# Carson City Human Services

900 E. Long Street
Carson City, NV 89706
phone 775-887-2110 ~ fax 775-887-2539

# EMERGENCY INDIGENT CREMATION APPLICATION

**Person(s) completing the application for Emergency Cremation Assistance must complete the application with information regarding the household of the deceased and/or immediate family members survived by the deceased**. Read each page carefully and answer every question, if information is none, write "none".

The following list of documents is required in order to apply for Emergency Cremation Assistance with Carson City Human Services Division. Upon decease, completed application and all documentation must be returned to the Carson City Human Services office for review.

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- ❑ Completed Application
- ❑ Identification (Driver's License, Photo ID, death certificate)
- ❑ Verification of all monies received within the last 30 days
  (Payroll stubs, Award letter for Child support, Food Stamps, SSI, TANF, Unemployment, Workman's compensation, etc…)
- ❑ Proof of VA Benefits
- ❑ Proof of Social Security Disability
- ❑ Bank Statements for deceased (last 30 days)
- ❑ Proof of Residency (Rental Lease Agreement, utility bill, rent receipts, etc)
- ❑ Most recent IRS Tax Filing for deceased.

## Deceased MUST be a resident of the County of Carson City.

Upon completion of application bring application and all documentation to the Carson City Human Services office. **Faxed or mailed applications will not be accepted, as further information may be required upon review.** ***Should you have any questions please call 775-887-2110.***

## Person Completing Application:

First Name: _____ Last Name: _____ Phone: _____

Relationship to Deceased: _____ Are you over the age of 18 yrs old? _____

## Deceased Information:

First Name: _____ Middle Name: _____Last Name: _____

Maiden Name: _____

**Date of Birth: _____ Date of Death: _____Age: _____ SS#: _____**

**Gender:** Male ❑ Female ❑ **Funeral Home_____**

**Ethnicity**:
Caucasian ❑ Pacific Islander ❑ African American ❑ Native American ❑ Asian ❑ Hispanic ❑ Other: _____

**Household Type:**

- ❑ One Parent – Male
- ❑ One Parent –Female
- ❑ Two Adult w/ Children
- ❑ Two Adult w/out Children
- ❑ Single Person (living alone)
- ❑ In Care Facility
- ❑ Married
- ❑ Divorced
- ❑ Separated
- ❑ Single
- ❑ Widowed
- ❑ Unmarried Partners
- ❑ Other _____

**Home Address** (if in facility, prior to facility):

_____

_____

City State Zip

**Mailing Address:**

_____

_____

City State Zip

**Facility Name: _____**_____

**Please List All Members of Deceased Household:**

**1)**_____
First and Last Name Relationship Age

**2)**_____
First and Last Name Relationship Age

**3)**_____
First and Last Name Relationship Age

**4)**_____
First and Last Name Relationship Age

**Does Deceased Have?**

❑ Life Insurance ❑ Medical Insurance (if so, please specify)
❑ Medicare ❑ Private ❑ VA ❑ Medicaid
❑ Employer Provided ❑ Spouse ❑ Other _____

**Was Deceased:**

❑ Disabled ❑ Military Veteran

**List all cars, trucks, recreational vehicles, trailers, etc…, for all people in household.**
**(Include vehicles that do not run)**

❑ Car ❑ Motorcycle ❑ Motor Home ❑ Trailer/Camper ❑ None
❑ Truck/Van ❑ Snowmobile ❑ Boats ❑ Other_____

| Owner(s) | Year, Make & Model: | Value: | Registered: | Owner(s) | Year, Make & Model: | Value: | Registered: |
|---|---|---|---|---|---|---|---|
| | | | Y/N | | | | Y/N |
| | | | Y/N | | | | Y/N |
| | | | Y/N | | | | Y/N |
| | | | Y/N | | | | Y/N |

**Has anyone in household sold, traded or given away money, vehicles, property or other resources or closed any bank accounts, in the last 36 months?**

If Yes, Describe property or gift_____
Gift/sale date _____ Value or property/cash _____ Total sale price _____

**Has anyone in household executed a trust or court order?**

If Yes, Please attach a copy(ies) of the document(s) with application.

# INCOME INFORMATION:

**List current AND last employer for ALL household members.**

| Employment/ Dates MM/YY | Employer Name/ Employer Address | How Often Paid: | Pay Rate/ Hours Worked: | Reason for Leaving: |
|---|---|---|---|---|
| Person Employed:<br>Start Date:<br>End Date: | | | | |
| Person Employed:<br>Start Date:<br>End Date: | | | | |
| Person Employed: | | | | |

**Has anyone in household applied for or is currently receiving monies other than from a job?** ❑ Yes ❑ No

If Yes, complete boxes below.

❑ Child Support/Alimony (absent parent)
❑ Contributions/Gifts
❑ County Assistance/General Assistance
❑ Educational Assistance
❑ Foster Care Payments
❑ Employers Ins. Co. of Nevada (EICON)
❑ Insurance Settlements
❑ Interest/Dividends
❑ Loans
❑ Lump Sum Payment
❑ Other
❑ Military Allotment
❑ Mining Claims
❑ Pan Handling
❑ Pensions/Retirement
❑ Railroad Retirement
❑ Royalties
❑ Social Security Disability
❑ Social Security Retirement
❑ Social Security Survivors
❑ Strike Benefits
❑ Supplemental Security Income
❑ TANF
❑ Temp Disability Insurance
❑ Tribal Assistance/ IGA
❑ Unemployment Insurance
❑ Utility Allowance from Housing
❑ Utility Rebate Check
❑ Veterans Benefits
❑ Winnings
❑ Worker's Compensation

_____

| Income Type: | Who Receives: | Amount: | How Often Paid: | Income Type: | Who Receives: | Amount: | How Often Paid: |
|---|---|---|---|---|---|---|---|
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## RESOURCES and ASSETS:

**List all resources held by anyone in the household such as: bank accounts, stocks or bonds, property, life and burial insurance etc.**

❑ Available Trust Funds ❑ Individual Indian Money Accounts ❑ Other Account Types
❑ Burial Funds/Plans ❑ Individual Retirement Accounts (IRAs) ❑ Other Houses/Land/Buildings
❑ Business Checking Acct. ❑ Keogh Accounts (401K) ❑ Promissory Notes/Contracts
❑ Business Equip/Inv. ❑ Land/Mineral Rights ❑ Safe Deposit Box
❑ Cash on Hand ❑ Life Estates/Life Leases ❑ Savings Account
❑ Cert. of Deposits (CDs) ❑ Life Insurance Policies ❑ Savings Bonds
❑ Christmas Club ❑ Livestock/Horses ❑ the Home You Live In
❑ Credit Union Acct. ❑ Mining Claims ❑ Unavailable Trust Funds
❑ Checking Accounts ❑ None ❑ Other_____

| Owner(s) | Resource Type: | Amount Value: | Amount Owed: |
|---|---|---|---|
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| | | | |
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## EXPENSES:

**Please provide proof of expenses with application.**

❑ Cable/Satellite ❑ Car Payment ❑ Cell Phone ❑ Credit Cards ❑ Electricity
❑ Garbage/Trash ❑ Gas/Propane/Wood ❑ Insurance ❑ Medical Expenses ❑ Mortgage/Rent
❑ Space/Lot Rent ❑ Telephone ❑ Water ❑ Sewer ❑ Other

| Expense Type: | Monthly | Who Bill Is Paid To | Expense Type: | Monthly | Who Bill Is Paid To |
|---|---|---|---|---|---|
| | $ | | | $ | |
| | $ | | | $ | |
| | $ | | | $ | |
| | $ | | | $ | |
| | $ | | | $ | |
| | $ | | | $ | |
| | $ | | | $ | |
| | $ | | | $ | |

**Does anyone else pay a portion of your expenses?**

If YES, Who? _____ How Much?_____

Is the rent government subsidized (HUD, Section 8, Federal Public Housing, etc.) ❑ Yes ❑ No

**Please describe why you are applying for Emergency Cremation Assistance:**

_____

_____

_____

_____

_____

_____

_____

**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 5 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, 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