

Respite Emergency Funds Request

I first heard about the Emergency Funds from: _____

Caregiver Intake

| | | | | |
|--------------------------------|-------------------------------|-------------------------------|---------------------------------|--------------------------------|
| Name: _____ | | <input type="checkbox"/> Male | <input type="checkbox"/> Female | <input type="checkbox"/> Other |
| Date of Birth: _____ | Phone: _____ | Email: _____ | | |
| Physical Address: _____ | Mailing Address: _____ | | | |
| SAMS: _____ | Date Received: _____ | | | |

Caregiver Demographics

Are you providing care to more than one person? (i.e. children, grandchildren, and/or other adults?) Yes No

If yes, give the ages of all the people you provide care to:

0-3 4-17 18-24 25-39 40-64 > 65

Care Recipient

Person in your Care

Enrolled w/ NVCC: Yes No

| | | |
|---|--|--|
| Name: _____ | Poverty(per the most current Federal Poverty Guidelines) At or Below Poverty <input type="checkbox"/> Above Poverty <input type="checkbox"/> | |
| Age: _____ | | |
| Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other | | |
| Relationship to person in your care: _____ | | |
| Does he/she have a diagnosed dementia (i.e. Alzheimer's, dementia, Vascular dementia, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Specify diagnosis: <i>If yes, what stage of dementia?</i> <input type="checkbox"/> Early <input type="checkbox"/> Mild/Middle <input type="checkbox"/> Severe <input type="checkbox"/> Unknown <i>If no, are you concerned about dementia or a memory impairment?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Household Status: Lives alone <input type="checkbox"/> Lives with Others <input type="checkbox"/> | | |
| Ethnicity: | | |
| Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> | | |
| Race: | | |
| American Indian <input type="checkbox"/> | | |
| Asian <input type="checkbox"/> | | |
| Black or African American <input type="checkbox"/> | | |
| Native Hawaiian or Pacific Islander <input type="checkbox"/> | | |
| White <input type="checkbox"/> | | |
| Other <input type="checkbox"/> | | |
| Assistance/Supervision Needed (Check all that apply): | | |
| <input type="checkbox"/> Bathing & Hygiene | <input type="checkbox"/> Dressing & Grooming | <input type="checkbox"/> Toileting/Bladder Care |
| <input type="checkbox"/> Eating or feeding | <input type="checkbox"/> Meal Preparation | <input type="checkbox"/> Transfers In/Out |
| <input type="checkbox"/> Standing or Walking | <input type="checkbox"/> Social/Recreation | <input type="checkbox"/> Give/Arrange Transportation |
| <input type="checkbox"/> Medication reminders | <input type="checkbox"/> Medical care (medication administration) | <input type="checkbox"/> Decisions/Advocacy |
| <input type="checkbox"/> Communication/Coordination | <input type="checkbox"/> Behavioral Support | <input type="checkbox"/> Light Housekeeping/Chores |
| <input type="checkbox"/> Manage Finances/Pay Bills | <input type="checkbox"/> Shopping | <input type="checkbox"/> General supervision |

Request Details



| | |
|---|---------------------------------|
| Purpose of Request: | |
| Justification (<i>Why Funds Are Needed</i>): | |
| Amount Requested: | Pay to the Order Of: |
| Address for Payment: | |
| Memo on Check: | Date Payment to be Made: |

Emergency Request can be submitted via email or regular mail. Send completed application to:

Nevada Aging and Disability Services Division

Attn: Yazmin Orozco

Email: Yorozco.contractor@adsd.nv.gov

Phone: 775-575-9406

Please NOTE: In subject line of email- LSR: ER- (Last Name of Caregiver) and please provide a brief summary of anything you think may be pertinent or important for Program coordinator to be aware of.