

Clark County Social Service

Office Use Only

Date Received: _____
 Received by: _____
 Assigned Worker: _____
 Pin: _____
 Case #: _____

- Homemaker Home Health Aide Service
- Alternative Health Care Program

Applicant: _____ SS# _____ D.O.B _____

Spouse: _____ SS# _____ D.O.B _____
 (Information is necessary for married couples)

Address: _____ Telephone # _____

City, State, Zip _____ Message # _____

Referral source name _____ Phone # _____

Has the applicant been in the hospital in the past 30 days? _____

Admit to hospital _____ Date of discharge _____ Physician name _____

INCOME/ASSETS			Please List applicant assets:
Source	Applicant	Spouse	
	\$	\$	
	\$	\$	
	\$	\$	
TOTAL	\$		

Please list health insurance coverage, if any. Medicaid, Medicare & other health insurance:

Medical condition _____

Assistance Requested: P/C Medication pick up Meal Prep Shopping Laundry Cleaning

Remarks _____
