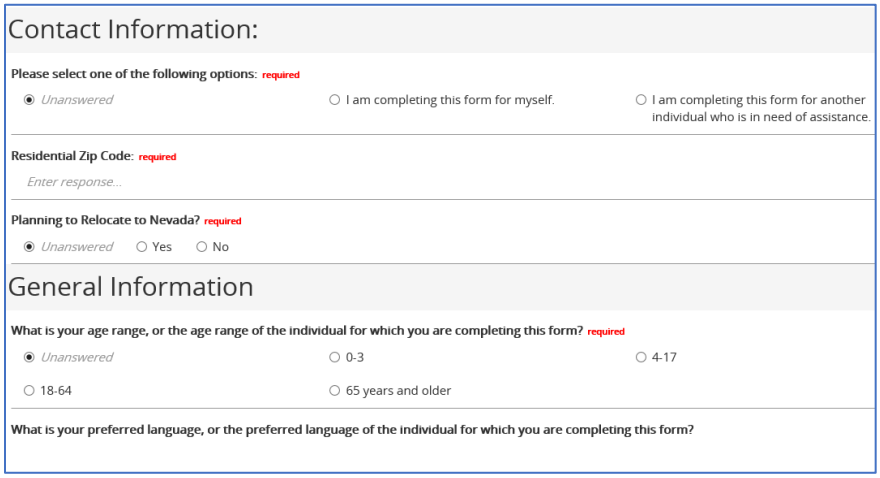
How to Send Referrals Using the Assess My Needs Form

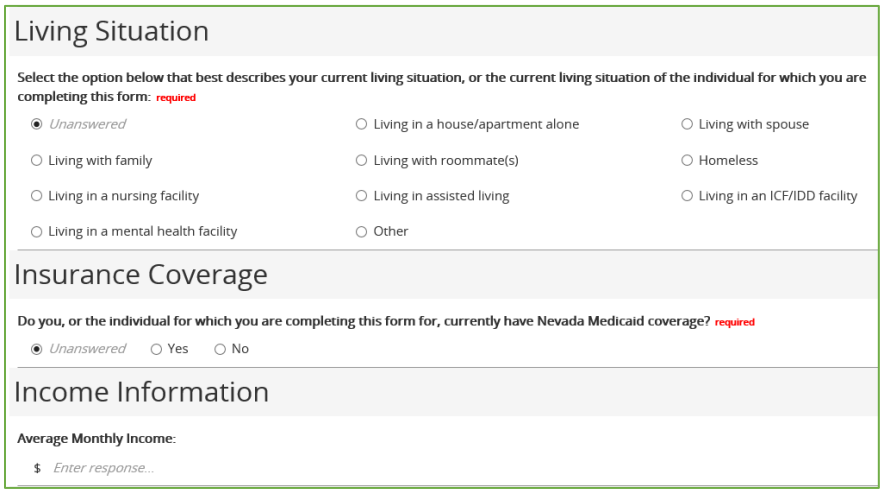
This form is used to connect individuals seeking services to various programs throughout Aging and Disability Services Division and our partners. This means not having to jump around from agency to agency looking for services but filling out one form and getting connected to various agencies based on your answers and needs identified.

Click the following link to get connected to the online assessment:

[Assess My Needs Form]



Sections 1 & 2 ask for information about the person completing the form (if applicable) and the person in need of assistance. If you are a submitting the form for another person, select the option that best describes your relationship to the individual.



Sections 3-5 discuss additional information about the person in need of assistance including their living situation, insurance coverage, and income information.

Resources & Assistance

I am, or the individual I am completing this form for is, a person with: (Check all that apply) required All / None

- ☐ A medical condition (e.g. heart disease, dementia, diabetes, stroke, HIV/AIDS, asthma)
- ☐ A physical condition or disability
- ☐ A mental health condition (e.g. depression, anxiety, PTSD, ADHD)
- ☐ An intellectual or developmental disability (e.g. cerebral palsy, epilepsy, autism, or concern for delay in child development)
- ☐ A substance use disorder (e.g. alcohol, prescription or illegal drugs)
- ☐ An acquired or traumatic brain injury
- ☐ Memory Loss (e.g. dementia, Alzheimer's or other memory condition)
- ☐ None of the above

I am, or the individual I am completing this form for is, in need of assistance with one or more of the following: (Check all that apply) required

All / None

- ☐ Bathing
- ☐ Brushing Teeth
- ☐ Combing Hair
- ☐ Communicating
- ☐ Decision Making
- ☐ Dressing
- ☐ Eating
- ☐ Employment
- ☐ Getting In/Out of Bed
- ☐ Housekeeping
- ☐ Legal Assistance or Support
- ☐ Managing Money
- ☐ Meals/Cooking
- ☐ Medical - Telehealth (primary care, geriatrics, and social work)
- ☐ Mental and Substance Use Disorder Services
- ☐ One-on-One Check-In Telephone Calls

In section 6, select ALL options that apply.

Do your best to select all of the items that best fit what the individual needs.

Depending on the items selected, more questions may appear.

Mental & Behavioral Health

Do you have concerns about risk of suicide for yourself or others?

◉ *Unanswered* ○ Yes ○ No

Are you, or the individual for which you are completing this form for, seeking assistance for behavioral health services such as depression, anxiety, substance use, or because of problems thinking clearly?

◉ *Unanswered* ○ Yes ○ No

During the past 4 weeks, have you, or the individual for which you are completing this form for, experienced emotional problems (such as feeling depressed, anxious, irritable, impulsive, or angry)?

◉ *Unanswered* ○ Yes ○ No

Section 7 discusses mental and behavioral health services. Select any statements that apply to the individual requesting assistance.

Additional Information

Please add any general/additional comments that will be helpful for the Resource Navigator to know prior to contacting you or the individual for which you are completing this form for: (i.e. Deaf, limited minutes on cell, availability time/days, etc.)

Enter response...

In this section, you can provide any other additional information you think would be helpful.

Authorization for the Use and Disclosure of Protected Health Information

I hereby authorize the use or disclosure of my protected health information by the State of Nevada, Department of Health and Human Services, as described below. I understand the following:

* The purpose of the disclosure is for the Aging and Disability Services Division (ADSD) and their network partners to assist me in obtaining services. They may share the information I have provided in this webform with any social service agency that may provide me services, such as housing, meals, health care, and counseling services.

* The information I provided in this webform may be redisclosed and no longer protected by federal privacy regulations.

* I may inspect or copy the information used or disclosed.

* This authorization is voluntary, and I may revoke this authorization at any time by notifying ADSD in writing. This authorization expires when I no longer seek services from ADSD.

Authorization and Consent required All / None

☐ By checking this box, I hereby authorize the use or disclosure of my protected health information as described above.

There is also a section for authorization of information disclosure. This information will be kept confidential, but will be distributed to the appropriate agencies for assistance. You must click this box for your form to be submitted.

✔ Submit ✖ Cancel 🖶 Print

At the end of the form, submit, cancel or print the form for your records.