LINCOLN COUNTY HUMAN SERVICES
PO BOX 508
PANACA, NV 89042
775-962-8084

The money that we are able to use for emergency assistance is provided by grants. The granting agencies **require** certain information before assistance is given.

ASSISTANCE MAY BE PROVIDED ONLY ONCE PER 12 MONTH PERIOD. ONCE YOU RECEIVE ASSISTANCE YOU MUST WAIT 12 FULL MONTHS UNTIL YOU APPLY OR RECEIVE ASSISTANCE AGAIN.

All information is confidential and is not for public knowledge. There is **NO GUARANTEE** assistance will be provided. After all information is received and reviewed then a decision will be made and provided in writing to the applicant.

IT IS YOUR RESPONSIBILITY TO SUBMIT YOUR APPLICATION COMPLETE AND WITH THE FOLLOWING ITEMS. WE WILL NOT CONTACT YOU FOR ANY MISSING INFORMATION. ANYTHING MISSING IS AN AUTOMATIC DENIAL. YOU MUST READ AND SIGN ALL SPACES NEEDED.

IT IS YOUR RESPONSIBILITY TO CONTACT THE OFFICE 3 WORKING DAYS AFTER SUBMITTAL TO SEE IF YOU ARE ELIGIBLE FOR THE ASSISTANCE REQUESTED.

- **Copies of all household income for the last 30 days for all ADULTS in the household. (Including social security, social security disability, VA benefits, child support, unemployment income, alimony, pension, etc.)**
- **Housing expense - rent or mortgage**
- **Utility expenses (water, electric, propane, etc)**
- **Medical Bills**
- **Telephone Bills**
- **Internet**
- **Cable/satellite**
- **Child support payments made**
- **Copies of your most recent 2 bank statements.**

Read each question carefully and answer every question. If the answer is none then write N/A in the space provided.

If you need help filling out the form, you may want to ask your family, a friend, or someone qualified in this office.

If you do not understand any question, ask for an explanation from someone in this office.

If you are applying for someone other than yourself (child, parent, etc) check boxes as they pertain to the person applying.

You are certifying the correctness of your answers, whether you are completing the form for yourself or someone else, by signing the form.

Information verifies answers given on this form. False information or willful concealment of money and resources could result in rejection of application, or criminal prosecution.

THE CUSTOMER SELF ASSESSMENT MUST BE FILLED OUT IN IT'S ENTIRETY

If you have any questions please contact Toni Acuff 775-962-8084.

Return application to: Lincoln County Human Services
PO Box 508
Panaca, NV 89042

Date_____

Name First_____**Middle**_____**Last**_____

Date of Birth (MM/DD/YYYY)_____**SS#** _____

Mailing Address_____

Physical Address_____

Phone Number_____ **Cell Phone Number**_____

Gender: Male____ **Female**____

Do you have Medical Insurance Yes___ No___ Medicaid ___Medicare ___
Private___ VA_____ NV Check Up _____

Applicant – Veteran Yes____ No ____ VA Benefits _____

Head of Household: Me_____ Other (name) _____
Relationship: spouse____ child____ in-law____ niece/nephew____
Sibling ____ parent____ aunt/uncle____ other_____

Ethnicity: Non Hispanic _____ **Hispanic** _____

Race: White___ Black___ Asian___ Pacific Islander___ Native American____
Middle Eastern___ Other_____

Family Type: Single parent family (with children) _____ Male___ Female___
Two parent family (with children) _____
Two adult family (no children) _____
Single person (living alone) _____ Male___ Female___

Education: 9^{th} – 12^{th} grade, Non-graduate _____
Associate Degree _____
Bachelor's Degree _____
Graduate Degree _____
High School or GED _____
Less than 9^{th} grade _____
Some College _____
License _____
Certification _____

Housing

Homeless	____
Living w/Others	____
Living w/Relatives	____
Own	____
Rent	____
Shelter	____
Other	____

Marital Status:

Single	____
Married	____
Divorced	____
Separated	____
In a relationship	____
Widow	____
Widower	____

Household Size _____

Household Members (please complete for everyone **besides** yourself)

Name (first, middle, last)	Gender	DOB	Relationship	Soc Sec No	Ethnicity	Education	Disabled	Health Ins.

EMPLOYMENT and INCOME

Are you currently employed? ___yes ___no
Employer_____
Address_____
Phone_____Supervisor_____
How long at job (years, months, weeks)_____

Are you actively looking for work? Yes ___ No ___ Why?_____

SOURCE OF INCOME

	AMOUNT	HOW OFTEN	WHO
Employment	_____	_____	_____
TANF	_____	_____	_____
SSI	_____	_____	_____
SSD	_____	_____	_____
Social Security	_____	_____	_____
Retirement	_____	_____	_____
SIIS	_____	_____	_____
Unemployment	_____	_____	_____
Child Support	_____	_____	_____
Food Stamps	_____	_____	_____

EMPLOYMENT

Employed full time _____
Employed at part time job (s) _____
Going to school or job training program _____ Where?_____
Unemployed and seeking employment _____
How long without employment? _____
Unemployed, not seeking employment _____
How long with out employment? _____
On disability leave _____ How long?_____
Retired _____
Self-employed _____
Temporary or seasonal worker _____ Type of Business_____

ASSETS

Do you have: Life insurance Yes____ No____
Dental insurance Yes____ No____
Auto insurance Yes____ No ____
Checking account Yes ____ No ___ Balance_____
Savings Account Yes ____ No ____ Balance_____
Cash on hand Yes ____ No ____ Balance_____
Trust Account Yes ____ No ____

Does the family currently have a vehicle? _____Make_____Model_____Year_____

Are you purchasing a vehicle? _____Yes _____NO _____Mo. Payment

Has anyone in this household ever received rental assistance?_____
When? _____
Where? _____
Amount? _____

How long have you lived at your current residence_____

How long have you lived in Nevada?_____ Lincoln County?_____

How many times have you moved in the past 12 months_____

Where did you live previously_____

Do you __Rent __Own __Other (explain)_____

Is this residence __Section 8 subsidized __Tribal funded

Have you ever received an: Eviction Notice__ Homeless in past 12 months__
Explain:_____

MONTHY EXPENSES:

Please be specific and give as much information a you can, this helps us determine the best way to help you.

	Balance	Pmt Amt.	Paid to Who
Mortgage or Rent	_____	_____	_____
Power	_____	_____	_____
Propane	_____	_____	_____
Water	_____	_____	_____
Landfill	_____	_____	_____
Telephone	_____	_____	_____
Cell Phone	_____	_____	_____
Cable/Satellite	_____	_____	_____
Internet	_____	_____	_____
Food	_____	_____	_____
Clothing	_____	_____	_____
Transportation	_____	_____	_____
School Supplies	_____	_____	_____
Medical Expenses	_____	_____	_____
Prescriptions	_____	_____	_____
Other ( )	_____	_____	_____

What is your priority at this time? Food_____ Rent Assistance_____ Security/Utility Deposit_____ Medical/Medication _____Dental_____ Catching up on Utilities_____ Transportation-work related_____

What caused the need for Assistance?

_____
_____
_____

Exactly how will this assistance help you?

_____
_____
_____

Where was your last job? Name and address?

_____
_____

When did you start?_____ When did it end?_____
Reasons for leaving (be specific)_____
_____
_____

Have you applied for our programs in the past? __yes __no

What assistance did you receive?_____
_____

What obstacles are keeping you from reaching your goal? (Child care, GED, lack of

Work experience, lack of transportation, drug or alcohol problems) _____
_____

What additional services would help you meet your goal? _____
_____

SIGNATURE AND AFFIRMATION

I understand information provided on this application is subject to verification by Federal, State or local officials. If any information if found inaccurate, I may be denied assistance and/or be subject to criminal prosecution for knowingly providing false information.

I understand the questions on this application and the penalty for hiding or giving false information. I certify under penalty of perjury my answers are correct and complete. I agree to notify the agency where I made application for assistance of any changes in my circumstances that may affect my eligibility.

I understand if my assistance is computed to be less than $10, I will receive medical assistance only and no money payment/voucher.

I hereby assign to the Nevada State Welfare Division and the County, as a condition of eligibility, all rights to medical support or other payments for medical care for myself and all persons for whom I am applying/receiving assistance to the extent the Division/County paid for those benefits.

I understand I have a duty to inform the Nevada State Welfare and County Welfare if I or anyone on my behalf commences a legal action against anyone for recovery of money as reimbursement for medical care and treatment paid for by the Medical Program and County. I must further advise the Nevada State Welfare Division and County should I, or anyone on my behalf, solicit or receive any offer of settlement of money as reimbursement for medical care and treatment paid for by the Medical Program and county.

I hereby authorize the agency to which I am applying for assistance to make any investigation concerning me or other members of my household or my children's legal/putative parent(s) whom is necessary to determine eligibility for any benefit I have received or will receive under programs administered by this agency. I hereby authorize and consent to the release of any and all information concerning me or my household members to the agency 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 privileges under NRS 49.225 or any other provision of law or otherwise. I hereby release the holder of such information from liability, if any, resulting from the disclosure of the required information. I authorize the agency to contact my employer to obtain wage information. A reproduced copy of this application and authorization legally constitutes an original copy.

I authorize the Nevada State Welfare Division, County Welfare Departments and agencies for which I may be eligible for assistance to exchange information essential for effective case management.

This release is valid for a period of one year from the date of authorization.

_____ _____

Signature or Mark of applicant Date

I CERTIFY UNDER PENALTY OF PERJURY BY SIGNING MY NAME BELOW THAT I AM A UNITED STATES CITIZEN OR ALIEN IN LAWFUL IMMIGRATION STATUS.

_____ _____

Name Date

I AGREE TO ACT ON BEHALF OF THE ABOVE APPLICANT. I UNDERSTAND MY RIGHTS AND OBLIGATIONS AS A REPRESENTATIVE AND RESPONSIBLE PARTY.

_____ _____

Signature of Authorized Representative Complete Address

LINCOLN COUNTY HUMAN SERVICES
PO BOX 508
PANACA, NV 89042
775-962-8084
FAX 775-728-4297

AUTHORIZATION FOR RELEASE OF INFORMATION

I understand that an investigation may be made in which information regarding my financial, medical, employment, or any other applicable situation may be received in consideration for assistance for Lincoln County Human Services. I authorize anyone possessing this information to furnish it to Lincoln County Human Services upon request, and I release Lincoln County Human Services from all liability and damages whatsoever in furnishing, obtaining or using said information.

I authorize any health professional or healthcare facility to release to Lincoln County Human Services, any information with respect to myself that may be related to me gaining assistance from Lincoln County Human Services, including any relevant review of drug, alcohol, or psychiatric treatments.

I fully understand that my healthcare records will be used in accordance to all HIPPA rules and regulations and that Lincoln County Human Services does not have my authority to share my healthcare records with any other agency without my written consent.

I certify that all statements are true to the best of my knowledge, and I agree and understand that any misstatements or omissions of material facts on my part may result in a suspension or denial of services and/or prosecution even after I have received assistance from Lincoln County Human Services

SIGNED_____DATE_____

ADDRESS_____

CITY_____STATE_____ZIP_____

DAYTIME TELEPHONE_____

OTHER TELEPHONE_____

SOC. SEC. NUMBER_____

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RESIDENCE VERIFICATION

Tenant Name_____

Rental Address_____

Move in date_____Monthly Rent $_____Deposit: __yes __no

Is rent up to date? __yes __no

If no, please list amount owed and months owed for_____
_____

Is rent assistance provided? __yes __no

By what agency? _____

List all persons that will be or are residing in this residence:
_____

_____

_____

_____ _____
(MANDATORY)Landlord signature Date

Address_____
_____
_____

_____
Telephone

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PRIVACY NOTICE

Lincoln County Human Services will not disclose non-public, personal information to any non-affiliated third party except as required by law, or with the client's written permission.

Client information will not be accessible to any persons other that authorized Service Provider personnel, or authorized personnel for Lincoln County, CSBG, WSA, or other partnering agencies for eligibility, Compliance Monitoring and/or Audit purposes.

COMPLAINTS:
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Toni Acuff, Lincoln County Human Services, Director
P.O. Box 508
Panaca, NV 89042

IF you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the address above.

You will not be penalized or otherwise retaliated against for filing a complaint. We can only improve what and how we do it with feedback.

Acknowledged Receipt: _____

Date : _____

CUSTOMER SELF ASSESSMENT

Customer: _____
Last First Middle
Date of Birth: _____ Gender: F / M

Address: _____

Phone Home: _____ Cell: _____ Email: _____

Alternative Contact Person: _____

In What Type of housing do You Live?

Rent Home or Apartment	YES NO	Transitional Living Facility	YES NO
Not Homeless-Living with Others	YES NO	Homeless-No Shelter	YES NO
Own Home	YES NO	Homeless-Living in Shelter	YES NO

Number of Years/Months at Current Address: _____
If Homeless, Do you need help with Finding Shelter: YES NO
Monthly Housing Cost: $ _____ (Mortgage/Rent)
Have You Received an Eviction Notice? YES NO
Have Your Utilities Been Disconnected? YES NO Are Utilities Working? YES NO
Major Appliance Working? YES NO Are There Safety Concerns? YES NO
Identify Any/All Concerns: _____

TRANSPORTATION

Do You Have Access to Transportation? YES NO
If Yes, What Type of Transportation Do You Use? _____
Do You Need Assistance with Transportation? YES NO
Other Pertinent Information: _____

LEGAL

Do You Have Any Current or Past Experience with:

Outstanding Warrants:	YES NO	Civil Record:	YES NO
Criminal Record:	YES NO	Civil/Criminal Charges:	YES NO
Family Court:	YES NO	Incarceration:	YES NO
Probation:	YES NO	Parole:	YES NO

If You are Currently on Parole/Probation, Who is Your Parole/Probation Officer? _____
Do You Need Assistance with:

Divorce:	YES NO	Child Custody:	YES NO
Child Support:	YES NO	Minor Guardianship Planning:	YES NO

Are You a U.S. Citizen? YES NO If No,
Do You Have Identification? YES NO
Residency Documents? YES NO A Visa? YES NO
Other Pertinent Information: _____

GENERAL EDUCATION, VOCATION AND LITERACY

Do You Speak English? YES NO
Do You Read English? YES NO
Do You Write in English? YES NO
Do You Speak Spanish? YES NO
Do You Read Spanish? YES NO
Do You Write in Spanish? YES NO
What Language Do You Prefer? _____
How Much School Have You Completed?
8th Grade or Less: YES NO
Between Grade 8th and 12th: YES NO
High School Diploma/GED: YES NO
Vocational/Technical Training: YES NO
College: YES NO
College Degree: YES NO
Other: _____
Other Pertinent Information: _____

BENEFITS/INCOME

Employment: $_____ /Month
Employer: _____
SSI/SSDI: $_____ /Month
Unemployment: $_____ /Month
TANF: $_____ /Month
SNAP/WIC: $_____ /Month
Other: $_____ /Month
No Income: YES NO
Total Monthly Household Income: $ _____
Outstanding Debts: $ _____
Number of Dependents: _____
Are You Able to Work: YES NO
If Yes, Would You Like to Be Working: YES NO
If Unemployed, Are you Interested in Career Coaching or Job Training? YES NO
If Employed, What Type of Work? _____
Have You Experienced Problems with Your Job In The Last 30 Days? YES NO
Other Pertinent Information: _____

ACCESS TO HEALTH CARE

Do You Currently Have Health Insurance? YES NO
If No, Please Explain Why? _____
Do You Currently Have a Doctor? YES NO
Are You Currently Being Treated for a Medical Condition? YES NO
Are You Able to Access Medications/Medical Equipment? YES NO
Other Pertinent Information: _____

ACCESS TO NUTRITION

Do You Have Access To Food Pantries? YES NO
Are You Receiving Food Stamps? YES NO
Are You Enrolled with Meals on Wheels? YES NO
Are You Skipping Meals Due to Lack of Food? YES NO
Other Pertinent Information: _____

ACCESS TO DENTAL CARE

Do You Have a Dentist? YES NO If Yes, When Was Your Last Appointment?
If No, Do You Have Teeth/Gum Problems? YES NO
If Yes, Would You Like a Dental Referral? YES NO
Other Pertinent Information: _____

ACCESS TO VISION CARE

Do You Have An Eye Doctor? YES NO If Yes, When Was Your Last Appointment?
If No, Do You Have Problems with Your Vision? YES NO
Do You Require Corrective Lenses? YES NO
If Yes, Would You Like a Vision Referral? YES NO
Other Pertinent Information: _____

ACCESS TO HEARING CARE

Do You Have Any Problems with Hearing in One or Both Ears? YES NO
Do You Require Hearing Aids? YES NO
Are You Currently Being Seen By a Doctor For Your Hearing Needs? YES NO
If No, Would You Like a Hearing Referral? YES NO
Other Pertinent Information: _____