Account for Victims of Human Trafficking (VHT)

Emergency Assistance 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 _____ Female _____ Prefer Not to Disclose

1000 N Division Street ● Carson City, Nevada 89703
775-684-4000 ● dhhs.nv.gov

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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, GMU Program Specialist Date

DHHS, Director Authorization (or Director's designee)

_____

Signature Date

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