Please PRINT Clearly & Use a Pen

City/County:_____

Date: _____

RSVP Client Application and Service Plan

Nevada Rural Counties RSVP Program, Inc.

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

Mailing Address: P.O. Box 1708, Carson City, NV 89702

Phone: (775) 687-4680 Fax: (775) 687-4494

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: _____/_____/_____ **Are you a Caregiver?** Yes_____ No_____

Marital Status: Married _____ Single _____ Who are you caring for? ☐ Spouse ☐ Parent

Do You Have a Disability? ☐ Yes ☐ No Child 0—18 ☐ Adult Child 18+ ☐

Do You Consider Yourself Frail? ☐ Yes ☐ No Other _____

EMERGENCY CONTACT INFORMATION (Attach additional pages if more than one person):

NAME (First/Last):_____ RELATIONSHIP _____

HOME PHONE: (_____) _____ WORK OR CELL PHONE: (_____) _____

Services Requested: Please check all that apply below:

Respite Care: ____Transportation: ____Companionship: ____ PERS:_____ Homemaker:_____

Suggested Donation: Donations are gratefully accepted, however service will not be denied because of inability to contribute. $3 per trip for local rides **$10** for a round trip ride 50 miles or more **$5** per hour for Respite Care **$2** per hour for Homemaker Services **How did you hear about RSVP?** _____

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 ☐ Wheelchair ☐ Walker ☐ Cane

Your Household Income Is: (Please answer ALL!)

☐ BELOW POVERTY ☐ ABOVE POVERTY

Based on 2019 Federal Poverty Guidelines:

1 Person $12,490.00 ($1040.83 per month)

2 People $16,910.00

Each additional person add $4,420.00

Supplemental Social Security Income Level (SSI):

BELOW 300% SSI ☐ ABOVE 300% SSI ☐

1 Person $2,313 per month

Do you live alone? ☐ Yes ☐ No

Do you receive State Medicaid? ☐ Yes ☐ No

Female Head of Household? ☐ Yes ☐ No

Number of persons in household _____

Relationship to the client: _____

PLEASE check areas of physical LIMITATION:

☐ Ambulation ☐ Vision Hearing ☐ Ability to stand Ability to grasp, bend, reach, lift ☐ Ability to transfer

☐ Ability to go outside the home without assistance

Client Name:_____

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

☐ **None – I can perform these activities**
Activities of Daily Living (ADLs):
☐ Eat ☐ Walk ☐ Get Dressed
☐ Bathe ☐ Use the Bathroom
☐ Transfer In/or Out of a Bed/Chair

☐ **None – I can perform these activities**
Instrumental Activities of Daily Living (IADLs):
☐ Prepare Meals ☐ Shop ☐ Use Telephone
☐ Take Medication ☐ Light Housework ☐ Heavy Housework
☐ Manage Money ☐ Use Transportation Services

Medical diagnosis of client: _____
Recent hospitalizations and related reasons: _____
Physical impairments and severity of impairments: _____
Mental health conditions:_____

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: _____

INSTRUCTION FOR THE VOLUNTEER (please complete if volunteer will be in client's home)

Answer the door: ☐ Yes ☐ No Answer the telephone: ☐ Yes ☐ No Sign for deliveries: ☐ Yes ☐ No

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

_____ _____
CLIENT SIGNATURE DATE

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

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

NV Rural Counties RSVP

SERVICE PLAN

2621 Northgate Lane, Ste. 6
Carson City, NV 89706

The Parties agree as follows:

1. Please briefly describe the services that you would like for our volunteer (s) to provide
   (Please note that RSVP volunteers do not provide medical services. We are not able to provide toileting, bathing, lifting, or dispense medications. Volunteers are prohibited from smoking while providing service).

_____

_____

Additionally, you may choose from the list below:

____ Watch Television	_____ Grocery Shopping
____ Read to client	_____ Help with laundry
____ Use the Computer	_____ Running errands
____ Play board games or cards	_____ Arts and crafts
____ Resistance Exercise Training Tapes	_____ Sorting through mail
____ Interact by talking	_____ Transportation

2. What days of the week and times would you like for a RSVP volunteer to provide service to you? Indicate specific days of the week with a check mark and times – circle am or pm.
   Example: Monday from: 10:00am to 3:00pm

Monday	from: _____am/pm	to: _____am/pm	
Tuesday	from: _____am/pm	to: _____am/pm	
Wednesday	from: _____am/pm	to: _____am/pm	Or _____By Appointment
Thursday	from: _____am/pm	to: _____am/pm	
Friday	from: _____am/pm	to: _____am/pm	
Saturday	from: _____am/pm	to: _____am/pm	
Sunday	from: _____am/pm	to: _____am/pm	

Please Note: If the condition of you or your loved one changes, or if the Service Plan needs to be revised, please notify RSVP immediately so that a reassessment and a new Service Plan may be established. Indicate by your signature that the activities and times listed above are agreed to by both parties and that you will inform us of any changes.

_____Date:_____ _____Date:_____

Signature of Applicant Signature of RSVP Representative

If you have questions, comments, or concerns please contact your local Field Representative or RSVP Office.