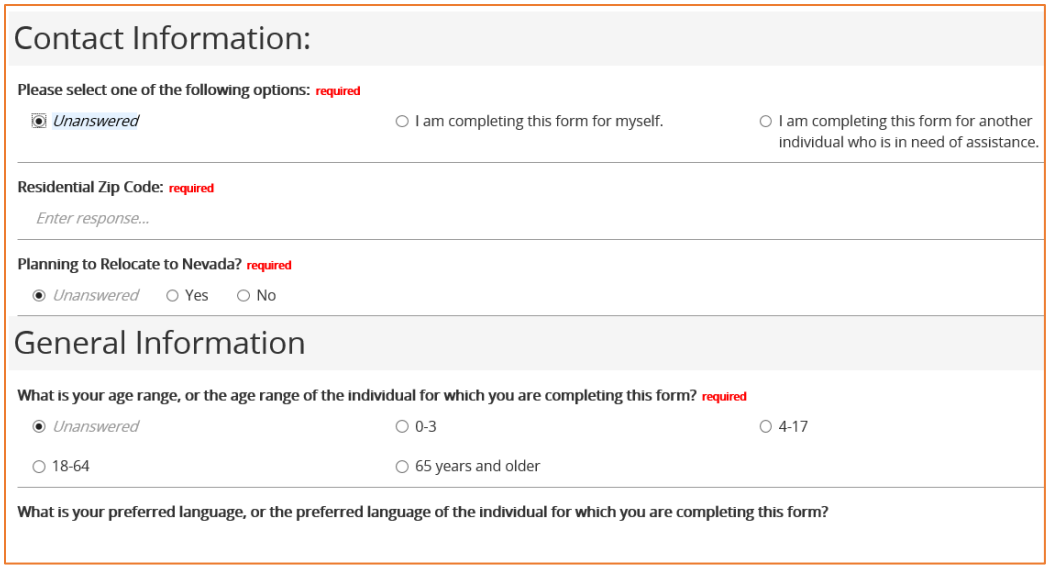
How to Send Referrals Using the Assess My Needs Form

This form is used to connet individuals seeking services to various programs throughout Aging and Disabiltiy 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 different agencies based on your answers and needs identified.

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

Assess My Needs Form



Contact Information:

Please select one of the following options: required

◉ Unanswered ○ I am completing this form for myself. ○ I am completing this form for another individual who is in need of assistance.

Residential Zip Code: required

Enter response...

Planning to Relocate to Nevada? required

◉ Unanswered ○ Yes ○ No

General Information

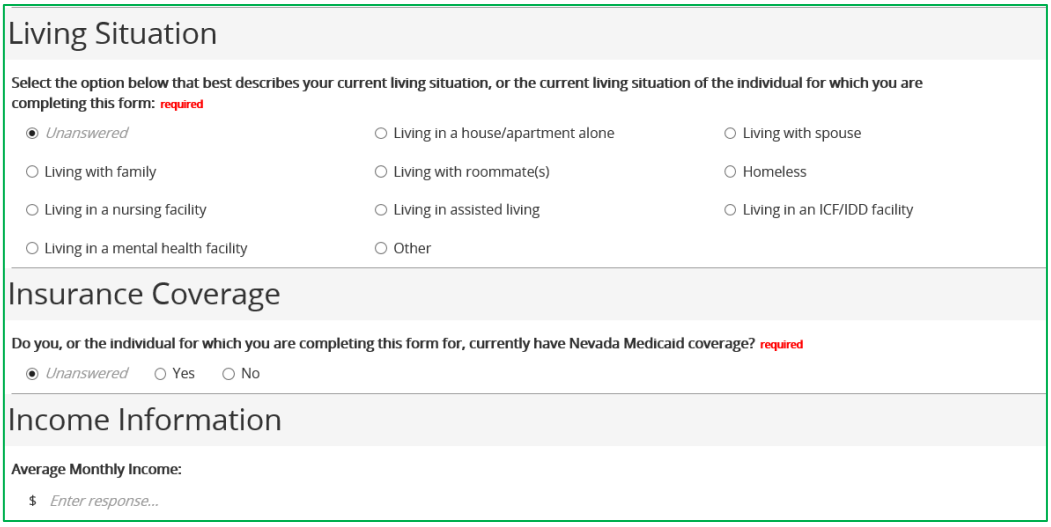
What is your age range, or the age range of the individual for which you are completing this form? required

◉ Unanswered ○ 0-3 ○ 4-17

○ 18-64 ○ 65 years and older

What is your preferred language, or the preferred language of the individual for which you are completing this 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 indivdiual.



Living Situation

Select the option below that best describes your current living situation, or the current living situation of the individual for which you are completing this form: required

◉ Unanswered ○ Living in a house/apartment alone ○ Living with spouse

○ Living with family ○ Living with roommate(s) ○ Homeless

○ Living in a nursing facility ○ Living in assisted living ○ Living in an ICF/IDD facility

○ Living in a mental health facility ○ Other

Insurance Coverage

Do you, or the individual for which you are completing this form for, currently have Nevada Medicaid coverage? required

◉ Unanswered ○ Yes ○ No

Income Information

Average Monthly Income:

$ Enter response...

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
- ☐ Respite (taking a break)
- ☐ Shopping
- ☐ Small-Group Social Activities (online and teleconference)
- ☐ Taking Medicine
- ☐ Temporary Emergency Financial Assistance
- ☐ Transportation
- ☐ Using Technology
- ☐ Using the Bathroom
- ☐ Using the Telephone
- ☐ Walking/Mobility

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 disucsses menatal and behavioral health services. Select any statements that apply to the individual requesting assistance.

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.

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

Thank you for completing the screening questions. Click the "Submit" button below to complete the questionnaire.

After we have reviewed your questionnaire, a representative from a network partner in your area will contact you using the contact information you provided.

If you're not contacted within 7 business days, please go to http://nevadacareconnection.org to find your local resource center to help assist you with your needs or call 2-1-1.

✔ Submit ✖ Cancel 🖶 Print

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