public transportation available, assistance needed |
| <input type="checkbox"/> | Public or private transportation/vehicle rarely available |
| <input type="checkbox"/> | No public or private transportation |