Carson City Human Services
900 E. Long Street
Carson City, NV 89706
775-887-2110

EQUAL HOUSING OPPORTUNITY

General Assistance Application

Items checked are *required* to complete this application.

Rcvd	Need	
☐	☐	Client Application **completed by person in charge of household earnings or benefits**.
☐	☐	Valid Driver's License, State Picture ID Card for **ALL Adults**
☐	☐	**Children's** Birth Certificate **or** **Children's** Immunization Records
☐	☐	Proof of all monies received within the last **30** days for **ALL** household members such as, Payroll Stubs, Child Support, Unemployment, TANF, SSA,SSI, SSDI
☐	☐	Bank Statements (for last 30 days)
☐	☐	Rental Lease Agreement and Last Paid Rent Receipt (for proof of residency)
☐	☐	**CURRENT** Heating & Electrical Utility Bills in your name (for proof of residency)

*****

Determination and Appeal Process

1 After notification, the person denied assistance may request a hearing in writing within 30 days from the date of the issuance of denial. The hearing must be conducted by the manager or her designee, but must not be the employee or representative of the county whom investigated or made the initial decision to deny your assistance.

2 A decision adverse to the person denied assistance must be in writing and set forth the factual basis for the decision and the applicable regulation. A copy of the decision must be served personally or by certified mail upon each party and his representative.

3 A person aggrieved by the final decision of the county may, within 30 day after the date on which written notice of the decision is served or mailed, petition the district court where he resides to review the decision.

Determinación y Proceso de Apelación

1. Después de la notificación, la persona a la que fue negada la asistencia puede pedir una audiencia por escrito dentro de los siguientes 30 días desde la fecha en que se le fue rechazado(a). La audiencia debe realizarse por el administrador o representante asignado, pero no debe ser el empleado o representante del Condado quien investigó o tomó la decisión inicial de negar su asistencia.

2. Una decisión adversa a la persona a la cual se le negó asistencia debe ser por escrito y establecer la base factual de la decisión y la regulación aplicable. Una copia de la decisión debe ser entregada personalmente o por correo certificado a cada partido y su representante.

3. Una persona perjudicada por la decisión final del Condado, dentro de los siguientes 30 días después de la fecha en la que se le entrego o recibió por correo el informe de la decisión, Puede solicitar al tribunal del distrito donde reside una reevaluación de la decisión.

Head of Household **Middle Name** **Last Name**

- - ( ) 000 -00 -

Date of Birth: **Age:** **Last 4 Digits of Social Security Number**

Gender: ☐ Male ☐ Female **Maiden Name**: _____ **Place of Birth**: _____

US Citizen: ☐ Yes ☐ No ☐ Disabled ☐ Military Veteran

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

RACE: ☐**White** ☐**Latino** ☐**Black or African American** ☐**Native American-Alaskan Native** ☐**Asian** ☐**Middle Eastern** ☐**Pacific Islander** ☐**Other Multi Race** ☐**Black/African American & American Indian/Alaskan Native** ☐**Black/African American & Asian** ☐**Black/African American & White** ☐**White & Asian** ☐**White & American Indian/Alaskan Native** ☐**White & Black/African American & Asian** ☐**White& Black/African American and American Indian**

Family Type/Parental Status:

- ☐ One Parent – Male
- ☐ One Parent – Female
- ☐ Two Adult with Children
- ☐ Two Adult Family – No children
- ☐ Single Person – living alone
- ☐ Grandparents raising Grandchildren
- ☐ Foster Family
- ☐ Other

Marital Status:

- ☐ Married
- ☐ Unmarried Partner
- ☐ Separated
- ☐ Divorced
- ☐ Single
- ☐ Widowed

Home Address: (No PO Box):_____**Space #**:_____**Apt #**: _____

City: _____**State:**_____ **Zip Code:** _____

Mailing Address: _____

PO Box/Address City State Zip

Home/Cell Phone #:_____**Message #:**_____

Total # of Persons in Household: _____

Signed in Office

I _____certify under penalty of perjury that my answers are correct and complete ____/____/____

Education:

☐	0-8	☐	Associates Degree	☐	Other Graduate/Professional Degree
☐	9-12/non graduates	☐	Bachelor Degree	☐	Certificate of Advance Training
☐	High school grad	☐	Master Degree	☐	Skilled Artisan
☐	GED	☐	Doctorate Degree		
☐	Post-Secondary				

Additional Household Members (do not include Applicant)

Name (First, Middle & Last)	Gender	Relationship To Head of Household	Birth Date	Educ. Level	Race*	Pregnant Yes / No	Disabled or Veteran	US Citizen	Lasts 4 Numbers of Social Security
								☐ Yes ☐ No	
								☐ Yes ☐ No	
								☐ Yes ☐ No	
								☐ Yes ☐ No	

* **RACE: 1-White 2-Latino 3-Black or African American 4-Native American-Alaskan Native 5-Asian 6-Middle Eastern 7-Pacific Islander 8-Other Multi Race 9-Black/African American & American Indian/Alaskan Native 10-Black/African American & Asian 11-Black/African American & White 12-White & Asian 13-White & American Indian/Alaskan Native 14-White & Black/African American & Asian 15-White& Black/African American and American Indian**

Applicant's Employer:

☐ Current ☐ Last

Employer: _____Employer Location: _____

☐ Full Time ☐ Part-Time ☐ Seeking Employment ☐ Not Seeking Employment ☐ Retired

Rate of Pay: _____ Job Title: _____

Start Date: ____/____/_____ End Date: ____/____/____ Reason for Leaving:_____

When are you available to start a job _____/____/____?

Household's Earned Income:

Household Member :	Employer:	Employment Dates: Begin:	End:	Rate of Pay:	Position:	Reason for Leaving:

Signed in Office

I _____certify under penalty of perjury that my answers are correct and complete ____/____/____

Household's Unearned Income:

Household Member:	Unemployment $:	SSI $:	SSDI $:	SS $:	Pension $:	Other $:

TOTAL MONTHLY INCOME FROM ALL MEMBERS OF HOUSEHOLD: $_____

Has anyone in the household sold any property in the last 60 months? ☐ No ☐ Yes

If Yes: Description: _____Value: $_____Date Sold: _____/_____/____

Daycare or Childcare: What arrangement have you made for child care? _____

Children's Schools:

Child's Name: _____ School: _____Grade: _____

Child's Name: _____ School: _____Grade:_____

Child's Name: _____ School: _____Grade:_____

Any Barriers to Enrolling Children in School: _____

Has anyone in household ever received Rental Assistance (from any agency)?

☐ No ☐ Yes If Yes, please answer the following:

When: ____/____/_____ Amount: $_____ Agency: _____

Has anyone in the household received assistance from Carson City Human Services?

☐ No ☐ Yes If Yes, please answer the following:

What type of services? _____Date of Service: _____/_____/_____

Does the Household currently have transportation? ☐ Yes ☐ No

☐ Private Vehicle (Make/Model) _____ ☐ Public Transportation

☐ Some other regular arrangement ☐ Other: _____

Insurance Coverage (Current):

☐ Auto Insurance ☐ Life Insurance ☐ Dental Insurance ☐ Medical Insurance *(Check all that apply)*:

☐ Medicaid: Who is covered_____ ☐ Medicare ☐ VA Medical Services

☐ Employer Provided ☐ Spouse ☐ NV Check-Up ☐ Private_____

Signed in Office

I _____certify under penalty of perjury that my answers are correct and complete ____/____/____

Client Characteristics:

Applicant's Place of Birth: _____

Mother's Maiden Name: _____

Barriers/Services Needed *(Check all that apply):*

☐Alcohol use - Last time used _____ ☐Drug use - Last time used _____☐Expect Long-Term Substance use
☐ Mental Illness – Receiving Care ☐yes ☐no ☐Expect Long-Term Mental Illness
☐Chronic Health Condition
☐Convicted of a Crime Parole ☐yes ☐no Probation ☐yes ☐no
☐Active HIV/AIDS ☐ Other Special Needs (please specify) _____

Experienced Domestic Violence: ☐ Yes ☐ No
If Yes, when:

☐ Less than 3 months ago ☐ 3-6 months ago ☐ 6-12 months ago

☐ More than 1 year ago ☐ I refuse to answer

HUD considers chronic homelessness is living in someone else's home or in a motel/hotel

Are You At Risk of Homelessness? ☐ Yes ☐ No
Are you homeless now? ☐ Yes ☐ No
Were You Homeless before 18? ☐ Yes ☐ No
Have you been homeless more than 3 times in a year?
☐ Yes ☐ No

Cause of Homelessness: *(Check all that apply)*

☐Not Homeless ☐New to Area ☐New to Area-No Deposit money
☐New to Area-No Social Supports ☐Financial ☐Credit Problems
☐Gambling ☐Unable to get Job ☐Eviction-Loss of Housing
☐Eviction-Non-Financial Reasons ☐Eviction-Non-Payment ☐Fire or Condemnation
☐Previous Eviction/Non-Payment of Utilities ☐Medical or Social Problems
☐Domestic Violence ☐Drug or Alcohol Problems ☐Incarceration
☐Medical Problems-Non-Mental ☐Mental Health Problems

Prior Living-Type of Housing Situation:

☐Place not Habitation (Streets) ☐Emergency Shelter
☐Transitional Housing ☐Permanent Housing for Former Homeless
☐Psychiatric Facility/Hospital ☐Substance Abuse Treatment Facility
☐Hospital (Non-Psychiatric) ☐Jail or Juvenile Detention
☐Domestic Violence Situation ☐Living with Family/Relatives
☐Living with Friends ☐Rented Room/Apartment/House
☐Hotel/Motel ☐Foster Care Family/Group Home

Duration of Prior Living Situation:

☐1 week ☐Over 1 week-1 month ☐1-3 months
☐Over 3 months-1 year ☐1 year or more

Zip code of last permanent address: _____

Signed in Office
I _____certify under penalty of perjury that my answers are correct and complete ____/____/____

For Veterans Only:

☐ **I am not a veteran** *(If not a Veteran please go to the next page)*

Branch of Service

☐Air Force ☐Navy
☐Army ☐Other
☐Marines ☐Unknown

Duration of Active Duty [Months] _____

Served in War Zone

☐Yes
☐No

War Zone of Service

☐ Afghanistan ☐ Persian Gulf
☐China, Burma, or India ☐ South China Sea
☐Europe ☐ South Pacific
☐ Korea ☐ Vietnam
☐ Laos or Cambodia ☐ Refused
☐ North Africa ☐ Other

Duration of War Zone Service [Months] _____

Era of Service

☐ Post September 11, 2001 (September 11, 2001 to Present)
☐ Persian Gulf Era [Aug '91 to Present]
☐Post-Vietnam Era [May '75 to July '91]
☐Vietnam Era [Aug'64 to April '75]
☐Korea to Vietnam [Aug '64 to April '75]
☐Korean War [June '50 to Jan '55]
☐WW2 to Korean War [Aug '47 to May '50]
☐World War II [Sept '40 to July '47]
☐WW1 toWW2 [Dec '18 to Aug '40]
☐Other Era of Service
☐Not Applicable
☐Unknown

Discharge Status

☐Honorable
☐General [Under Honorable Conditions]
☐Medical Discharge
☐Under Other than Honorable Conditions
☐Entry Level Separation [ELS]
☐Bad Conduct Discharge [BCD]
☐Dishonorable Discharge [DD]
☐Refused
☐Unknown

Signed in Office
I _____certify under penalty of perjury that my answers are correct and complete ____/____/____

Unearned Income:

UNEARNED INCOME	RECEIVING:	APPLIED FOR:	WHO:	AMOUNT Wk/Mo/Semi-Mo:
1) Child Support/ Alimony				$ PER:
2) Unemployment Benefits or Worker's Compensation				$ PER:
3) Secured Supplemental Retirement Income (SSI)				$ PER:
4) Secured Supplemental Disability Income (SSDI)				$ PER:
5) Food Stamps				$ PER:
6) WIC				$ PER:
7) Income Grants or Assistance [**TANF** or Foster Care, etc.]				$ PER:
8) Veteran Benefits Pension or Disability				$ PER:
9) Indian General Assistance				$ PER:
10) Military Allotment				$ PER:
11) Money from Relatives				$ PER:
12) Retirement Pensions [Civil Service, Railroad, Military, Public, Employee, Private or Union, Etc.]				$ PER:
13) Money From Property [Rentals or Lease]				$ PER:
14) Utility Allowance/ EAP				$ PER:
15) Rent from Boarder/Roomers				$ PER:
16) Section 8/ HUD Rental Assistance				$ PER:
17) Any Other Income Benefit Type:				$ PER:

Signed in Office

I _____certify under penalty of perjury that my answers are correct and complete ____/____/____

Assets and Resources:

- ☐ Savings Account Balance: $_____
- ☐ Credit Union Balance: $ _____
- ☐ Savings Bond
- ☐ **Vehicle[s]** Year/Make/Model _____
- ☐ Stocks/Bonds Interest $ _____
- ☐ Individual Retirement Accounts [IRA]
- ☐ Certificates of Deposit [CD]
- ☐ Individual Indian Money Account [IIMA]
- ☐ Other House, Land or Building
- ☐ Life Estates / Life Leases
- ☐ Land / Mineral Rights
- ☐ Business Checking Account
- ☐ Livestock / Horses
- ☐ Checking Account Balance: $_____
- ☐ Burial Funds
- ☐ Life Insurance Policies
- ☐ **Cash on Hand** Amount: $_____
- ☐ Trust Funds
- ☐ Keogh Accounts [401k]
- ☐ Christmas Club Accounts
- ☐ Other Account Type $_____
- ☐ Promissory Note or Contracts
- ☐ Mining Claims
- ☐ Safe Deposit Boxes
- ☐ Business Equipment / Inventory
- ☐ Other _____

MONTHLY EXPENSES:

Type	Monthly	Your Share	Company Name [Who bill is paid to]	Who Else Pays
Cable / Satellite	$	$		
Car Payment	$	$		
Credit Cards	$	$		
Electricity	$	$		
Garbage / Trash	$	$		
Gas/Propane/Wood Heating	$	$		
Insurance	$	$		
Medical Expenses	$	$		
Mortgage/Rent	$	$		
Space/Lot Rent	$	$		
Telephone/Long Distance	$	$		
Water/Sewer	$	$		
Other	$	$		

Signed in Office

I _____certify under penalty of perjury that my answers are correct and complete ____/____/____

CARSON CITY, NEVADA
CONSOLIDATED MUNICIPALITY AND STATE CAPITAL

Consent to the Release and Affirmation of Information

_____I understand information provided on this application is subject to verification by Federal, State or local officials. If any information is found inaccurate, I may be denied assistance and/or be subject to criminal prosecution for knowingly providing false information.

_____I understand the questions on this application and the penalty for hiding or giving false information. I certify under penalty of perjury that my answers are correct and complete. I agree to notify the agency where I made application for assistance of any changes in my circumstances that may affect my eligibility.

_____I understand I have a duty to inform Carson City Human Services if I, or anyone on my behalf, commence a legal action against anyone for recovery of money as reimbursement for medical care and treatment paid for by the county. I must further advise Carson City County Human Services should I or anyone on my behalf, solicit or receive any offer of settlement of money as reimbursement for medical care and treatment paid for by the Medicaid Program and/or county.

_____I hereby authorize the agency to which I am applying for assistance to make any investigation concerning me or other members of my household, or my children's legal/punitive parent(s) whom is necessary to determine eligibility for any benefit I have, receive or will receive under programs administered by this agency. I hereby authorize and consent to the release of any and all information concerning me or my household members to the agency, by the holder of the information, regardless of the manner of form held, including, without limitation, information made confidential by law, or otherwise, and patient information privileged under NRS 49.225 or any other provision of law, or otherwise. I hereby release the holder of the information liability, if any, resulting from the disclosure of the required information. I authorize the agency to contact my employer to obtain wage information. A reproduced copy of this application, and authorization, legally constitutes an original copy.

_____I authorize the State of Nevada Welfare Division, County Welfare Department and agencies for which I may be eligible for assistance, to exchange information essential for effective case management.

_____I understand that all of the information provided on the preceding 7 pages of my application are necessary and important in determining my eligibility status and that any change in circumstances may affect my eligibility for assistance; therefor I agree to notify CC Humans Services of any change in circumstances within 5 days of the change

_____This release is valid for a period of one year from the date of authorization.

_____ _____

Applicant's Signature or Mark Date

I agree to act on behalf of the above application, and understand my rights and obligations as a representative and responsible party.

_____ _____

Authorized Representative's Signature Date

_____

Authorized Representative's Address City State/Zip Phone Contact

Carson City Health & Human Services
900 E Long Street • Carson City, Nevada 89706
Human Services (775) 887-2110 Fax: (775) 887-2539

CARSON CITY, NEVADA

CONSOLIDATED MUNICIPALITY AND STATE CAPITAL

CONSENT TO USE OF DISCLOSE HEALTH INFORMATION

I authorize Carson City to use and disclose my medical records for the purposes of Treatment, Payment and Health Care Operations.

Treatment includes activities performed by a health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultation with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician.

Payment includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.

Health Care Operations include the necessary administrative and business functions of our office.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire 365 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

You may review Carson City's 'Notice of Privacy Practices' for additional information about the uses and disclosures of information described in this Consent prior to signing this Consent.

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the current Notice. We will also provide you with a copy of the notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purpose. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the Notice.

I understand that I have the right the revoke this Consent provided that I do so in writing, except to the extent that Carson City has already used or disclosed the information in reliance on this Consent and to examine the City's Notice of Privacy Practices.

Signature of Patient or Person Authorized by Law Date

Printed Name of Patient or Person Authorized by Law Date

Carson City Health & Human Services

900 E Long Street • Carson City, Nevada 89706

Community Health
(775) 887-2190
Fax: (775) 887-2248

Preventative Health
(775) 887-2195
Fax: (775) 887-2192

Human Services
(775) 887-2110
Fax: (775) 887-2539

Code Enforcement
(775) 887-2190
Fax: (775) 887-2248

Animal Services
(775) 887-2171
Fax: (775) 887-2128

CARSON CITY HUMAN SERVICES
CLIENT WORK SEARCH

Please ask prospective employers to complete the following form as evidence of your search for employment. Be sure that the place of business is hiring for a position you are qualified for. Your application will be verified with the place of business listed, be sure that all phone numbers and contact names can be verified.

You must complete ten (10) applications.

If you are applying for *Employment Online*, print out a copy of the confirmation or the application as proof and attach to this log sheet.

If we are unable to verify information provided, your assistance will be delayed, possibly denied.

Client declares all employment information listed is true and understands if false information is provided they may be ineligible for assistance.

Print Name: _____ **Signature:** _____

Last four of SS# _____ **Phone #** _____

	Date:	**PRINT** Name of Business Position Applied for:		**PRINT** Name of Manager Contacted & Signature	**PRINT** Business Telephone:	Office Use: Verification Notes:
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

Attach Copied Online Applications

For Office Use

Copies Made By:_____ **Date:**_____

Missing Documents: _____ **Appt Date:** _____

Business Managers: Client gives prospective employers permission to release employment information to this agency.

Landlord to Complete

Landlord's Name: _____

Mailing Address: _____
PO Box/Address City State Zip

Apartment Complex Name: _____ **Phone#:** _____

Number of Bedrooms: _____ **Square Footage:** _____

Lease Date: _____/_____/_____ **Move-In Date:** ____/_____/_____ **Month-to-Month** ☐ **Yes** ☐ **No**

Own Home ☐ **Yes** ☐ **No** **Move-In Date:** ____/_____/_____ **Rent Space Lot** ☐ **Yes** ☐ **No**

Type of Unit: ☐ **2 & 3 Story Walk up Apartment;** ☐ **Mobile Home** ☐ **Condo**

☐ **Duplex** ☐ **Studio** ☐ **Home** ☐ **Motel**

☐ **Other**

Location/Accessibility: ☐ **Schools** ☐ **Grocery Store** ☐ **Bus route** ☐ **Etc.**_____

Amenities: ☐ **Pool** ☐ **Playground** ☐ **Laundry Room** ☐ **Covered Parking**

☐ **Garage** ☐ **Etc:** _____

Property Condition: ☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor**

Neighborhood Type: ☐ **New** ☐ **Old** ☐ **Industrial**

Was the Building Built Before 1978? ☐ **Yes** ☐ **No** **Year it was Built:** _____

Utilities (Type): ☐ **Gas** ☐ **Electric** ☐ **Propane** ☐ **Water/Sewage** ☐ **Trash**

Utilities Included: ☐ **Yes** ☐ **No**

What Utilities are Included

in the Rent: ☐ **Gas** ☐ **Electric** ☐ **Propane** ☐ **Water/Sewage** ☐ **Trash**

Utility Allowance: ☐ **Yes** ☐ **No**

Unit Rent: $_____

Gross Rent: $_____ **Is the Unit Handicap Accessible?** ☐ **Yes** ☐ **No**