



Operated by:
Clark County Social Service

2820 W. Charleston Blvd. #B-15
Las Vegas, Nevada 89102

**STEP-UP
INITIAL APPLICATION FORM**

Personal Information

Today's Date: _____ Full Name (Legal): _____

Date of Birth: _____ Age: _____ SS#: _____

Ethnic origin: _____ Religion: _____ Email Address: _____
(Optional) (Optional)

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone :(_____) _____ Cell Phone :(_____) _____

Is it okay to leave a message for you at the numbers listed above? Circle: YES / NO

Marital Status: Single Married Divorced Partnership
If married, what is your maiden name _____

Do you have children? Yes No If yes, please list their name(s), D.O.B. and whom they reside with.

Are you currently pregnant or expecting a child? Yes No
If yes, expected due date _____ If yes, date you enrolled with WIC: _____

Do you have a NV driver's license? Yes No
Drivers License Number _____ Exp. Date _____

Do you have a NV identification card Yes No
Identification card number _____ Exp. Date _____

Phone Number (702) 455-0468

Fax Number (702) 822-1203

www.ClarkCountyNV.gov/depts/social_service/



Operated by:
Clark County Social Service

2820 W. Charleston Blvd. #B-15
Las Vegas, Nevada 89102

Do you have your original birth certificate? Yes No

Do you have a social security card? Yes No

Are you a high school graduate? Yes No Date: __/__/__ School: _____

Have you received your G.E.D? Yes No Date: __/__/__

Are you currently in school: Yes No If yes, where? _____

Full Time or Part Time (circle one)

Are you receiving assistance with your educational expenses from any of the following programs:

ETV Through the Eyes of a Child FAFSA CASA Other _____

Client Employment status (circle): Full-time / Part-time / Unemployed Other: _____

Employer: _____ Employment Position/Title: _____

Employer Benefits: _____

Start Date: _____ How long: _____ years _____ months

RESOURCES

Please list any other income you are receiving. (SSI/Welfare/Food Stamps/Income from a Trust)

Have you applied for Medicaid? Yes, date applied: _____ No

If approved, Medicaid # _____

Has Medicaid denied you coverage in the past? Yes No If so, when? _____

Have you applied for Step Up in the past? Yes, date _____ No

In what area(s) you like assistance and/or information:

- Independent living skills Transportation Employment/Vocational Training
- Medicaid Housing Education Substance Abuse Rent/Utilities
- Mental Health Other _____

Phone Number (702) 455-0468

Fax Number (702) 822-1203

www.ClarkCountyNV.gov/depts/social_service/



Operated by:
Clark County Social Service

2820 W. Charleston Blvd. #B-15
Las Vegas, Nevada 89102

HOUSING

Where were you living at the age of 18? _____

Do you have a place to sleep tonight? Yes No

If so, how long have you stayed there? _____ years _____ months _____ days

You are (please check all that apply): Staying with someone Renting a room

Have own apartment with your name on the lease In a transitional living program

Other _____

Please list members of your household (everyone living in your home - related or not):

Name of Person Living in the Home:	Age:	Relationship to Client:

Person to notify in case of emergency: Name: _____

Relationship: _____ Phone: _____

Address: _____

Foster Care Information

At what age did you enter DFS custody? _____ Why? _____

Have you had a pre-exit consultation with your planning team? Yes If so, date __/__/__ No

Biological parent's first and last names:

Mother: _____ Father: _____

Phone Number (702) 455-0468

Fax Number (702) 822-1203

www.ClarkCountyNV.gov/depts/social_service/



Operated by:
Clark County Social Service

2820 W. Charleston Blvd. #B-15
Las Vegas, Nevada 89102

How many foster homes were you in? _____

Please describe your experience and your current relationship with your foster family:

Your current or former case worker's name and phone number:

Have you used any other names, including adopted names and street names:

Do you have siblings in care (please list their first and last names):

For Internal Use Only:
Foster Care Exit Date: _____ Date emailed DFS: _____ Initials: _____

Medical & Mental History

In order to better assist you with your needs, could you provide information on your current or previous outpatient medical and/or mental health treatment provider, or indicate if you have substance abuse or gambling issues and are in or need treatment:

Date/s	Reason	Where?

Have you ever dropped out of treatment? _____

Previous Medical and/or Psychiatric Hospitalizations (for mental health issues):

Date/s	Reason	Where?

Phone Number (702) 455-0468

Fax Number (702) 822-1203

www.ClarkCountyNV.gov/depts/social_service/



Operated by:
Clark County Social Service

2820 W. Charleston Blvd. #B-15
Las Vegas, Nevada 89102

Please list any medications you have taken or are currently taking for mental health issues only:

Medication	Dose	Frequency	Response	Start Date	Side Effects

What doctor prescribes these medications? _____

Please list any medications you have taken for medical issues only:

Medication	Dose	Frequency	For what condition	Start Date	Side Effects

What doctor prescribes these medications? _____

Have you ever been told that you are dealing with issues related to early development? If so, please describe (i.e. low birth weight, poor attention or concentration, learning issues, slow to walk or talk, etc.):

Have you ever been told that you are dealing with a learning disability? If so, please describe and indicate if you were in special education classes and if so, what years did you have an IEP?

Phone Number (702) 455-0468

Fax Number (702) 822-1203

www.ClarkCountyNV.gov/depts/social_service/



Operated by:
Clark County Social Service

2820 W. Charleston Blvd. #B-15
Las Vegas, Nevada 89102

_____ (initial) I will cooperate with the requirements of the Step Up self sufficiency program administered by Clark County Social Service.

_____ (initial) I plan to spend the funds given to me by the Clark County Social Service Step Up program in a legal manner as truthfully stated above.

_____ (initial) I am aware that the funds accessed will be monitored and or sampled to determine spending patterns of funds distributed.

_____ (initial) I understand that Tobacco products and Alcohol purchases with Clark County Social Service Step Up monies (or cards) is prohibited.

RIGHT TO APPEAL

Your exit date from foster care must first be verified before funds can be dispersed and all requests are subject to approval. In circumstances in which funds are denied, you have the right to request an appeal to the decision. Appeals must be made, in writing, to Clark County Social Service within 10 days of denial date. _____ (initial)

_____ Date: _____
Signature of Applicant

For Office Use Only:
 Initial appt date: _____ With: _____
 Case #: _____ Pin #: _____ Application #: _____
 Assigned to: _____ Date Assigned: _____

Phone Number (702) 455-0468

Fax Number (702) 822-1203

www.ClarkCountyNV.gov/depts/social_service/