Joe Lombardo
Governor

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIRECTOR'S OFFICE

Helping people. It's who we are and what we do.

Richard Whitley, MS
Director

The Contingency Account for Victims of Human Trafficking (VHT)

Emergency Services Request Form

Submit to GMU@dhhs.nv.gov

Date: ___________________________

Agency Requesting Funds: ____

Contact Person: ____

Phone: ___________________________ Email: ____

Mailing Address: ____

____

Amount Requested: $_________

Signature of Requestor: _______________________ Printed Name of Requestor: __________________

Note: Receipts and bank/credit card statements with charges highlighted must be provided for reimbursement.

Client Information

Client Identification Code: ____
(*please do not use client name or social security number*)

Client's Location:

County: ____ City: _____________________________

Age: ____

Description and justification of client need: (e.g., emergency housing, transportation, medical care, description of the relation to trafficking):

The following information is used to comply with the requirements set forth by NRS 239B.022 - 239B.026. Only the Department of Health and Human Services will have access to this information. Your responses will be kept private and secure. The information will not be used for a discriminatory purpose. Providing this information is voluntary.

Gender assigned at birth:

_____ Male _______ Prefer Not to Disclose

_____ Female

400 West King Street, Suite 300 ● Carson City, Nevada 89703
775-684-4000 ● Fax 775-684-4010 ● dhhs.nv.gov

How do you describe yourself:

______ Male

______ Female

______ Transgender Man/Trans Male

______ Transgender Woman/Trans Female

______ Genderqueer/Gender Non-Conforming

______ Different Identity, Please Specify:

______ Prefer Not to Disclose

Which of the following best represents your sexual orientation identity? (Mark one answer):

______ Straight or Heterosexual

______ Gay

______ Lesbian

______ Bisexual

______ Not Listed:

Please Specify______________________

______ Prefer Not to Disclose

Race/Ethnicity:

______ Hispanic, Latino or Spanish origin

______ White

______ Black African American

______ Asian

______ Native Hawaiian/Pacific Islander

______ American Indian/Alaska Native

______ Middle Eastern

______ North African

______ Multi-race (two or more of these options)

For Department Use Only

Amount $____________ Vendor number verified in DAWN: Yes ☐; Vendor number: ____________

☐ Approved

☐ Denied Reason for denial: ________

Make check payable to: ____________

Grants Management Unit Authorization

____

Signature of DHHS, Grants Management Unit Program Specialist Date

DHHS, Director Authorization (or Director's designee)

____

Signature Date

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