

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"/>
Age: _____	Above Poverty <input type="checkbox"/>
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"/> Eating or feeding	<input type="checkbox"/> Meal Preparation
<input type="checkbox"/> Standing or Walking	<input type="checkbox"/> Social/Recreation
<input type="checkbox"/> Medication reminders	<input type="checkbox"/> Medical care (medication administration)
<input type="checkbox"/> Communication/Coordination	<input type="checkbox"/> Behavioral Support
<input type="checkbox"/> Manage Finances/Pay Bills	<input type="checkbox"/> Shopping
	<input type="checkbox"/> Toileting/Bladder Care
	<input type="checkbox"/> Transfers In/Out
	<input type="checkbox"/> Give/Arrange Transportation
	<input type="checkbox"/> Decisions/Advocacy
	<input type="checkbox"/> Light Housekeeping/Chores
	<input type="checkbox"/> General supervision

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: 775-525-9406

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.