September 3, 2021

Form Release Memo (FRM) - CBC Program Application

Purpose

This form captures the information necessary to process an inquiry for the Community Options Program for the Elderly (COPE), Personal Assistance Services (PAS), the Home and Community Based Services (HCBS) Waiver for the Frail Elderly (FE) or the HCBS Waiver for Persons with Physical Disabilities (PD).

> Note: This application supersedes the CBC 102-R Referral form. The CBC 102-R form became obsolete 4/1/21.

Requirements

1. This application is required by all applicants requesting an evaluation for the COPE, PAS, HCBS FE Waiver or HCBS PD Waiver.
2. Income and resources will be required to be verified.
3. This application may be submitted to any Aging and Disability Services Division (ADSD) office by the following methods:
   - **a.** In person
   - **b.** Mail
   - **c.** Fax
   - **d.** E-mail
4. Contact information for each office can be found on the ADSD Website: http://adsd.nv.gov/Contact/Contact_AgingDisability/

General Instructions to complete the application.

Program Selection: Check the box(es) of the program the applicant is requesting.

- Additional information for each program can be found at the following links:
  - Personal Assistance Services (PAS) http://adsd.nv.gov/Programs/Seniors/PersAsstSvcs/PAS_Prog/
  - Community Service Options Program for the Elderly (COPE) http://adsd.nv.gov/Programs/Seniors/COPE/COPE_Prog/
  - Home and Community Based Services (HCBS) Waiver for the Frail Elderly (FE) http://adsd.nv.gov/Programs/Seniors/HCBS_(FE)/HCBS_(FE)/
  - HCBS Waiver for Persons with Physical Disabilities (PD) http://adsd.nv.gov/Programs/Seniors/PD_Waiver/Waiver_for_Person's_with_Physical__Disabilities_(PD)/

Demographic Information	
Name of Applicant (Last, First Middle)	Enter the name of the applicant: Last, First, Middle
Social Security Number	Enter the applicant's Social Security Number
Date of Birth	Enter the applicant's date of birth
Primary Language of the applicant	Select the appropriate box for English, Spanish or Other. If Other is selected, write in the applicant's primary language.
Physical Address	Enter the applicant's physical address
Medicare Number	Enter the applicant's Medicare Number. If none enter N/A
Age	Enter the applicant's age
Sex	Enter the applicant's gender
City, State, Zip Code	Enter the applicant's city, state, and zip code from physical address
Marital Status	Applicant's marital status: Married, Divorced, Single, Separated
Race/Ethnicity	Enter the applicant's race and ethnicity
Mailing Address	Enter the applicant's mailing address
City, State, Zip Code	Enter the applicant's city, state, and zip code for mailing address
Telephone Number	Enter the applicant's telephone number. If none enter N/A
Email Address	Enter the applicant's email address. If none enter N/A
Secondary Phone Number	Enter the applicant's secondary telephone number. If none enter N/A
Referring Party and Relationship	If the referral is from someone other than the applicant, list their name and the relationship to the applicant. If no one enter N/A
Who is completing the application	Enter the name of the person completing the application if not the applicant. If it is the applicant enter N/A
Phone Number	Enter the phone number of the person completing the application if not the applicant. If it is the applicant enter N/A
Current Living Situation	Select the most appropriate option from the selection on the application. If other must enter what it is. If Nursing Facility or a Group Home, must enter the name of the residential setting
Is the Applicant Currently in a Hospital or Nursing Facility	Select Yes or No
If Yes, Name and Address of Facility	If selected Yes in a Hospital or Nursing Facility, enter the name and address of the facility
Anticipated Discharge Date (If Known)	If the applicant is in a Hospital or Nursing Facility, enter in the anticipated discharge date. If unknown, enter N/A
Does the Applicant have a Power of Attorney (POA), Guardian, or Supported Decision Making Arrangement	Select Yes or No
If Yes, name and phone number	If yes selected, enter the name and phone number of the POA, Guardian or person involved in the supported decision-making arrangement
Other Medical Insurance	Enter Yes or No If Yes, enter the name of the insurance company and policy number

All Persons Residing with Applicant (Social Security Number (SSN) and Marital Status needed for Applicant and Spouse Only)	
Name	Name of person residing with the applicant
Social Security #	This field is only required if applicant is married and living with their spouse
DOB	Date of Birth of person residing with applicant
Sex	Enter in the legal gender of the person residing with the applicant
Marital Status	This field is only required if the applicant is married and living with their spouse
Relationship with Applicant	Enter in the relationship of the person residing with the applicant

HOUSEHOLD is defined as:
The applicant/recipient, their spouse, and any minor dependent child(ren), under the age of 18 residing in the home more than ½ time.

Income – List Anyone in the Household including Applicant			
Source	Received by Whom	Gross Amount	Frequency
Source of the income	List who in the household receives the income	Amount received before any deductions	Weekly, bi-weekly, semi-monthly, monthly, annual
Types of Income			
Social Security (RSDI)	Social Security - Retirement, Survivors, Disability Insurance		
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Supplemental Security Income (SSI)	Social Security - Supplemental Security Income		
Supplemental Security Income (SSI)	Social Security - Supplemental Security Income		
Veterans Benefits	Income received from the Veterans Administration		
Job Income	Income received from a place of employment		
Pension	Income received from a pension		
IRA/401K Distributions	Income received from an Individual Retirement Account (IRA), or a 401k distribution		
Other	Any other source of income or additional income from the sources mentioned above		
Other	Any other source of income or additional income from the sources mentioned above		
Other	Any other source of income or additional income from the sources mentioned above		

Has the applicant applied for but not yet received any other income	Select Yes or No
Date Applied	Date applied for the additional income
If Yes, who will be receiving and from what source	If Yes, enter the household member who will be receiving the income, the source of the income, frequency and amount if known

Resources – List all owned and Shared Ownership			
Resource Type	Owner(s)	Source/Company	Value
Kind of resource	List the owner(s) of the resource	The source or company where the resource is held	The value of the resource - will be the lowest value during the month
Resource Types			
Savings Account	Account with a financial institution – the value will be the lowest in the month of application or month preceding application		
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Checking Account	Account with a financial institution – the value will be the lowest in the month of application or month preceding application		
Checking Account	Account with a financial institution – the value will be the lowest in the month of application or month preceding application		
Trust	A legal document which may identify income and resources of an individual or family. The entire document is required to be submitted to the ADSD for review.		
Savings Bond	Account with a financial institution – the value will be the lowest in the month of application or month preceding application		
Safe Deposit Box	May contain copies of deeds, insurance policies, money and other countable resources. Verification of the contents is required to be reviewed during the application process.		
IRA	Individual Retirement Account		
401k	401k retirement account		
Burial Insurance	Insurance purchased to cover the costs of burial upon one's death		
Life Insurance	Insurance purchased to support survivor(s) after one's death, usually entitled to settle debts and provide assistance to maintain a household. May be a Term life or a Whole life plan.		
Cash on Hand	Cash the applicant has at the time of application		
Vehicle	Vehicle registered to the applicant/spouse		
Vehicle	Vehicle registered to the applicant/spouse		
Vehicle	Vehicle registered to the applicant/spouse		
Other	Other resources not mentioned above		
Other	Other resources not mentioned above		
Has the Applicant, within 60 months of the date of this application, divested or transferred his or her assets in an attempt to qualify for services from the program for which they are applying		Select Yes or No	

Medical Expenses – Personal Assistance Services (PAS) ONLY Include Expenses Paid for By Applicant Only			
Medical Expense	**Company Source**	**Amount Paid**	**Frequency of Payments**
Prescriptions	Where the prescriptions are filled	Amount paid by applicant	Frequency paid
Medical Insurance/Premiums	Insurance company	Amount paid by applicant	Frequency paid
Other	Other medical expenses incurred and paid by the applicant	Amount paid by applicant	Frequency paid
Other	Other medical expenses incurred and paid by the applicant	Amount paid by applicant	Frequency paid
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Social/Health Information	
Diagnosis	Enter the diagnosis(es) of the applicant
Physician Name/Phone number	Name and phone number of the applicant's physician
Does the Applicant have Difficulties making Decisions	Select Yes, No or Unknown
Does the Applicant have Difficulties with Short Term Memory	Select Yes, No or Unknown
Other Care Needs	List any care needs the applicant has that are needed for the application review
Current Services Receiving (Hospice, Home Health, etc.)	List all services the applicant is currently receiving.
Does the Applicant Need Help With Any of the Following?	Check all that apply
Does the Applicant Use Any of the Following Equipment?	Check all that apply

Service Needs	
Is the Applicant in need of any of the following services?	Check all that apply

Signature and Affirmation

Review the text which explains the application process, requirements, and consent for the application. If agree, sign the bottom of page 5, and if there is an authorized representative assisting the applicant indicate this on the second line after the signature. Proof of guardianship, Power of Attorney or other representative status is required at the time of application.

Once the application is received by the Community Based Care (CBC) Department of ADSD, it will be reviewed, and contact will be made either by telephone or mail with the decision or next steps in the process.