Storey County Health and Community Service Department

REQUEST FOR SERVICE INSTRUCTIONS

- Please read each page carefully and answer every question. If the answer is “none”, then write in “none”.
- If you are applying for someone other than yourself, check boxes or complete blank spaces as they apply to the person for whom the application is made.
- The Human Services office will verify the answers you give on this form. False information or willful concealment of money, resources or assets will result in denial of your application and could result in prosecution.

REQUIRED DOCUMENTATION

IMPORTANT: PLEASE PROVIDE ALL DOCUMENTS LISTED BELOWIF REQUIRED . DOCUMENTS ARE NOT PROVIDED, YOUR APPLICATION WILL BE RETURNED TO YOU.

Assets (checking, savings, 401k, retirement payments, etc.)

Identification for all household members (driver’s license, state issued I.D. card, birth certificate, etc.)

Proof of residence (rental contract, car registration, utility bill, etc.)

Verification of all monies received within the last 30 days for all household members (pay stubs, SSI, TANF, unemployment, child support, etc.)

Registration for all vehicles (cars, trucks, motorcycles, trailers, RVs, etc.)

Copies of all household bills for the last 30 days (telephone, mortgage, cable, electricity, propane, cell phones, etc.)

Hospital bills

YOU MAY BE REQUESTED TO FURNISH ADDITIONAL INFORMATION UPON REVIEW OF YOUR APPLICATION.

NOTE: Per NRS 218A.100 a “Household” means an association of persons who live in the same home or dwelling and who are related by blood, adoption, marriage, or domestic partnership.

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Request for Service

Please Print

Name:		**DOB :**	
Other Names Used:			
Gender:		**Race/Ethnicity :**	
Physical Address:			
Mailing Address:		**County:**	
City:	**State :**	**Zip Code:**	
Home Phone:		**Cell Phone:**	
Email:		**Head of Household :**	**Yes ☐ No ☐**

What is your preferred method of contact: Phone ☐ Text ☐ Email ☐

May we leave a message regarding your application or services at the number provided? Yes ☐ No ☐

Do you currently have medical insurance: Yes ☐ No ☐ If yes, name provider:

_____

Additional Household Members

Household Member Name	Date of Birth	Gender	Relationship to Head of Household	Race/Ethnicity

Use additional sheets if necessary.

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Please provide a brief explanation of your immediate need(s):

Please check here if you are requesting cremation assistance: ☐	
Decedent's Name:	Date of Birth:
County of Residence:	Meets County Eligibility Requirements: **Yes** ☐ **No** ☐

Please check each type of assistance you or someone in your household is receiving:

Supplemental Nutrition Assistance Program **(**SNAP) ☐ Medicaid ☐ Medicare ☐

Temporary Assistance for Needy Families (TANF) ☐ Kinship Care ☐ Nevada Check-Up ☐

Omenn, Infants and Children Supplemental Program (WIC) ☐

Please check which housing situation best fits your household:

Rent ☐ Own ☐ Homeless ☐ Living with others ☐ Single Family ☐

Multi-Family ☐ Multi-Generational ☐ Other ☐ Describe:

_____

INCOME CALCULATIONS

What is your annual earned income for all household members including self :
(See Attachment A - Earned Income Worksheet)

$ _____

What is your annual unearned income amount for all household members including self:
(See Attachment B - Unearned Income Worksheet)

$ _____

The following questions are voluntary.

Within the past twelve months:

1. We worried whether our food would run out before we got money to buy more.
   ☐ Often True ☐ Sometimes True ☐ Never True
2. The food bought just didn't last and we didn't have money to get more.
   ☐ Often True ☐ Sometimes True ☐ Never True

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Over the last two weeks:

1. Have you been bothered by having little interest or pleasure in doing things?
   ☐ Yes ☐ No
2. Have you been bothered by feeling down, depressed or hopeless?
   ☐ Yes ☐ No
   Have you been bothered by feeling nervous, anxious, or on edge?
   ☐ Yes ☐ No
3. Have you been bothered by not being able to stop or control worrying?
   ☐ Yes ☐ No

In the last year:

1. Have you ever drunk more alcohol or used more drugs than you meant to?
   ☐ Yes ☐ No
2. Have you felt like you wanted or needed to cut down on your drinking and drug use?
   ☐ Yes ☐ No

Have you recently wished you were dead or wished you could go to sleep and not wake up?
☐ Yes ☐ No

Have you had any actual thoughts of killing yourself in the last 24 hours?
☐ Yes ☐ No

I agree to furnish any information Storey County Health and Community Services may require with respect to this application. I further agree to notify Storey County Health and Community Services of any changes in personal circumstances including real or personal property transactions; financial conditions; employment status for any household member; change in marital status of any household member; changes in address or contact information; and any other changes that may affect my application for assistance. I understand that failure to comply constitutes an act of fraud. I solemnly swear or affirm that the statements made within this application are true and correct to the best of my knowledge.

Applicant Signature	Date	Co-Applicant Signature	Date

FOR STAFF USE ONLY

Family Resource Center
Goal 1: Client will be connected to services. ☐ Yes ☐ No
Goal 2: Client will be connected to application services. ☐ Yes ☐ No

_____

Attachment A
Earned Income Worksheet

Storey County Health and Community Service Department

Please complete the following for all household members that generate household earned income.
(Annual income equals total monthly income X 12)

Use one line for each position held.

Name	Relationship	Employer	Monthly Income
	Self		
Use additional sheets if necessary.		**Total Monthly Income**	

Total Household Annual Income (equals monthly income X 12): $_____
(for use on Policy 800.001-F1, income calculations, earned income sections)

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Attachment B
Unearned Income Worksheet

Please complete the following for all household members that generate household unearned income.

Type	Receiving	Applied For	Recipient	Monthly Amount*
Child support / Alimony				$
Unemployment Benefits				$
Social Security				$
SNAP				$
Income Grants (TANF, Foster Care, etc.)				$
Veteran's Benefits				$
Native American Benefits				$
Military Allotment				$
Family Support				$
Retirement / Pensions				$
Property income (rental / leases)				$
Utility Allowance				$
Rent from boarders or roommates				$
Workman's Comp				$
Other				$
Use additional sheets if necessary.			**Total Unearned Income:**	$

NOTE: Please designate if the unearned income is for a period other than one month.

Total Household Annual Unearned Income (equals monthly amount X 12):
$_____
(for use on POLICY #800.001-F1, income calculations, earned income sections)