JOE LOMBARDO
Governor

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF WELFARE AND SUPPORTIVE SERVICES

RICHARD WHITLEY, MS
Director

ROBERT THOMPSON
Administrator

☐ TANF ☐ MEDICAID ☐ SNAP

Date: _____
Case Name: _____
Case ID: _____

REQUEST FOR A RESOURCE ASSESSMENT

Please completely answer all questions. The Division will evaluate and assess the value of all countable resources owned by you and your spouse based on the information provided.

Name of the spouse who is institutionalized: _____

Social Security No.: _____ Birth Date: _____ Sex: _____

The date he/she entered the medical facility: _____

Name and address of the medical facility: _____

_____

Check the box for each item below that you or your spouse owns or jointly owns with someone else, as of the date your spouse entered the medical facility.

a. Life Insurance ☐ YES ☐ NO

b. Funds for burial ☐ YES ☐ NO

c. Savings (Time) Certificates ☐ YES ☐ NO

d. Individual Retirement Account ☐ YES ☐ NO

e. Stocks or Bonds ☐ YES ☐ NO

f. Banking/Credit Union Accounts ☐ YES ☐ NO

g. Safe Deposit Box ☐ YES ☐ NO

h. Cash on Hand ☐ YES ☐ NO

i. Livestock ☐ YES ☐ NO

j. Machinery or Equipment ☐ YES ☐ NO

k. Real Property (located anywhere) ☐ YES ☐ NO

l. Vehicle (all kinds) ☐ YES ☐ NO

m. Anything other than above (specify) _____

_____

If you answered YES to any of the above items, please describe the resource, its location and value on the following table. Provide copies of current documentation for all resources listed.

DESCRIPTION	LOCATION	ACCOUNT NUMBER	VALUE

We request the Division to provide an assessment of our resources at the time of institutionalization. We understand fully in assessing the value of resources, the Division is relying on our representation herein.

		/ /	
Client Signature	Print Name	Date	Telephone Number

		/ /	
Client Signature	Print Name	Date	Telephone Number

Mailing Address: