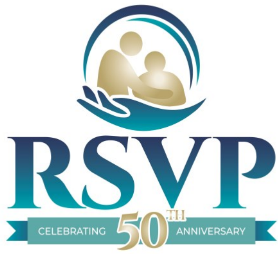

Please PRINT Clearly & Use a Pen

City/County: ____________________

Date: ____________

Initial HV Due By: ____________

RSVP Client Application

Nevada Rural Counties RSVP Program, Inc.

2621 Northgate Lane, Suite 6,Carson City, NV 89706

Mailing Address: P.O. Box 1708, Carson City, NV

Client Information

Services Requested: **Please check all that apply below:**

Respite Care: __Transportation: __Companionship/Good Neighbor: __PERS:__ Homemaker:__ Telephone Reassurance:__

RSVP's volunteers do not perform medical related services, toileting, bathing, administering medications.

VOLUNTEERS ARE STRICTLY PROHIBITED FROM LIFTING OR TRANSFERING CLIENTS

Legal Name (First/Last): ____ Sex: Male: ___ Female: ___

Nickname: ____

Physical Address: ____ ☐ No current address/residence

Mailing Address: ____

City: ____ State: __NV__ Zip Code: __________________

Home Phone #: _____________________________ Cell Phone #: _______________________________

E-Mail Address: _____________________________ **Are you a Veteran?** ☐ **Yes** ☐ **No**

DATE OF BIRTH: _____/______/______ **Do You Have a Disability?** ☐ **Yes** ☐ **No** ***(If yes, see note on pg 3)***

Marital Status: Married _____ Single _____ Do You Consider Yourself Frail? ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION ***(If a caregiver is also this client's ER contact, see next page.)***

NAME (First/Last):____________________________________ RELATIONSHIP _____________________________

HOME PHONE: (______) ______________________ WORK OR CELL PHONE: (_____) _______________________

Ethnicity:

☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Race:

☐ White, Caucasian ☐ Hispanic ☐ Asian

☐ American Indian/ Alaskan Native

☐ Black/African American

☐ Native Hawaiian or Other Pacific Islander

☐ Other ______________________________

If you do not speak English, what is your primary Language?

____

Assistive Devices :

☐ Oxygen ☐ Walker

☐ Wheelchair ☐ Cane Other: _____________

PLEASE check areas of physical LIMITATION:

☐ Ability to transfer

☐ Ability to stand, grasp, bend, reach, lift

☐ Ability to go outside the home without assistance

☐ Ambulation

☐ Vision

☐ Hearing

Severity of Limitations: Mild Moderate Severe

(Please circle one)

Medical diagnosis of client: ____

Recent hospitalizations and related reasons: ____

Physical impairments and severity of impairments: ____

Mental health conditions:____

Allergies: ____

Continued Client Information

Which of the following are you UNABLE to perform without assistance?

Activities of Daily Living (ADLs):

- ☐ Eat
- ☐ Walk
- ☐ Get Dressed
- ☐ Use the bathroom
- ☐ Transfer In/or Out of a Bed/Chair
- ☐ Basic hair and oral care

Instrumental Activities of Daily Living (IADLs):

- ☐ Prepare Meals
- ☐ Take Medication
- ☐ Manage Money
- ☐ Shop
- ☐ Light Housework
- ☐ Use Transportation
- ☐ Use Telephone
- ☐ Heavy Housework
- ☐ Driving

Pre-Service Survey (Please answer to the best of your ability)

In general how would you describe your emotional well being?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

During the past 3 months, how many times have you been able to attend to personal errands such as shopping, banking etc.?
☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5 or more

In the past 3 months have you felt isolated?
☐ Often ☐ Sometimes ☐ Never

I often feel stress over my situation
☐ Often ☐ Sometimes ☐ Never

I have received the Notice of Privacy Practices: ☐ Yes ☐ No

Caregiver Information *(Skip if client does not have a caregiver)*

Legal Name (First/Last): ____ Sex: Male: ___ Female: ___
Relationship to client: ____ Date of Birth:_____________
Physical Address: ____ No current address/residence
Mailing Address: ____
City: ____ State: __NV__ Zip Code: _________________
Phone #: _______________________________ Race/Ethnicity: _______________ Age: ____________

EMERGENCY CONTACT INFORMATION

NAME (First/Last):____________________________________ RELATIONSHIP _____________________________
HOME PHONE: (______) ______________________ WORK OR CELL PHONE: (_____) _______________________

Pre-Service Survey (Please answer to the best of your ability)

In general how would you describe your emotional well being?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

During the past 3 months, how many times have you been able to attend to personal errands such as shopping, banking etc.?
☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5 or more

In the past 3 months have you felt isolated?
☐ Often ☐ Sometimes ☐ Never

I often feel stress over my situation
☐ Often ☐ Sometimes ☐ Never

I have received the Notice of Privacy Practices: ☐ Yes ☐ No

Household Information

Home Environment:

Pets: ☐ Yes ☐ No   Type: ☐ Dog ☐ Cat ☐ Other: ______________________________

Are the interior/exterior doors, stairs, halls accessible? ☐ Yes ☐ No

Is the kitchen accessible and clear of fire hazards? ☐ Yes ☐ No

Is the refrigerator, oven, heating and plumbing working? ☐ Yes ☐ No

Are the electric outlets and controls accessible and clear? ☐ Yes ☐ No

Are the living and dining areas accessible and clear? ☐ Yes ☐ No

Is a telephone accessible? ☐ Yes ☐ No

Is there a fire extinguisher? ☐ Yes ☐ No   Location: ______________________________

Indicate any unsafe conditions: ______________________________

Your Household Income Is: (Please answer ALL!)

☐ BELOW POVERTY ☐ ABOVE POVERTY

Based on 2023 Federal Poverty Guidelines:

1 Person	**$26,973 ($2,248 per month)**
2 People	**$36,482 ($3,041 per month)**

Supplemental Social Security Income Level (SSI):

☐ BELOW 300% SSI ☐ ABOVE 300% SSI

1 Person **$ 3,465 per month**

Do you live alone? Yes No *(Circle one)*
Do you receive State Medicaid? Yes No *(Circle one)*
Female Head of Household? Yes No *(Circle one)*
Number of persons in household __________
Relationship to the client: ______________________

Suggested Donation:

Donations are gratefully accepted, however service will not be denied because of inability to contribute.

$10 per trip for local rides
$20 for a round trip ride 50 miles or more
$10 per hour for Respite Care
$10 per hour for Homemaker Services
$10 per shopping and prescription pick-up

How did you hear about RSVP? ______________________

Referring Agency Contact Name: ______________________

Phone #: ________________ Email: ______________________

RSVP does not discriminate with regards to race, color or national origin.

Please Note: If you are under the age of 60 and have a disability, you MUST attach your SSDI letter to this application in order to qualify for RSVP services.

______________________________ ______________________________
CLIENT SIGNATURE DATE   RSVP REP. SIGNATURE DATE

In order to continue receiving RSVP services, a new client application and Notice of Privacy must be completed each year.

(RSVP STAFF USE ONLY):

Additional Notes: