



## **Clark County Social Service Long Term Care Placement Request**

Please completely fill out the attached application, including the first section. If a section does not apply, please mark N/A.

Gather and copy all verifications that apply as listed on Page 6 of the application.

Return application and verifications to:

Clark County Social Service  
Long Term Care/Homemaker Services  
1600 Pinto Lane  
Las Vegas, NV 89119  
Fax: 702-455-8682

You may mail the application and verifications, or bring them in person and leave them with the receptionist. A social worker **will not** be available at this time to go through the application or answer your questions. Bringing the paperwork in person only saves the time in mailing.

If you have **any** questions while you are filling out the application, please call 455-8687.

To obtain a Nevada State Welfare Screening, which must be done before placement into a nursing home, please call 1-800-525-2395.



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To obtain a Nevada State Welfare Screening, which must be done before placement into a nursing home, please call 1-800-648-7593.

# Clark County Social Service Long Term Care Placement Request

**Please complete the entire application. Leave no space blank;  
if a section does not apply, please mark N/A.**

**OFFICE USE ONLY**

Date Received: \_\_\_\_/\_\_\_\_/\_\_\_\_

Assigned Worker: \_\_\_\_\_

PIN: \_\_\_\_\_

Case #: \_\_\_\_\_

Date of Request: \_\_\_\_/\_\_\_\_/\_\_\_\_

Submitted By: \_\_\_\_\_

Relationship/Agency: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Date Patient Admitted to Hospital or Long Term Care Facility: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date Acute Care No Longer Required: \_\_\_\_/\_\_\_\_/\_\_\_\_

Potential Discharge Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Nevada State Welfare Level of Care Assessment \_\_\_\_\_

Medical Problems/Reason for Placement: \_\_\_\_\_

Person to Contact for Appointment: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**PLEASE SELECT ONE:**

Nursing Home

Adult Group Care

Adult Day Care

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Long Term Care Patient Information**

M  F

Name: \_\_\_\_\_ Maiden Name/AKA's: \_\_\_\_\_

SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Ethnicity:  Hispanic  Non – Hispanic  Not - Chosen

Race:  American Indian / Alaskan Native  Asian  Black / African American  
 Observed Hispanic or Latino  White  Native Hawaiian / Other Pac. Islander

Medicare #: \_\_\_\_\_ Part A Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Part B Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Birthplace: \_\_\_\_\_ If Foreign Born, Alien Status: \_\_\_\_\_ Marital

Status: Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Single  Married  Separated  Divorced  Widowed

Military Branch: \_\_\_\_\_ Serial #: \_\_\_\_\_ From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_

Service Connected Disability: Yes  No  \_\_\_\_\_% Disability

Current Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Message #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Spouse Information** (Complete whether person is living, divorce, or deceased)

M  F

Name: \_\_\_\_\_ Maiden Name/AKA's: \_\_\_\_\_

SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Ethnicity:  Hispanic  Non – Hispanic  Not - Chosen

Race:  American Indian / Alaskan Native  Asian  Black / African American  
 Observed Hispanic or Latino  White  Native Hawaiian / Other Pac. Islander

Medicare #: \_\_\_\_\_ Part A Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Part B Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Birthplace: \_\_\_\_\_ If Foreign Born, Alien Status: \_\_\_\_\_

Military Branch: \_\_\_\_\_ Serial #: \_\_\_\_\_ From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_

Service Connected Disability: Yes  No  \_\_\_\_\_% Disability

Current Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Message #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Others Residing in Household** (Be Specific: Son, Daughter, Cousin, Ex-Wife, Friend, Etc.)

Name	Sex	DOB	SSN	Relationship to HH

**Household Income** (List **All** Monies Received by **Long Term Care Patient, Spouse, and Any Dependent Minor Children**, Such as Employment, Unemployment Benefits, Pension, Social Security, VA, ADC, SII, Child Support, Etc.)

Household Member	Source	Amount	Award Date/ Per Week/Mo.	Claim #

Total Household Income:\$ \_\_\_\_\_

**Household Expenses Actually Paid per Month**

Expense	Amount	Expense	Amount
Rent <input type="checkbox"/> Mortgage <input type="checkbox"/>		Child Support	
Prescriptions, RX Med Supplies		Child Care to Non-Relative	
Medical Insurance		IRS, Court Fines, Retribution	
Doctor/Dentist/Med Bill Payment		Other:	

Total Household Actual Monthly Expenses: \$ \_\_\_\_\_

**PRIOR RESOURCES**

Medical Insurance Co: \_\_\_\_\_ Payment per Month: \$ \_\_\_\_\_

If None, Reason: \_\_\_\_\_

Other Resources: I/We Have Applied for the Following Resource \_\_\_\_\_ (SSI, SSA, VA, ADC, SIIS, Other) on \_\_\_/\_\_\_/\_\_\_ (Date). I/We Plan to Apply on \_\_\_/\_\_\_/\_\_\_ (Date).

Lawsuits: Specify Any Currently Pending Suits for Automobile or Other Accidents, Business, Etc.:

\_\_\_\_\_  
 Attorney's Name and Address: \_\_\_\_\_

I/We Have Filed for Bankruptcy: No  Yes  I/We Plan to File  Date: \_\_\_/\_\_\_/\_\_\_

\_\_\_\_\_  
 Attorney's Name and Address: \_\_\_\_\_

Assets	Yes	No	Cash & Face Value/Balance	Company/ Location	Account/ Policy No.
Cash on Hand	<input type="checkbox"/>	<input type="checkbox"/>	\$		
LTC Client Trust Acct.	<input type="checkbox"/>	<input type="checkbox"/>	\$		
Checking Account	<input type="checkbox"/>	<input type="checkbox"/>	\$		
Savings Account	<input type="checkbox"/>	<input type="checkbox"/>	\$		
Savings Certificate	<input type="checkbox"/>	<input type="checkbox"/>	\$		
Safe deposit box contents	<input type="checkbox"/>	<input type="checkbox"/>	\$		
Life Insurance(s)	<input type="checkbox"/>	<input type="checkbox"/>	\$		
Burial Insurance	<input type="checkbox"/>	<input type="checkbox"/>	\$		
Stocks/Bonds	<input type="checkbox"/>	<input type="checkbox"/>	\$		
Residential Real Estate	<input type="checkbox"/>	<input type="checkbox"/>	\$		
Non-Residential Real Estate	<input type="checkbox"/>	<input type="checkbox"/>	\$		
Trusts/Deeds/Notes Payable	<input type="checkbox"/>	<input type="checkbox"/>	\$		
Trust Fund/IRA/Keough/Other	<input type="checkbox"/>	<input type="checkbox"/>	\$		
Vehicle(s)	<input type="checkbox"/>	<input type="checkbox"/>	\$		
Livestock	<input type="checkbox"/>	<input type="checkbox"/>	\$		
Machinery/Equipment	<input type="checkbox"/>	<input type="checkbox"/>	\$		

Beneficiary: \_\_\_\_\_

I/We Have Sold, Given Away or Transferred Ownership in Land, Money, Deeds of Trust, Other Assets to Someone in the Last 36 Months. No  Yes  If Yes, Provide Details:

Item: \_\_\_\_\_ Transferred to: \_\_\_\_\_

Relationship to Me/Us: \_\_\_\_\_

On Open Market? No  Yes  Date: \_\_\_/\_\_\_/\_\_\_ Real Value: \$ \_\_\_\_\_

I/We Have Received a Lump Sum of Money Within the Last 36 Months: No  Yes

Amount: \$ \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ Source: \_\_\_\_\_

**FAMILY HISTORY**

**Residence Last 3 Years**

Street Address	City/State/Zip	Dates	
		From	To

How Long Has Patient Been a Resident of Clark County? \_\_\_\_\_

**Employment --- Long Term Care Patient, Last 3 Years**

Employer & Address	Position	From	To	Reason for Leaving

Union Membership, Past or Present. Local: \_\_\_\_\_

**Employment --- Spouse, Last 3 Years**

Employer & Address	Position	From	To	Reason for Leaving

Union Membership, Past or Present. Local: \_\_\_\_\_

**Relatives (List Parents, Brothers, Sisters, Adult Children)**

Name	Relationship	Address	Telephone

**Statement of Patient and Spouse:**

I/We Hereby Declare That I/We Do  Do Not  Have Any Relatives Who Can Provide Financial Aid.

If Yes, Please Name: \_\_\_\_\_

**I/We do hereby expressly and forever waive and release, indemnify and hold harmless, Clark County and all of their respective officers, employees, agents, or representatives from any and all claims, demands, rights, damages, actions, attorneys' fees, costs, expenses, and compensation, known or unforeseen, for personal injuries or damages sustained, incurred, arising from, or connected in any way, with my/our placement in a long-term care facility (nursing home, adult group care, or adult day care) by Clark County Social Service.**

**To the best of my/our knowledge and under penalty of perjury, I/we declare that all information supplied in this application is true and correct. Clark County Social Service is hereby authorized to make any reasonable inquiries in order to establish my/our eligibility.**

**NOTE: Both patient and spouse or representative must sign.  
Application not valid without signature.**

X \_\_\_\_\_  
Patient/Parent/Guardian/Representative      Date

X \_\_\_\_\_  
Spouse      Date

X \_\_\_\_\_  
Institution Worker

Person Completing Application:      Relationship to Patient:  
\_\_\_\_\_  
\_\_\_\_\_



**Notice to Patient or Representative:** This packet is a request by the patient and institution to determine the patient's household eligibility for medical institutional care. It must be completed accurately and in specific detail as well as signed by the **patient and spouse or representative** and the institution worker. The family is required to attest to the truthfulness of its contents.

In order to determine eligibility, the following information must be provided with referral. It will help the application process if **copies** of the following items are submitted with the completed packet:

1. Identification for patient (or parent/guardian) and spouse. Must include a Social Security Number, and proof of citizenship or alien status if foreign born.
2. Identification for all related household members. Proof of citizenship or alien status if foreign born.
3. Verification of shelter expense (rent receipt, house payment coupons, etc.).
4. Verification of **all** sources of monies received by household (copies of checks or award letters are acceptable).
5. Copies of medical insurance policies, and proof of cash/loan amount for life and burial policies.
6. Bank accounts: Last **three** monthly activity statements. For ongoing Long Term Care patients, a copy of bank statement is required for **each month** County assistance is required.
7. Verification of application to other resources: Pending slips, denial notices and documents from all sources, such as AFDC, SSI/SSD.
8. Copies of registrations and verification of ownership of all vehicles, including autos, trucks, trailers, campers, motor homes, motorcycles, dune buggies, boats, etc., licensed or unlicensed, regardless of location (not necessary if household has only one vehicle declared to be their essential vehicle).
9. Written documents pertaining to sale or transfer of assets, money or other property which occurred within the last 36 months.
10. Safe deposit box(es): provide location(s), signatories and list of contents.
11. Level of Care Assessment (NSW PASARR).
12. History and Physical (H&P)
13. All applicants are required to have a Chest X-Ray prior to admission.

A letter may be sent to advise the patient, institution or representative to contact a designated County caseworker to provide further information, if required. **It may be necessary for the patient, spouse or representative to be interviewed by Clark County Social Service.**

**Failure to cooperate or provide information may result in denial of assistance.**

A notice of decision of the patient's eligibility will be provided to the institution and the patient or representative.

SIGNED: \_\_\_\_\_  
Patient or Representative

\_\_\_\_\_  
Witness (Institution Worker)



# Department of Social Service

Mission: Provide a safety net of human services to a growing community.  
Vision: Self-Sufficiency for at-risk people through a variety of services.



## AUTHORIZATION FOR LEVEL OF CARE ASSESSMENT

I, \_\_\_\_\_, hereby authorize Clark County Social Service to obtain medical, social and/or psychiatric information concerning me.

I hereby authorize Clark County Social Service to obtain information as needed regarding my daily physical functioning ability and physical condition. I understand this information will be used to determine the level of care required prior to/and during admission to an adult group care or long term care facility through on-going audit procedure.

This authorization is valid for the period I am eligible to receive Clark County assistance. A photocopy of this authorization is considered the same as the original.

\_\_\_\_\_  
Signature of Applicant/Recipient

\_\_\_/\_\_\_/\_\_\_  
Date

\_\_\_\_\_  
Legal Guardian

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Witness



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## RELEASE OF INFORMATION

To the best of my knowledge and under penalty of perjury, I declare that all information provided by me is true and correct. I will not sell, trade, or willfully destroy any supplies or services given to me. I will notify Clark County Social Service (CCSS) whenever there is any change in my circumstances that might affect my eligibility for assistance.

I hereby authorize Clark County Social Service to make any investigation concerning me or other members of my household/service unit which is necessary to determine eligibility for any benefits I have or will receive under programs administered by Clark County Social Service. I hereby authorize and consent to the release of any and all information concerning me and my household/service unit members to Clark County Social Service by the holder of the information, regardless of the manner or form held, including, without limitation, information made confidential by law or otherwise and patient information privileged under N.R.S. 49.225 or any other provision of the law or otherwise. I also authorize CCSS to give any other governmental agency (local, state, or federal) information necessary to determine my (our) eligibility for your program or the other agency's program. I hereby release the holder of such information from liability, if any, resulting from the disclosure of the required information. **A REPRODUCED COPY OF THIS AUTHORIZATION LEGALLY CONSTITUTES AN ORIGINAL COPY.**

\_\_\_\_\_  
Signature/Date

\_\_\_\_\_  
Signature/Date

\_\_\_\_\_  
Signature/Date

\_\_\_\_\_  
Signature/Date

SS-9105 Release of Information



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\_\_\_\_\_  
Signature/Date

\_\_\_\_\_  
Signature/Date

\_\_\_\_\_  
Signature/Date

\_\_\_\_\_  
Signature/Date

SS-9105 Release of Information



# Department of Social Service

Mission Statement: "The mission of Clark County Social Service is to provide, within guidelines, progressive, multi-faceted social services and programs which enhance the quality of life and promote self-sufficiency for Clark County residents."



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\_\_\_\_\_  
Signature/Date

\_\_\_\_\_  
Signature/Date

\_\_\_\_\_  
Signature/Date

\_\_\_\_\_  
Signature/Date

SS-9105 Release of Information



# Department of Social Service

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## Authorization for Release of Information To Other Agencies/Resources

I hereby authorize Clark County Social Service to disclose information regarding my physical, psychological, social, financial circumstances and/or any other necessary information to any agencies, organization or facility in order to determine the need and eligibility for appropriate long term care services and payment sources.

This authorization is valid for the period my case is active for CCSS services. A photocopy of this authorization is considered the same as the original.

\_\_\_\_\_  
Name

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature of Applicant or Recipient

\_\_\_\_-\_\_\_\_-\_\_\_\_  
SSN

\_\_\_\_\_  
Signature of Applicant or Recipient

\_\_\_\_\_  
Clark County Social Service Worker

SS-6113