



Clark County Social Service Hospital Referral

Hospital Staff Only

Pinto - 1600 Pinto Lane FAX:(702) 676-1107

Referring Agency: _____
 Worker Name: _____
 Phone Number: _____
 FAX Number: _____
 Date: _____

ATTN: Lead Worker / Supervisor

Services Requested

FAS (Financial) Transportation Home Visit

Personal Demographics

Client Name: _____ Male Female Transgender DOB: _____
 Phone: _____ Room/Bed: _____ SSN: _____
 Address: _____ City _____ State _____ Zip Code _____
 Mailing Address: _____ City _____ State _____ Zip _____
 U.S. Citizen: Yes No Birthplace: _____ Ethnicity: _____ Race: _____

Communication

Preferred Language: _____ Preferred Communication: _____

Household Composition

Marital Status: Single Married Divorced Separated Widowed Number in Household: _____
 Spouse's Name: _____ DOB: _____ SSN: _____
 Other Member's Name: _____ DOB: _____ SSN: _____ Relationship: _____ Citizenship: _____
 Other Member's Name: _____ DOB: _____ SSN: _____ Relationship: _____ Citizenship: _____
 Other Member's Name: _____ DOB: _____ SSN: _____ Relationship: _____ Citizenship: _____

Financial

Monthly Rent/Mortgage: \$ _____
 Monthly Income: SSI/SSD/SSA \$ _____ TANF/VA/UIB \$ _____ Gross Wages \$ _____
 Pension \$ _____ Other income sources \$ _____ Total Monthly Household Income \$ _____

Medical

Medicaid Medicare No Insurance Pending TANF/MAABD Private Insurance Effective Date: _____
 Military Branch: _____ Service Dates: _____ Honorable Discharge: Yes No
 Service Connected Disability: Yes No
 Medical Diagnosis: _____ Admit Date: _____ Discharge Date: _____
 Disability Statement Requested: Yes No

Assets

Financial Institution Name: _____
 Type of Accounts*: Checking \$ _____ Savings \$ _____ 401K's \$ _____ CD's \$ _____
 Life Insurance \$ _____ Stocks \$ _____ Bonds \$ _____ IRA \$ _____ Safe Deposit Box _____
 Other \$ _____

**Indicate current value and/or contents of each of the above items.*

Vehicles (ATV, Autos, Boat, Motorcycle, Motorhome): Yes No If yes, how many? _____
 Does client own non-residential property? Yes No If yes, where is the property located? _____
 Has client sold a home, closed a bank account, or received a lump sum(s) in the last 36 months? Yes No
 Amount: \$ _____ Date: _____ Reason: _____

Physician Orders Attached Yes No

Does patient need: Oncology- Yes No Dialysis- Yes No Home Infusion- Yes No

Hospital Discharge Plan Attached Yes No

Does patient need Case Management Services Yes No

NOTE: Please attach Release of Information

Disclaimer: Eligibility determination for each referral received by Clark County Social Service will be based on program guidelines set forth by federal, state, or local governments.

CCSS Only: Assigned to: _____ Date: _____ Was risk indicator sent to a S.W. Spec. Yes No
 Interview Date: _____ Needs F/U: _____
 Case Number: _____ Pin Number: _____ Application Number: _____
 Comments: _____