Clark County Social Service
Senior Services Referral

Office Use Only
Date Received:
Received By:
Assigned Worker:
Application #:
Reference #:
IC Case #:

○ Adult Daycare
◉ Homemaker Home Health Aide Services (HHHA)
○ Alternative Health Care Program (AHC) – **ONLY** if applicant had in-patient stay within the last 30 days.

* If AHC - Please attach **DISCHARGE SUMMARY** & provide the following details:

Name of Institution/Hospital:	Admission Date:	Discharge Date:

****Incomplete Information will delay processing****

NAME: _____ **SS#** _____ **D.O.B.** _____

SPOUSE: _____ **SS#** _____ **D.O.B.** _____

***You must include spouse if married. Able & willing to receive texts? ☐ Yes ☐ No

CELL PHONE: _____ **ALTERNATE PHONE:** _____

ADDRESS, CITY, STATE, ZIP _____

EMAIL ADDRESS: _____

GROSS INCOME			ASSETS (Bank account balances, Life insurance cash surrender value, etc)
INCOME SOURCE:	**APPLICANT**	**SPOUSE**	
	$	$	
	$	$	
TOTAL HOUSEHOLD	$		$

INSURANCE INFORMATION (mark all that apply): ☐ Medicaid ☐ Medicare ☐ Other: _____

MEDICAL/HEALTH CONCERNS:

ASSISTANCE REQUESTED: ☐ Personal Care ☐ Medication Pick up ☐ Meal Prep ☐ Laundry ☐ Grocery Shopping ☐ Light Cleaning

ADDITIONAL INFORMATION:

REFERRED BY: **PHONE:**

RELATIONSHIP TO APPLICANT: