



DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIRECTOR'S OFFICE

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



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

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