Clark County Social Service

- ☐ Homemaker Home Health Aide Service
- ☐ Alternative Health Care Program
- ☐ Adult Daycare

Office Use Only

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

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

Spouse: _____ **SS#** _____ **D.O.B** _____
You must include spouse if you are married

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 problems_____

_____

_____

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

Does this residence have bed bugs? _____

Remarks _____

_____

_____

_____

Worker's Name