

RSIC HUMAN SERVICES

405 Golden Lane ♦ Reno, Nevada 89502

Ph. (775) 329-5071 ♦ Fax (775) 785-8758



COVID-19 EMERGENCY ASSISTANCE (CRISIS RELIEF under the CARES ACT FUND) APPLICATION

APPLICANT NAME: _____

PLEASE PROVIDE ITEMS LISTED BELOW EACH BULLET POINT CATEGORY

♦ IDENTIFICATION

- State Issued Driver License OR;
- State Issued ID

♦ TRIBAL MEMBERSHIP

- RSIC Enrollment Card OR;
- Official letter from RSIC Enrollment Department

♦ RESIDENCY

- Utility Bill OR;
- Lease/Housing Agreement

♦ PROOF OF HARDSHIP AS A DIRECT RESULT OF COVID-19

- Documentation of lay-off, furlough, or other job related loss;
 - Reduction in work hours due to COVID-19.
 - Documentation of diagnosis of COVID-19;
 - Documentation of death in immediate family due to COVID-19;
 - Order/recommendation to self-isolate from a medical provider that resulted in a salary reduction;
 - Placement letter for children placed in temporary, out of home placement after March 19th, 2020;
 - A completed Verification of Employment Separation signed by a bona fide representative of the employer;
 - Proof of non-essential business ownership in the state of Nevada and/or Reno-Sparks Indian Colony;
 - Other types of documentation illustrating financial hardship caused by COVID-19;
 - Denial of unemployment benefits;
 - Denial of TANF benefits
 - Documentation NOT accepted are hand written notes, verbal reports of job loss, self-diagnosis of COVID-19, etc.
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CRISIS RELIEF INFORMATION And DISCLOSURE CHECK RECEIPT

PLEASE READ and SIGN

Certification: By signing below, I certify that I am in receipt of a check from the Reno-Sparks Indian Colony in the amount of \$_____ (Check # _____). The payment is in response to my application for financial assistance to offset losses I and my family members (if applicable) have suffered as a result of the COVID-19 Pandemic. I further certify and represent that the funds I received will be used only to purchase essential goods and services to relieve the impacts of COVID-19 and support my self-sufficiency and the self-sufficiency of my family members, if applicable. I agree to use these funds for essential needs including, but not limited to, housing, utilities, groceries, hygiene items, cleaning agents and other household necessities.

I certify that the information in my application is true and correct to the extent of my knowledge. I understand that submitting false information and/or documentation may be a crime that is punishable under Tribal and Federal Law. I also understand that false information is also a basis to disqualify me for future assistance.

Applicant Name (print) _____ Date _____

Applicant Signature _____ Date _____

Human Services Employee _____ Date _____

COVID ASSISTANCE
SHOPPING GUIDELINES

Allowable Food Items:

- Meats
- Milk and Dairy Products
- Produce
- Bread
- Soup
- Fruit/Vegetable Juices
- Granulated Sugar or Sweeteners
- Butter
- Canned/Jarred Foods
- Pasta and Cereal
- Frozen Foods
- Baby Formula and Food

Allowable Hygiene Items:

- Shampoo and Conditioner
- Body soap/wash
- Lotion
- Toilet Paper
- Paper Towels
- Diapers and Wipes
- Feminine Hygiene Products
- Toothpaste/Brushes
- Laundry and Dish Soap
- PPE (masks, gloves, etc.)
- Disinfectant/Cleaning Agents

Unallowable Items:

- Alcohol
- Cigarettes
- Electronics
- Camping/Outdoor gear
- Toys
- Automotive items

**Please Note: No other items are allowable for purchase if not listed above.
I've read and understand the Shopping Guidelines.**

Client Signature: _____ Date: _____



RENO-SPARKS TRIBAL HEALTH CENTER

1715 Kuenzli Street, Reno, Nevada 89502
 Office (775) 329-5162 * Fax (775) 334-4359

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
Please Complete and Sign

DURING THE COVID-19 PANDEMIC

Patient Name (<i>First, Middle, Last</i>)	:	Date of Birth (<i>Month Day, Year</i>)	:	Medical Record #
	:		:	
	:		:	

	The information is to be disclosed by:	And is to be provided to:
Name of Facility	___ Reno Sparks Tribal Health Center ___	Reno Sparks Indian Colony Human Services ___
Street Address	___ 1715 Kuenzli Street ___	___ 34 Reservation Road ___
City/State/Zip Code	___ Reno, NV 89502 ___	___ Reno, NV 89502 ___
Telephone Number	___ (775) 329-5162 ___	___ (775) 329-2936 ___
Fax Number	___ (775) 334-4359 ___	___ ___

The purpose or need for this disclosure is: DURING THE COVID-19 PANDEMIC (*Please initial appropriate purpose*)

Further medical care
 Housing
 Tribal Response
 Other (*Specify*) _____
 Personal Use
 Human Services
 Contact tracing

The information to be disclosed: (*Please initial information you want disclosed*)

Laboratory Reports (*Date/s*) _____
 Only records pertaining to: ___ COVID19 ___
 Only the period of events from: ___ March 18, 2020 ___ to: ___ March 18, 2021 ___

I hereby voluntarily authorize the disclosure of the above information. I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, **it will terminate one year from the date of my signature.** I understand that RSTHC will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating PHI for disclosure to a third party. I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA Privacy Rule 45 CFR Part 164 and the Privacy Act of 1974 5 USC 552a.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE (*State relationship to patient*) DATE _____

SIGNATURE OF WITNESS (*If signature of patient is a thumbprint or mark*) DATE _____

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretense shall be guilty of a misdemeanor (5USC 552a (i) (3)).

RCVD BY: _____ DATE: ___/___/___
 FAX/SCANNED/MAILED ___/___/___ INITIAL _____