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.

- 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: ______________________

Revised January 2015
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 ___________________

<table>
<thead>
<tr>
<th>Owner(s)</th>
<th>Year, Make &amp; Model:</th>
<th>Value:</th>
<th>Registered:</th>
<th>Owner(s)</th>
<th>Year, Make &amp; Model:</th>
<th>Value:</th>
<th>Registered:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Y/N</td>
<td></td>
<td></td>
<td></td>
<td>Y/N</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Y/N</td>
<td>Y/N</td>
<td></td>
<td></td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Y/N</td>
<td>Y/N</td>
<td></td>
<td></td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Employment/ Dates MM/YY</th>
<th>Employer Name/ Employer Address</th>
<th>How Often Paid:</th>
<th>Pay Rate/ Hours Worked:</th>
<th>Reason for Leaving:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person Employed:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Start Date:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>End Date:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Person Employed:
Start Date:
End Date:

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) Income
☐ Contributions/Gifts
☐ County Assistance/General Assistance
☐ Educational Assistance
☐ Foster Care Payments
☐ Employers Ins. Co. of Nevada (EICON) Housing
☐ Insurance Settlements
☐ Interest/Dividends
☐ Loans
☐ Lump Sum Payment
☐ Other

Income Type: ☐ Military Allotment ☐ Supplemental Security
☐ Mining Claims ☐ TANF
☐ Pan Handling ☐ Temp Disability Insurance
☐ Pensions/Retirement ☐ Tribal Assistance/ IGA
☐ Railroad Retirement ☐ Unemployment Insurance
☐ Royalties ☐ Utility Allowance from Housing
☐ Social Security Disability ☐ Utility Rebate Check
☐ Social Security Retirement ☐ Veterans Benefits
☐ Social Security Survivors ☐ Winnings
☐ Strike Benefits ☐ Worker’s Compensation

<table>
<thead>
<tr>
<th>Income Type:</th>
<th>Who Receives:</th>
<th>Amount:</th>
<th>How Often Paid:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Income Type:</th>
<th>Who Receives:</th>
<th>Amount:</th>
<th>How Often Paid:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Income Type:</th>
<th>Who Receives:</th>
<th>Amount:</th>
<th>How Often Paid:</th>
</tr>
</thead>
</table>

Revised January 2015
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
- Burial Funds/Plans
- Business Checking Acct.
- Business Equip/Inv.
- Cash on Hand
- Cert. of Deposits (CDs)
- Christmas Club
- Credit Union Acct.
- Checking Accounts
- Houses/Land/Buildings
- Notes/Contracts
- Individual Indian Money Accounts
- Individual Retirement Accounts (IRAs)
- Keogh Accounts (401K)
- Liabilities/Leases
- Livestock/Horses
- Life Estates/Life Leases
- Mortgage/Rent
- Promissory Notes/Contracts
- Savings Account
- Savings Bonds
- Safe Deposit Box
- the Home You Live In
- Unavailable Trust Funds

Other_________________________________________________

<table>
<thead>
<tr>
<th>Owner(s)</th>
<th>Resource Type:</th>
<th>Amount Value:</th>
<th>Amount Owed:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

EXPENSES:

Please provide proof of expenses with application.

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

<table>
<thead>
<tr>
<th>Expense Type:</th>
<th>Monthly</th>
<th>Who Bill Is Paid To</th>
<th>Expense Type:</th>
<th>Monthly</th>
<th>Who Bill Is Paid To</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td></td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$</td>
<td></td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$</td>
<td></td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$</td>
<td></td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$</td>
<td></td>
<td></td>
<td>$</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$</td>
<td></td>
<td></td>
<td>$</td>
<td></td>
</tr>
</tbody>
</table>

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; therefore 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

_________________________________  City  _________________________
Authorized Representative’s Address  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

Revised January 2015