



2950 S. Rainbow Blvd., Ste. 220
Las Vegas, NV 89146
702-889-4216 (V/TDD) West Las Vegas
702-649-3822 (V/TDD) East Las Vegas
702-889-4574 (Fax)

SERVICES APPEAL PROCESS

For Services Provided By SNCIL Staff and Volunteers

Authority: 29 U.S.C. 711 8

The first step before initiating an informal appeal process, the individual with the significant Disability (ies), his/her parent, legal guardian, representative advocate or legal advocate, hereafter referred to as the involved individual, will discuss concerns regarding the decision with the SNCIL Service Provider. Discussion should be directed to:

Their Assigned SNCIL Independent Living Specialist and/or Coordinator/Advocate

If the concerns cannot be resolved at this level, the involved individual should begin the appeal process.

APPEAL PROCESS

An involved individual has the right to appeal any decision regarding the request for or the provision of services under Part C Title VII of the Rehabilitation Act. As a guideline the appeal should be made as soon as possible after the decision, which has led to the dissatisfaction, preferably within 15 working days.

Per the requirements of 34 CRF 364.59 (Federal Register, Vol. 59, No. 156, Monday August 15, 1994, p. 41897) the Southern Nevada Center for Independent Living establishes the following Appeal process for individuals with significant disabilities.

The request for appeal should be directed to the Southern Nevada Center for Independent Living:

Mary Evilsizer, MA, MBA
SNCIL Executive Director
2950 S. Rainbow Blvd., Suite 220
Las Vegas, NV 89146
702-889-4216 (V/TDD) 702-649-3822 (V/TDD) FAX: 702-889-4574

If the individual is not satisfied with the Executive Director's decision, the Executive Director will appoint an impartial individual review panel (IRP). This panel will consist of three individuals with significant disabilities, two SNCIL individuals and one board member, who will review the involved individuals decision with which he/she is dissatisfied. No employee of the designated Center for Independent Living will be a member of the impartial IRP. Prior to the review, the IRP may request additional information from either the involved individual or the service provider. The IRP will render in writing their decision no later than 30 working days

Updated 06/12/2021

following the review. Because SNCIL is a consumer driven organization the decision of the Consumer Review Panel will be final.

Accessibility

Reviews will be accessible to involved individuals. The Southern Nevada Center for Independent Living provides accessible formats to inform each individual who seeks or is receiving Independent Living Services about the appeal process.

CLIENT ASSISTANCE PROGRAM

The involved individual may contact the Client Assistance Program (CAP) for information, mediation, advocacy or representation regarding a Center for Independent Living Services Program Appeal.

Client Assistance Program: Anita Frantz, (CAP)
Nevada Disability Advocacy & Law Center (NDALC)
2820 West Charleston Blvd., Ste. 11
Las Vegas, NV 89102
Phone: 1-888-349-3843 or (702) 257-8150
Fax Number: (702) 257-8170
Nevada Relay 711
Internet: www.ndalc.org



Southern Nevada Center for Independent Living

2950 S. Rainbow Blvd., Suite 220, Las Vegas, NV 89146

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SATISFACTION SURVEY

The Southern Nevada Center for Independent Living (SNCIL) would like information on how to serve you better. Please tell us how we can do this by filling out the following form.

Name _____

Today's Date _____

Parent/Guardian Name _____

Start Date _____

Address _____

Case Manager _____

Phone _____

Languages Spoken:

☐ English

☐ Spanish

☐ American Sign Language

☐ Other _____

1. Please check the services YOU received from SNCIL

☐ Advocacy

☐ Equipment

☐ Communication Services

☐ Mobility Training

☐ Transportation

☐ Vocational

☐ Legal Services

☐ Housing

☐ Skills Training

☐ Benefits Counseling

☐ Birth Certificate/Social Security Card

☐ Information & Referral

☐ Peer Counseling

☐ Other Services (Medicaid, SNAP, SSA)

Please Circle

2. Were you satisfied?

Yes No

3. Do you understand what SNCIL can do for you?

Yes No

4. Did we give you what you needed?

Yes No

5. Has the staff been professional and polite?

Yes No

6. Would you use our services again?

Yes No

7. How can we improve our service?

For Office Use Only:

(Answer question #8 for Goal Completed Survey Only not 30 Days goals) and (Case Inactivated)

8. How did your independence improve due to the services provided here?

☐ 1. Not Improved at all

☐ 2. Same

☐ 3. Somewhat Improved

☐ 4. Improved

☐ 5. Greatly Improved

Please explain _____

_____ Annual Follow up – once every 12 months

_____ 90 Days

_____ Goals Achieved _____ Case Inactivated

Southern Nevada Center for Independent Living

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1. Where do you see yourself in 6 months?

Where do you see yourself in 1 year?

Where do you see yourself in 5 years?

2. What type of community service would help you in 5 years?

3. Do you see SNCIL helping you achieve your goals within 5 years?

4. Will your current goals be able to assist you in your 5 years plan?

(Follow-up Assistive Technology Devices) Communication board, walker, hearing aids, wheelchairs, etc.

Southern Nevada Center For Independent Living

Case Notes

Name: _____ **Internal ID:** _____

[illegible]

SOUTHERN NEVADA CENTER FOR INDEPENDENT LIVING

IL Service Agreement

Name _____

Part 1: Eligibility Information (Individual)

The grants that fund our Independent Living Services may only be for individuals with a significant disability. A Staff member must determine your eligibility for service, partly from how you answer the following questions.

- ◆ Please list your disability or disabilities: _____
- ◆ Please check whether your disability or disabilities substantially limit(s) your ability:
To function independently in the ☐ Home or ☐ Community or
To: ☐ Obtain Employment ☐ Maintain Employment ☐ Advance in Employment.

Part 2: Requested Service Information – Please check the appropriate box below

- ◆ I understand that, at any time, I may request communications in alternate formats when needed for effective communication. Please communicate with me using: ☐ Braille ☐ Large Print
☐ Audio Tape ☐ Computer Disk ☐ (specify format) ☐ Sign Language ☐ TTY/VRP
☐ Other Language: _____ ☐ Other: _____ ☐ None
- ◆ I understand that, at any time, I may request that you change the way you do things when needed, because of my disability, to grant me equal access to programs and services (a “reasonable accommodation”). Please provide me with the following accommodations (s):
☐ None ☐ Assistance Filling Out Forms ☐ Alternate Service Location
☐ Other: _____
- ◆ I understand that I have the option to develop a written Independent Living Plan (ILP) showing my goals and action steps. I also understand that I can choose not to develop a written plan and can receive the same services without a written plan.
☐ I **want** to develop an ILP with help from an Independent Living Specialist. (The next step will be developing a written ILP for you to sign.)
☐ I **do not want** an ILP now but I will contact SNCIL if I change my mind.
- ◆ I have received information about:
☐ Verbal consent was given to PRINT Consumers name due to services being provided remotely because of COVID-19
☐ SNCIL Code of Conduct & AGREE to follow the Code
☐ Independent Living Services provided by SNCIL
☐ How to appeal, including information about the Client Assistance Program
☐ Confidentiality
☐ Satisfaction Survey given and discussed for services and goals.

Signature: _____ Date: _____ / _____ / _____

Signature of Parent or Guardian: _____ Date: _____ / _____ / _____

Eligibility Determination (To Be Completed by SNCIL staff)

Individual ☐ **is** or ☐ **is not** eligible for State/Federally Funded Independent Living Services.

Individual ☐ **is** or ☐ **is not** eligible for other services: _____

Staff Signature: _____ Date: _____ / _____ / _____

☐ Disclaimer- If this intake was conducted remotely, the signature was obtained verbally.

This was followed up with a mail out to obtain a hard signature.

Independent Living Plans: An Introduction

Independent Living Services help individuals with significant disabilities to identify and set goals for living independently, and work toward them. Goals may involve:

- ◆ Learning new Skills
- ◆ Better access to needed benefits or services
- ◆ Becoming a better self-advocate
- ◆ Learning from the experiences of other individuals with disabilities how to overcome obstacles to independence
- ◆ Identifying and accessing needed technology
- ◆ Making the transition from a Nursing Home or other institution to living independently in the community
- ◆ Making the transition from living at home with Mom and Dad to living independently
- ◆ And many other activities related to becoming more independent

The role of the Independent Living Specialist is to work with people with disabilities (individuals) to help them decide their goals, figure out the steps needed to achieve them, and provide support with each step in the process. A list of the individual's goals and steps is called a formal Independent Living Plan (ILP). An ILP helps to clearly identify what it is the individual is working on. The Independent Living Specialist can help the individual to develop an ILP to reach their goals, or the individual can choose not to have a formal written plan. Either way, the work they do together will be focused on the goals the individual decides they want to accomplish. Goals can be changed or added to the plan at any time in the process.

Goal Categories

(These are examples of some of the different types of goals you might have for living independently.)

- ◆ Self-Advocacy/Self-Empowerment
- ◆ Communication
- ◆ Education/Training
- ◆ Employment/Vocational
- ◆ Equipment/Assistive Devices
- ◆ Finances/Benefits
- ◆ Health Care/Nutrition
- ◆ Housing
- ◆ Mobility
- ◆ Personal Assistance Services
- ◆ Self Help/Independent Living Skills
- ◆ Social/Recreation
- ◆ Transportation

Sample Independent Living Plan

(This is an example of how you and the IL Specialist you are working with might identify a goal you have and the steps needed to achieve it.)

Goal #1 Category: Housing: Become more independent in current living situation.

Steps:

1. *Assess current barriers to independence at home
2. *Make a list of changes to increase independence
3. *Prioritize list based on:
 - a. Free or low-cost changes
 - b. Changes that will increase independence the most
4. *Locate resources to assist with any higher-cost changes (Could be a separate goal)
5. Implement changes on list in Order of priority
6. *Assess impact of changes Implemented

***These steps performed with help from staff.**

Staff: _____

Date of Intake: _____

SOUTHERN NEVADA CENTER FOR INDEPENDENT LIVING INTAKE

First Name _____ Middle Name _____ Last Name _____ Home Phone: _____

Cell Phone: _____

Address: _____ City: _____

STATE _____

ZIP CODE _____

County _____

Email Address _____

Date of Birth: _____ Age: _____ Gender: _____

Ethnicity:

- a) _____ White d) _____ Black/African American c) _____ Hispanic/Latino of any race or Hispanic/Latino only d) _____ Asian
e) _____ American Indian/Alaskan f) _____ Native Hawaiian/Other Pacific Islander g) _____ 2 or more Races

US Veteran: Yes _____ No _____

Referred By: _____ Referrer Phone: _____

Beginning Community-Based Living:

- a) _____ Institution b) _____ Dependent w/family & friends c) _____ Assisted Living
d) _____ Independent e) _____ Homeless

Employment Status at Entry:

- a) _____ Full Time c) _____ Retired e) _____ Looking
b) _____ Part Time d) _____ Sheltered f) _____ None

Education: (Optional)

- a) _____ Grade School/Less d) _____ Vocational/Trade g) _____ Post Graduate Study
b) _____ Some Jr./Sr. High School e) _____ Some College h) _____ Now In School
c) _____ High School Graduate f) _____ College Graduate i) _____ None of the Above

Education Goal if in School _____

Transportation:

- a) _____ Drives Own Vehicle b) _____ Uses Driver
c) _____ Arranges Transportation d) _____ Public Transportation e) _____ No Transportation

Marital Status:

- a) _____ Single c) _____ Divorced e) _____ Separated #Minor Children: _____
b) _____ Married d) _____ Widowed f) _____ Other

In HSHLD: _____ Head of HSHLD: Y or N Accessible: Y or N

Source of income:

SSDI: _____ SSI: _____ Food Stamps: _____
VA: _____ Private: _____ Other: _____ None: _____
Other type: _____ Annual Income: _____

Health Benefits:

- a) _____ Medicare b) _____ Medicaid c) _____ Private d) _____ Other

Are you a registered voter? Yes _____ No _____ Have you completed a registration form? Yes _____ No _____

For Office Use Only:

Funding Source: _____

1 = 03 _____ 2 = 08 _____ 3 = 22 _____

Primary Disability:

A) COGNITIVE

- 1) _____ Mentally Challenged
- 2) _____ Learning Disabilities
- 3) _____ TBI
- 4) _____ Age Onset

D) PHYSICAL

- 1) _____ Amputation
- 2) _____ Paraplegic
- 3) _____ Quadriplegic
- 4) _____ Arthritis/Rhe
- 5) _____ Back Injury
- 6) _____ Spina Bifida
- 7) _____ Cerebral Palsy
- 8) _____ MS
- 9) _____ MD
- 10) _____ Stroke

E) OTHER

- 1) _____ AIDS
- 2) _____ Diabetes
- 3) _____ Heart Disease
- 4) _____ Respiratory
- 5) _____ Environment Allergies
- 6) _____ Chemical Dependency
- 7) _____ Speech
- 8) _____ Epilepsy
- 9) _____ Asthma
- 10) _____ Autism
- 11) _____ Other _____

F) VISUAL

- 1) _____ Vision Impaired
- 2) _____ Blind

B) MENTAL/EMOTIONAL

- 1) _____ Mental Illness
- 2) _____ Behavioral Disorder

G) HEARING

- 1) _____ Hard of hearing
- 2) _____ Late deafened
- 3) _____ Deaf

C) Multiple Disabilities: _____

Requested Services:

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

2021 Federal Poverty Level Chart

(<https://www.nevadahealthlink.com/start-here/income-based-costs/>)

Household Size	138%	150%	200%	250%	300%	400%
1	\$17,609	\$19,140	\$25,520	\$31,900	\$38,280	\$51,040
2	\$23,791	\$25,869	\$34,480	\$43,100	\$51,720	\$68,960
3	\$29,974	\$32,580	\$43,440	\$54,300	\$65,160	\$86,880
4	\$36,156	\$39,300	\$52,400	\$65,500	\$78,600	\$104,800
5	\$42,338	\$46,020	\$61,360	\$76,700	\$92,040	\$122,720
6	\$48,521	\$52,400	\$70,320	\$87,900	\$105,480	\$140,640
7	\$54,703	\$59,460	\$79,280	\$99,100	\$118,920	\$158,560
8	\$60,886	\$66,180	\$88,240	\$110,300	\$132,360	\$176,480

Add \$4,540 for each person in household over 8 persons.

SOUTHERN NEVADA CENTER FOR INDEPENDENT LIVING

WRITTEN GOAL PLAN

First Name: _____ Last Name: _____

IL Plan (704 Reg.)	<div style="display: flex; justify-content: space-between;"> _____ Waived Goal Outcome: (704 Req.) </div> <div style="display: flex; justify-content: space-between;"> _____ Accepted _____ Ongoing </div> <div style="display: flex; justify-content: space-between;"> _____ Achieved </div> <div style="display: flex; justify-content: space-between;"> _____ Dropped </div>	
Date Defined:	<div style="display: flex; justify-content: space-between;"> _____ Outcome Date: (704 Req.) _____ </div>	
Goal Category:	<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <div style="display: flex; justify-content: space-between;"> _____ A. Self-Advocacy/Self-empowerment A. _____ COVID-19 </div> <div style="display: flex; justify-content: space-between;"> _____ B. Communication B. _____ COVID-19 </div> <div style="display: flex; justify-content: space-between;"> _____ C. Mobility/Transportation C. _____ COVID-19 </div> <div style="display: flex; justify-content: space-between;"> _____ D. Community- Based Living D. _____ COVID-19 </div> <div style="display: flex; justify-content: space-between;"> _____ E. Educational E. _____ COVID-19 </div> <div style="display: flex; justify-content: space-between;"> _____ F. Vocational F. _____ COVID-19 </div> <div style="display: flex; justify-content: space-between;"> _____ G. Self-Care G. _____ COVID-19 </div> <div style="display: flex; justify-content: space-between;"> _____ H. Information Access/Technology H. _____ COVID-19 </div> <div style="display: flex; justify-content: space-between;"> _____ I. Personal Resource Management I. _____ COVID-19 </div> <div style="display: flex; justify-content: space-between;"> _____ J. Relocation from a Nursing Home or Institution to Community-Base Living Care/Nutrition J. ____ COVID-19 </div> <div style="display: flex; justify-content: space-between;"> _____ K. Community/Social Participation K. _____ COVID-19 </div> </div> </div>	

Goal Type: _____

Goal Note: _____

****Signature:** _____ **Date** _____

****Verbal consent was given to print Consumer's name due to services being provided remotely because of COVID-19. This form will also be mailed out to obtain a hard signature.**

Staff Signature: _____ **Date** _____

State Goal: Action Steps	Review Date	Review satisfaction with goal progress and service they have received so far (note comments below)	Date Action Step Completed
Step 1:			
Step 2:			
Step 3:			
Step 4:			

To be completed when work on this goal has ended:

☐ I felt I was successful in achieving my goal / ☐ I felt I was unsuccessful in achieving my goal Please select:

I feel my independence increased on a level of one to five , with five being the highest so far:

1 2 3 4 5

Comments: _____

SERVICES

- A. Advocacy/Legal Services
- B. Assistive Devices/Equipment Services
- C. Children's Services
- D. Communication Services
- E. Counseling & Related Services
- F. Family Services
- G. Housing, Home Modifications, and Shelter Services
- H. IL Skills Training and Life Skills Training Services
- I. Information & Referral Services
- J. Mental Restoration Services
- K. Mobility Training
- L. Peer Counseling Services
- M. Personal Assistance Services
- N. Physical Restoration Services
- O. Preventive Services
- P. Prosthesis & Other Appliances Services
- Q. Recreational Services
- R. Rehabilitation Technology Services
- S. Therapeutic Treatment
- T. Transportation Services (App)
- U. Youth Transition Services
- V. Vocational Services
- W. Other Services

GOALS

- A. Self-Advocacy/Self-Empowerment
- B. Communication
- C. Mobility/Transportation
- D. Community –Based Living
- E. Educational
- F. Vocational
- G. Self-Care
- H. Information Access/Technology
- I. Personal Resource Management
- J. Relocation from a Nursing Home or Institution to Community-Based Living
- K. Community/Social Participation

SNCIL CODE OF CONDUCT

SNCIL STRIVES TO PROVIDE A SAFE AND NON-THREATENING ENVIRONMENT

I, _____, have read and agree to comply with the following on _____.

**(Signature)

(Date)

****Verbal Consent was given to print Consumer's name due to services being provided remotely due to COVID-19. This form will also be mailed out to obtain a hard signature.**

- **The Following Conduct Is Prohibited:**

1. **Fighting**
2. **Harassment (Verbal/Physical)**
3. **Rude Gestures**
4. **Provoking Confrontation**
5. **Shouting**
6. **Making Loud Noises**
7. **Indecent Language**
8. **Bullying**
9. **Threats**

- **The Following Is Prohibited On The Premises:**

1. **Illegal Drugs**
2. **Alcohol**
3. **Tobacco**
4. **Weapons**
5. **Perfume/Aftershave/Etc.**

- **Discrimination On The Basis Of The Following Is Prohibited:**

1. **Gender**
2. **Ethnicity**
3. **Age**
4. **Religion**
5. **Disability**
6. **Sexual Orientation**
7. **Nationality**
8. **Political Opinion**

We ask that you respect and follow the SNCIL Code of Conduct. Employees and Volunteers make every effort to apply these codes in a fair, dignified, and positive manner for the benefit of everyone. Anyone choosing to disrespect the codes and refusing to modify behavior will be asked to leave. This will result in eviction and termination of SNCIL Services either voluntarily or by police escort.





DIVERSION

Maintaining Community-Based Living

Identifying the At Risk Individual

At Risk Factors

Name: _____

SNCIL Staff: _____ Date: _____

Please check ALL that applies.

- _____ 1. Have you been institutionalized in a long-term care facility (i.e. nursing home, mental health facility, state school, prison /jail, etc.) within the last 12 months?
- _____ 2. Are you Homeless?
- _____ 3. Do you feel at risk of institutionalization?
- _____ 4. Have you been diagnosed with one or more of the following health conditions?
- _____ Coronary Heart Disease
 - _____ Fractures due to falling
 - _____ Decubitus (i.e. pressure sore/bed sore)
 - _____ Diabetes
 - _____ Stroke
 - _____ Cancer
 - _____ Incontinence (bowel and/or bladder)
 - _____ Mental Illness (i.e. Bipolar Disorder, Major Depression, Schizophrenia, etc.)
 - _____ Alzheimer's or other form of dementia
- _____ 5. Have you been hospitalized for any of the health conditions mentioned above in the last 12 months?

- _____ 6. Have you made 6 or more visits to the emergency room within the last 12 months?
- _____ 7. Do you need assistance with three or more activities of daily living (i.e. bathing, dressing, toileting, grooming, etc.)?
- _____ 8. Do you have an in-home care provider or personal care attendant?
- _____ 9. Are you 65 years of age or older?
- _____ 10. Do you have issues with taking medications(s) as prescribed?
- _____ 11. Do you live alone?
- _____ 12. Is your current housing situation suitable (i.e. safe, accessible, rent and utilities current, etc.)?
- _____ 13. Is your income sufficient to cover basic living expenses such as, rent, utilities and food?
- _____ 14. Do you have a history of drug and/or alcohol abuse?
- _____ 15. Do you have informal supports (i.e. help from spouse, children, siblings, friends, etc.)?
- _____ 16. Have you contracted the COVID-19 Virus?
- If yes, around what date were you diagnosed? _____
- _____ 17. Have you been vaccinated?

- For individual assessment performed by IL Staff please check mark all statements which pertain to the individual. There are a total of 15 factors.
- If the Individual discloses they are at risk- they are at risk.
- If the Individual checks off 5 of the 15, they are at risk without self-disclosure per staff judgement.

DIVERSION DEFINITION

ILRU definition of Diversion:

- An instance of turning something aside from its course, rerouting
- Deflection
- Deviation
- Divergence

Four Types of Diversion by Goal

1. Mobility/Transportation (Transportation Diversion) - Provide assistance to individuals with significant disabilities with obtaining affordable and accessible transportation; this would include paratransit; bus passes; taxi cab coupons/discount fare; medical non-emergency transportation services; mobility assessment training through RTC.
2. Community Base Living (Institutional Diversion) – Provide assistance to individuals with significant disabilities who are at risk of entering institutions so that the individuals may remain in the community. A determination of who is at risk of entering an institution should include self-identification by the individual as part of the intake or goal –setting process. Examples: ASI; Nevada Hands; Southern Nevada Regional Housing Authority; Affordable Housing List; Senior Housing; Rehabilitation Centers; Hospitals; and Correctional Institution.
3. Self-Care (Medical Diversion) - Provide assistance to individuals with significant disabilities who are at risk of entering institutions by obtaining medical insurance (i.e. Medicaid; Medicare; mental health; PCA; Physical Therapy; Mobility equipment (wheelchair; cane; walker; scooters; ramps; home modification); Speech Board; Hearing Aides; Vision devices.
4. System Advocacy/Self-Empowerment (Financial Diversion) - Provide assistance to individuals with significant disabilities who are at risk of entering institutions by obtaining financial stability (i.e., social security benefits and employment.

Instructions for recording Diversions in CIL First

For each goal meet as defined above you will create a diversion goal in CIL first by:

- a. Select goal and record goal set and met dates
- b. Once data has been entered and saved, duplicate the goal; then resave; then edit with the new goal type (O – Diversion); indicate in the short term goal section that this is for in-house purposes only and does not require signed ILP
- c. Click on Save this will appear as another goal set and met
- d. When the 704 report is run for the specified period all Diversion goals within that time frame will show up in the report. A paragraph will be added to the 704 report to reflect the diversions set and met.

SOUTHERN NEVADA CENTER FOR INDEPENDENT LIVING

Independent Living Goal Areas

Name: _____

PLEASE SELECT ALL ITEMS THAT YOU NEED MORE INFORMATION OR ASSISTANCE
WITH. FROM THE ITEMS THAT YOU CIRCLED IN #1-15, PICK THE THREE WHICH ARE
MOST IMPORTANT TO YOU RIGHT NOW.

- a. _____
- b. _____
- c. _____

1. Socialization Skills

- a. Self-esteem/self-image
- b. Communication Skills
- c. Goal Setting
- d. Problem Solving

2. Health Care Issues

- a. Personal Care
- b. Personal Care Management Training
- c. Medical Needs and Emergency Procedures
- d. Substance Abuse

3. Homemaking

- a. Home Management/Maintenance
- b. Laundry Resources
- c. Accessing Resources
- d. Adaptive Equipment

4. Housing

- a. Accessible Housing
- b. Housing Options
- c. Subsidized Housing Options
- d. Tenant Rights/Responsibilities

5. Transportation

- a. Adaptive Equipment
- b. Community Transportation
 - i. Public
 - ii. Private
 - iii. Subsidized
- c. Drivers Education Options

6. Financial Management
 - a. Handling Money
 - b. Budgeting
 - c. Banking
 - i. Checking
 - ii. Saving
 - d. Insurance Coverage
 - e. Financial Benefits Assistance Options
7. Cooking
 - a. Nutrition
 - b. Meal Planning
 - c. Comparison Shopping
 - d. Food Preparation/Storage
 - e. Kitchen Safety
 - f. Adaptive Equipment
8. Sexuality
 - a. Myths, Attitudes, and Rights
 - b. Fears and Feelings
 - c. Community Resources
9. Community Resources
 - a. Available Resources
 - b. Accessing Resources
10. Employment
 - a. Preparation for Employment
 - i. Career Planning
 - ii. Benefits Counseling
 - iii. Work Incentive Planning
 - b. Job Seeking
 - i. Interview Skills
 - ii. Form Completion
 - iii. Employment Resources/Options
 - iv. Accessing Resources
 - v. Employment Laws and the ADA
 1. Rights and Responsibilities
 2. Reasonable Accommodations
 - c. Job Keeping
 - i. Work Behavior
 - ii. Problem Solving

11. Post-Secondary Education

- a. Identifying Post-Secondary Programs of Interest
 - i. Career Planning
 - ii. Visiting Post – Secondary Programs
 - iii. Study and Organizational Skills
 - iv. College Survival Skills
 - v. Financial Resources/Options
 - vi. Forms Completion
 - vii. Educational Accommodations
 - viii. Accessing Post-Secondary Resources

12. Recreation and Leisure

- a. Identification of leisure Interests
- b. Developing Leisure Skills
- c. Location Community Recreation Opportunities
- d. Accessing Community Recreation Opportunities
- e. Adaptive Equipment

13. Advocacy

- a. Developing Advocacy Skills
- b. Advocating Resources/ Options
- c. Advocating for Yourself
- d. Advocating for Disability Issues
 - i. Local
 - ii. State
 - iii. National

14. Disability Awareness

- a. Self-Awareness
- b. Educating Others
- c. Disability Awareness and the Community
- d. Accessing Resources

15. Safety

- a. Community Safety
- b. Home Safety
- c. Personal Safety
- d. Computer/Internet Safety

Southern Nevada Center for Independent Living

CASE FILE REVIEW FORM

Name: _____

1. _____ IL Service Agreement

Part 1

- _____ Self-Disclosure
- _____ How does the individuals disability/disabilities limit their ability to function independently

Part 2

- _____ Request for accommodation for alternative communication formats (when needed)
- _____ Equal access to programs and services
- _____ IL Plan waived or developed
- _____ SNCIL Information Received by Individual
 - _____ SNCIL Code of Conduct
 - _____ IL Services provided
 - _____ Appeal Process & C.A.P
 - _____ Confidentiality
- _____ Satisfaction Survey
- _____ Individual Signature & Date
- _____ Eligibility Determination by SNCIL Staff
 - _____ Eligible/Ineligible for Services
 - _____ Services eligible for
 - _____ Staff signature & date

2. _____ Intake Form

- _____ Date of Intake
- _____ Name of Staff
- _____ Demographics completed
- _____ Narrative
 - _____ Individual Descriptors
 - _____ Background Information
 - _____ Arrived on Time for Intake/Place of Intake
 - _____ Family or Friends at Intake
 - _____ General Appearance
 - _____ Individuals Eligibility for Services
 - _____ Age of Disability Onset if Applicable
 - _____ Funding Source
 - _____ Primary Disabilities
 - _____ Requested Services
 - _____ Reason for requested services by Individual
 - _____ Other General Observations
 - _____ Narrative flows well, tells a story
 - _____ Punctuation, grammar and sentence structure are professional

3. _____ SNCIL Written Goal Plan

_____ Individual's Name
_____ IL Plan
_____ Waived
_____ Accepted
_____ Outcome
_____ Ongoing
_____ Achieved
_____ Dropped
_____ Date Defined
_____ Outcome Date
_____ Goal Category
_____ Goal Type
_____ Goal Note (as needed)
_____ Signatures**
_____ Individual
_____ Staff
_____ Action Steps
_____ CIL's First Goal Sheet
_____ Situation
_____ Need
_____ Method
_____ Target Date
_____ Diversion

4. _____ SNCIL IL Goals Area _____ Optional form to be completed by Individual
(But needs to be included in case file)

5. _____ Other Optional Forms _____ SNCIL Authorization to Release Information Form
_____ SNCIL Registered Voter Form
_____ SNCIL Code of Conduct Form

6. _____ Resource Guide Book _____ Available upon Individuals request

Reviewed by: _____ Date: _____

Intake File Review:	_____ Staff Initials	_____ Date of Review
Update File Review:	_____ Staff Initials	_____ Date of Review
Annual File Review:	_____ Staff Initials	_____ Date of Review

Notes: _____

****Attn: SNCIL Casefile review Staff: Verbal consent was given to print Consumer's name due to services being provided remotely because of COVID-19.**



IF YOU ARE NOT REGISTERED TO VOTE WHERE YOU LIVE NOW,
would you like to register to vote here
today? (Please select one)

☐ YES

☐ NO

If you do not check either box, you will be considered to have decided not to register to vote at this time.

The **NATIONAL VOTER REGISTRATION ACT** provides you with the opportunity to register to vote at this location. If you would like help in filling out a voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

IMPORTANT NOTICE: Applying to register or declining to register to vote **WILL NOT AFFECT** the amount of assistance you will be provided by this agency.

Signature

Date

CONFIDENTIALITY: Whether you decide to register to vote or not, your decision will remain confidential.

IF YOU BELIEVE SOMEONE HAS INTERFERED with your right to register or to decline to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Office of the Secretary of State, Capitol Complex, Carson City, Nevada 89710.



Southern Nevada Center for Independent Living

TO: _____

RE: _____

S. S. Number

D.O. B.

AUTHORIZATION TO RELEASE INFORMATION

The information that you have provided may be disclosed, with your approval, to other agencies who work with Southern Nevada Center for Independent Living (SNCIL) to assist you in your path to independence and who, have need to have access to the records in order to assist you. You will be required to sign a release for each agency. Recipients of information shall be required to comply with the requirements of the Privacy Act of 1974, as amended, pursuant to 5USC 552a(m). I understand that the records will be used to provide a continuum of service and may be shared with other contacted services providers who participate on the individual interdisciplinary team. This release expires in one year from date of signature.

Authorized Signature

Date

Parent

Date

Legal Guardian/Representative Payee Signature

Date

Power of Attorney Signature

Date

Staff Signature _____

Specific Needs: _____

Las Vegas Office

2950 S. Rainbow Blvd., Ste. 220
Las Vegas, NV 89128

(702) 889-4216 V/TDD - West
(702) 649-3822 V/TDD - East
(800) 870-7003 Toll Free
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