STATE OF NEVADA
Aging & Disability Services Division (ADSD)
Facility Outreach and Community Integration Services (FOCIS)

A. REFERRAL INFORMATION

Date of Referral:	**Referring Party:**
Phone Number & Fax Number:	**Email:**

Applicant's Preferred Language (please specify):

Last Name:	**First Name:**	**MI:**	**DOB:**
SSN:	**Gender:** ☐ M ☐ F	**Marital Status:** ☐ S ☐ M ☐ D ☐ W	

Current Location (Facility name and address):

Room number: **Telephone Number:**

Medically Approved for Discharge: ☐ Yes ☐ No **Discharge Date:**

Other programs referred to:

Monthly Income: $

Current NV State ID: ☐ Yes ☐ No

Does recipient have Medicaid? ☐ Yes ☐ No

If yes, Medicaid #:

Other Insurance (name) and ID #'s:

Competent to Make Decisions on Own Behalf: ☐ Yes ☐ No

B. CONTACT INFORMATION

Include social workers, case managers, legal guardian, power of attorney, spouse, relatives, or friends.

Name	Relationship	Phone #

Please return this form to the following ADSD Regional Office:

Aging & Disability Services Division
ATTN: FOCIS
7150 Pollock Drive
Las Vegas, NV 89119
Email: CBCSouthIntake@adsd.nv.gov
Phone: (702) 486-5764
Fax: (702) 792-0143