State of Nevada
Aging and Disability Services Division (ADSD)
Facility Outreach & Community Integration Services (FOCIS)

<table>
<tr><th colspan="4">Referring Party Information</th></tr>
<tr><td>Date of Referral:</td><td>Referred by:</td><td colspan="2">Name of organization (if applicable):</td></tr>
<tr><td colspan="2">Phone Number:</td><td colspan="2">Fax Number:</td></tr>
<tr><td colspan="4">Email:</td></tr>
<tr><th colspan="4">Recipient Information</th></tr>
<tr><td>Last Name:</td><td>First Name:</td><td>MI:</td><td>DOB:</td></tr>
<tr><td>SSN:</td><td>Gender:</td><td colspan="2">Marital Status: ☐ Single
☐ Married ☐ Divorced ☐ Widowed</td></tr>
<tr><td colspan="2">Preferred Language:</td><td colspan="2">Phone Number:</td></tr>
<tr><td colspan="2">Facility Name:</td><td colspan="2">Room Number:</td></tr>
<tr><td colspan="4">Address:</td></tr>
<tr><td colspan="4">Medically Approved for Discharge: ☐ Yes ☐ No Discharge Date:</td></tr>
<tr><td colspan="4">Other Programs referred to:</td></tr>
<tr><td colspan="2">Does the recipient have Medicaid: ☐ Yes ☐ No</td><td colspan="2">Medicaid Number:</td></tr>
<tr><td colspan="2">Other Insurance (name):</td><td colspan="2">Other Insurance ID:</td></tr>
<tr><td colspan="2">Current NV state ID: ☐ Yes ☐ No</td><td colspan="2">ID Number:</td></tr>
<tr><td colspan="4">Monthly Income: $</td></tr>
<tr><td colspan="4">Do you feel that you are able to make decisions about your life and care in a way that reflects your personal preferences, needs and goals? ☐ Yes ☐ No</td></tr>
</table>

Recipient Contacts

Include case managers, family or friends, power of attorney, social workers, or others assisting with care transition

Name	Relationship	Phone Number

Return completed forms to:

ADSD Las Vegas Regional Office
Attn: FOCIS
7150 Pollock Drive
Las Vegas, NV 89119
Email: CBCSouthIntake@adsd.nv.gov
Phone: (702) 486-5764
Fax: (702) 792-0143