HOPE* REFERRAL FORM

HOPE is a Social Security grant program to assist chronically homeless disabled individuals in applying for OR who are suspended or terminated from Social Security or SSI.

FAX TO:
CLARK COUNTY SOCIAL SERVICE
BERNARD WEBBER 455-2910 Office and Patricia Ellis
-OR-
Mail to: CCSS-Community Resource Center
2432 No. MLK Blvd.
NLV, NV 89030

SENT BY:
Name of worker: ______________________________
Agency: ______________________________
Address: ______________________________
Phone Number: ______________________________
Signature: ______________________________

CLIENT INFORMATION:

Name of Client: ______________________________ DOB: ____________ SSN: ____________

☐ Male ☐ Female Birth place: ______________ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

US Citizen?: ☐ Yes ☐ No Attach copy of ID or proof of legal residency.

Present Location of Client: ______________________________

Address/City/State/Zip: ______________________________Phone Number: ____________

Living situation for the last 3 years:

____

____

____

Client is currently: ☐ homeless ☐ living in a shelter ☐ living in a program bed at: ______________________ ...

Hospitalized at: ______________________________ room #__________

Diagnosis: ______________________________ Attach one year disability statement.

Doctor's Name/Address/Phone number: ______________________________

SERVICES REQUESTED:

☐ Assistance to apply for SSI/SSD
☐ Assistance to apply for Medicaid
☐ DAS (housing voucher)
☐ Assistance with SSI/SSD suspension
☐ Assistance with SSI/SSD termination
☐ MAS (county medical)
☐ Other: specify ______________________________

FINANCIAL:

☐ Date/reason SSI/SSD was terminated/suspended: ______________________________

Explain any income from: ☐ Wages ☐ Pensions ☐ Government Checks ☐ Any other source?

Specify: ______________________________

☐ Checking - balance $________/name/address of institution: ______________________________

☐ Savings - balance $________/name/address of institution: ______________________________

☐ CD's ☐ 401K ☐ IRA ☐ stocks/bonds ☐ life insurance ☐ vehicle ☐ trust account ☐ other: ______________

Specify : ______________________________

Name/address/phone number of client's rep payee/legal guardian if applicable: ______________________________

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CCSS Use Only: Date/Time Received: ______________Assign To: ______________________________

Comments: ______________________________

Case #: ____________ Pin#: ____________

*** HOPE-Homeless Outreach Project and Evaluation**