Washoe County Human Services Agency – Senior Services Division

Referral: Fax to: (775) 325-8025 Phone: (775) 328-2575

*Required Info – PRINT CLEARLY & LEGIBLY

***Last Name/First Name:** ***Date:**

***Address:** ***Apt.#:**

***City:** **State:** ***Zip:**

***Phone: ( )** Home ☐ Cell ☐ Other:

Alt. Phone: ( ) Home ☐ Cell ☐ Other:

***Date of Birth:** ***Social Security Number:**

***Gender:** ☐ Male ☐ Female ***Veteran Status**: ☐ Veteran ☐ Non-Veteran ☐ Spouse of Veteran

***Lives Alone:** ☐ Yes ☐ No ***Marital Status:** ☐M ☐S ☐D ☐W ☐Other

*If No, lives with: ***SPOUSE NAME:** ***DOB:**

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic or Latino ☐ Unknown

***Gross Monthly Income:** _____ ***Source of income:** _____
(TOTAL household) (SS, SSI, 401K, PENSION, VA, ETC.)

***Ambulation:** ☐ Walker ☐ Wheelchair: ☐ Electric or ☐ Manual ☐ Cane

*Task	Independent	Need Assistance	Unable to Perform
Bathe	☐	☐	☐
Use the Bathroom	☐	☐	☐
Eat	☐	☐	☐
Get Dressed	☐	☐	☐
Walk	☐	☐	☐
Transfer In or Out Of a Bed or Chair	☐	☐	☐

*Task	Independent	Need Assistance	Unable to Perform
Shop	☐	☐	☐
Prepare Meals	☐	☐	☐
Do Light Housework	☐	☐	☐
Do Heavy Housework	☐	☐	☐
Take Medication	☐	☐	☐
Manage Money	☐	☐	☐
Use Transportation Srvs	☐	☐	☐
Use the Telephone	☐	☐	☐

***Reason for Referral (i.e.: Diagnosis/Health & Physical Conditions):**

***Support System:** ☐ Family ☐ Friend ☐ Neighbor ☐ Other

Name: Relationship: Phone #:

***SERVICE(S) BEING REQUESTED (☑ below)**

☐ INFO & REFERRAL ☐ HOME DEL. MEALS ☐ CASE MGMT ☐ HOMEMAKER ☐ REP PAYEE

☐ ADULT DAYCARE IS CLIENT ON HCBW (CHIP) W/ ADSD? ☐ **YES** ☐ **NO** ☐ **PEN** ☐ **WAITLISTED**

CLIENT AWARE & RECEPTIVE TO REFERRAL/SERVICES: ☐ **YES** ☐ **NO**

*REFERRED BY: *PHONE#:

FOR OFFICE USE ONLY:

☐ IN SYSTEM ☐ 2ND REFERRAL HDM STARTED: ☐ YES ☐ NO DATE RECEIVED:_____

SERVICE: ☐ ACCEPTED ☐ REFUSED ☐ WAITLISTED ☐ INELIGIBLE ☐ REFERRED TO:_____