Nevada Request for Assistance

Complete this form and tell us what you need. We will get you connected to a local provider, volunteer, government agency to meet your needs.

1 Step 1
Do you currently receive support from any aging services organization? Required
○Yes  ○No
If so, which organization?
Tell us what you need: Required - select all that apply
☐ Food  ☐ Prescription Medication  ☐ Medical Supplies  ☐ Medical – telehealth (primary care, geriatrics, and social work)  ☐ One-to-one check-in telephone calls  ☐ Small-group social activities (online and teleconference)  ☐ Emergency financial assistance  ☐ Legal information and support  ☐ Help cooking, cleaning or bathing  ☐ Telephone-based assistance using technology  ☐ Other
If yes which services. full name

If other please specify.

Do you currently have a primary care provider? Required
☐ Yes  ☐ No
If yes please provide their name. full name

Tell us how to contact you:

First Name Required

Last Name Required
Age

Telephone Number

Zip Code

Email Address

Please select your language

Select An Option

Are you completing this form for someone else? Required
○ Yes ○ No

Since you are completing this form on behalf of another individual, please make sure their information is provided in the fields above and enter your information in the “Caller” fields below.

Caller First Name

Caller Last Name

Caller Phone Number

Is the individual aware that you are completing this form on their behalf? Required
○ Yes ○ No

Submit Form