



Application for Health Insurance

You can use this application to:

- Apply for free or low-cost insurance from Medicaid or Nevada Check-Up.
 - You can apply for and receive Medicaid, even if you already have insurance.
- If you or your family members are determined to be ineligible for Medicaid or Nevada Check-Up, you may still qualify for help paying for health insurance from the federal government. A referral will be sent to Nevada Health Link. For additional information, visit their website at www.nevadahealthlink.com or call 855-768-5465.

Access your benefits faster.

Apply Online

Did you know that you can apply, enroll and start using your health benefits sooner by submitting your application online?

- Takes about 45 minutes for a typical household
- Follow the prompts and, when finished, click "SUBMIT"
- Once you create an account, you can check the status of your benefits online.

Go to: accessnevada.nv.gov

Get assistance with your application.

Personal Assistance

You can get personalized assistance completing your application at one of the Division's district offices or a Family Resource Center.

To find a location nearest your home:

Call 1-800-992-0900 (voice) or 1-800-326-6888 (TTY) or visit dss.nv.gov

Fill out the attached paper application.

A handwritten, paper application is an option for those who must use paper.

By Mail

- Follow the instructions and complete ALL areas that apply to you and your family.
- Submit your application to the local Social Service Office or mail to: DSS

PO Box 15400
Las Vegas, NV 89114

Contact Information (We will need to contact an adult member of the family.)				
First Name:	Middle Name:	Last Name:	Suffix	Date of Birth
Home Address:			Apartment Number:	
City:	State:		Zip Code:	
<i>If you don't have a permanent address, you still need to give a valid mailing address.</i>				
Mailing Address: (if different than home address)			Apartment Number:	
City:	State:		Zip Code:	
Daytime Phone #	Ext.	Secondary Phone #	Ext.	
Currently, all notifications are sent in paper format. In the future, if available, would you like to receive information by:				
Email:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Email address: _____	
Preferred language (if not English): <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____			Interpreter needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Household Information				
Your income and family size help us decide what programs you qualify for. With this information, we can make sure everyone gets the most coverage possible.				

Who needs to be included on this application:

- your spouse, if married
- your children who live with you
- your partner who lives with you (but only if you have children together who need health insurance)
- anyone you include on your federal tax return, **whether they live with you or not**
- **If you don't file a tax return, remember to still add family members who live with you.**

Anyone else who lives with you will need to file their own application if they want insurance. You don't need to file taxes to apply for health insurance.

Complete the Additional Member pages for each person in your family. Start with yourself. If you have more than 2 people in your family, you will need to make a copy of the 'Additional Member' pages and complete.

We need Social Security Numbers (SSNs) for everyone applying for health insurance that has one. An SSN is optional for people not applying for insurance but providing one can speed up the application process. **Please ensure the name is listed the same as it is displayed on your Social Security Card.**

American Indians or Alaska Natives (AI/AN) who enroll in Medicaid, Nevada Check-Up and the Silver State Health Insurance Exchange can also get services from the Indian Health Services, tribal health programs or urban Indian health programs.

If you or your family members are American Indian or Alaska Native, you may not have to pay premiums or cost sharing and may get special monthly enrollment periods. We will ask additional questions to make sure you and your family get the most help possible.

Need help with your application?
Call 1-800-992-0900 (voice) or 1-800-326-6888 (TTY) or visit us online at dss.nv.gov

Head of Household Information			
First Name, MI, Last Name & Suffix	Marital Status	If married, do you live with your spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship to you? SELF
Social Security Number (OPTIONAL)	Date of Birth	Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Due Date: If yes, how many babies are expected:	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Do you plan to file a federal income tax return NEXT YEAR?			
<input type="checkbox"/> Yes If yes, answer questions 1 - 3 <input type="checkbox"/> No If no, skip to question 3			
1. Do you expect to file a joint return with a spouse/partner? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of spouse/partner: _____			
2. Will you claim any dependents on your tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list name(s) of dependents: _____			
3. Are you being claimed as a dependent on someone else's tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list the name of the tax filer: _____ How are you related to the tax filer? _____			
Are you applying for Medicaid, Nevada Check-Up or assistance with your health insurance premiums (Advanced Premium Tax Credit - APTC)?			
If yes, answer all the questions below. <input type="checkbox"/> Yes <input type="checkbox"/> No If no, skip to the income questions. Note: Marking 'Yes' means you will be evaluated for federally funded medical assistance.			
Social Security Number - REQUIRED if not listed above	If you are a child, under the age of 19, do you have access to public employee coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you a U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you lived in the U.S. since 1996? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If not a U.S. citizen, do you have eligible immigration status? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type: _____ ID Number: _____		
If yes, provide the following information:			
Are you, your spouse, domestic partner or your parent (if you are a minor) an honorably discharged veteran or active-duty member of the military? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you an American Indian or Alaska Native? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, what tribe? _____			
If under age 26, have you ever been in foster care? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what state? _____			
Age when you left the program? _____		Did you receive health care through a state Medicaid program? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you the parent or primary caretaker relative of any child(ren), under the age of 19, in the household? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who? _____			
Do you have medical bills for the past three months that you need help with? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, what months? _____			

Head of Household Information continued:Are you legally blind or permanently disabled? Yes NoAre you receiving Supplemental Security Income (SSI)? Yes NoDo you need help with activities of daily living through personal assistance services or a medical facility?
 Yes No**Current Job and Income Information** **Not employed** - Skip to 'Other Income' section**CURRENT JOB:**In the past 3 months, did you: Change jobs Stop working Work fewer hours None of these

Employer Name: (if self-employed, write 'SELF')

Average hours worked each week

Employer Address:

Employer Phone Number:

City:

State:

Zip Code:

Gross wages/tips per pay period:

\$

How often are you paid?

 Weekly Every 2 weeks Semi-Monthly Monthly Annually**If self-employed, please answer the following questions:**

Type of work: _____

How much net income (profits once expenses are paid) will you receive this month? \$ _____

OTHER INCOME: Check all that apply and give amount and how often you receive it.**Note:** You don't need to tell us about child support or veteran disability payments. Certain money received may or may not be counted for Medicaid and Nevada Check-Up. Let us know if any money received is considered tribal income.

<input type="checkbox"/> None				Tribal Income?
<input type="checkbox"/> Unemployment	\$ _____	How often?	_____	
<input type="checkbox"/> Retirement	\$ _____	How often?	_____	
<input type="checkbox"/> Pensions	\$ _____	How often?	_____	
<input type="checkbox"/> Social Security (RSDI) Benefits	\$ _____	How often?	_____	
<input type="checkbox"/> Interest/Dividends	\$ _____	How often?	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Annuities	\$ _____	How often?	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Rental or Royalty Income	\$ _____	How often?	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Capital Gains	\$ _____	How often?	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Farming or Fishing Income	\$ _____	How often?	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Alimony	\$ _____	How often?	_____	
<input type="checkbox"/> Scholarships & Grants	\$ _____	How often?	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cash Advances	\$ _____	How often?	_____	
<input type="checkbox"/> Gambling Winnings	\$ _____	How often?	_____	
<input type="checkbox"/> Other	\$ _____	How often?	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Head of Household Information continued:**DEDUCTIONS (Only list deductions reported on the IRS form 1040): Check all that apply and give amount and how often.**

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could reduce your countable income. **Note:** You shouldn't include a cost that you already considered in your answer to net self-employment.

<input type="checkbox"/> Educator expenses	\$ _____	How often? _____
<input type="checkbox"/> Health savings	\$ _____	How often? _____
<input type="checkbox"/> Moving expenses	\$ _____	How often? _____
<input type="checkbox"/> Alimony	\$ _____	How often? _____
<input type="checkbox"/> IRA deductions	\$ _____	How often? _____
<input type="checkbox"/> Business expenses of reservists, performing artists, and fee-basis government officials	\$ _____	How often? _____
<input type="checkbox"/> Penalty paid on early withdrawal of savings	\$ _____	How often? _____
<input type="checkbox"/> Student loan interest	\$ _____	How often? _____
<input type="checkbox"/> Tuition and fees	\$ _____	How often? _____
<input type="checkbox"/> Domestic production activities	_____	How often? _____

Yearly Income

If the income you listed on this page is not steady from month to month, please tell us what you expect the yearly income to be. **For example**, some people expect their income to change because they only work some months of the year. If you do not expect a change to your monthly income, skip this question.

Total annual income expected this year: \$ _____ Year _____ Total annual income expected next \$ _____

RACE / ETHNICITY

Are you Hispanic, Latino or of Spanish origin? (optional) Yes No

Race (optional) - check all that apply

- | | | |
|--|---|--|
| <input type="checkbox"/> White | <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> Asian Indian |
| <input type="checkbox"/> African American or Black | <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Middle Eastern or North African |
| <input type="checkbox"/> Other Pacific Islander | <input type="checkbox"/> Other Asian: | Other |

Additional Member Information (If you have more than two people to include, make a copy of the Additional Member section and complete.)

First Name, MI, Last Name & Suffix	Marital Status	If married, do they live with their spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship to you?
Social Security Number (OPTIONAL)	Date of Birth	Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Due Date: _____ If yes, how many babies are expected: _____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female

Do they plan to file a federal income tax return NEXT YEAR?

Yes **If yes, answer questions 1 - 3** No **If no, skip to question 3.**

Note: They can still apply for health insurance even if they don't file a federal tax return.

- Do they expect to file a joint return with a spouse/partner? Yes No
If yes, name of spouse/partner: _____
- Will they claim any dependents on their tax return? Yes No
If yes, list name(s) of dependents: _____
- Are they being claimed as a dependent on someone else's tax return? Yes No
If yes, please list the name of the tax filer: _____
How are they related to the tax filer? _____

Are they applying for Medicaid, Nevada Check-Up or assistance with their health insurance premiums (Advanced Premium Tax Credit - APTC)?

Yes **If yes, answer all the questions below.** No **If no, skip to the income questions.**

Note: Marking 'Yes' means they will be evaluated for federally funded medical assistance.

Social Security Number - REQUIRED if not listed above	If they are a child, under the age of 19, do they have access to public employee coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Are they a U.S. citizen? Yes No Have they lived in the U.S. since 1996? Yes No

If not a U.S. citizen, do they have eligible immigration status? Yes No

If yes, provide the following information: **Type:** _____ **ID Number:** _____

Are they, their spouse or their parent (if they are a minor) an honorably discharged veteran or active-duty member of the military? Yes No

Are they a full-time student? Yes No

Are they an American Indian or Alaska Native? Yes No

If yes, what tribe?

If under age 26, have they ever been in foster care? Yes No **If yes, what state?** _____

Age when they left the program? _____ Did they receive health care through a state Medicaid program? Yes No

Are they a parent or primary caretaker relative of any child(ren), under the age of 19, in the household?
 Yes No **If yes, who?** _____

Do they have medical bills for the past three months that they need help with? Yes No

If yes, what months?

Additional Member Information continued:

Are they legally blind or permanently disabled? Yes No

Are they receiving Supplemental Security Income (SSI)? Yes No

Do they need help with activities of daily living through personal assistance services or a medical facility?
 Yes No

Current Job and Income Information **Not employed** - Skip to 'Other Income' section

CURRENT JOB:

In the past 3 months, did they: Change jobs Stop working Work fewer hours None of these

Employer Name: (if self-employed, write 'SELF')	Average hours worked each week
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Employer Address:	Employer Phone Number:
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City:	State:	Zip Code:
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Gross wages/tips per pay period: \$	How often are they paid? <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually
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If self-employed, please answer the following questions:

Type of work: _____

How much net income (profits once expenses are paid) will they receive this month? \$ _____

OTHER INCOME: Check all that apply and give amount and how often they receive it.

Note: They don't need to tell us about child support or veteran's disability payments. Certain money received may or may not be counted for Medicaid and Nevada Check-Up. Let us know if any money received is considered tribal income.

				Tribal Income?
<input type="checkbox"/> None				
<input type="checkbox"/> Unemployment	\$ _____	How often?	_____	
<input type="checkbox"/> Retirement	\$ _____	How often?	_____	
<input type="checkbox"/> Pensions	\$ _____	How often?	_____	
<input type="checkbox"/> Social Security (RSDI) Benefits	\$ _____	How often?	_____	
<input type="checkbox"/> Interest/Dividends	\$ _____	How often?	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Annuities	\$ _____	How often?	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Rental or Royalty Income	\$ _____	How often?	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Capital Gains	\$ _____	How often?	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Farming or Fishing Income	\$ _____	How often?	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Alimony	\$ _____	How often?	_____	
<input type="checkbox"/> Scholarships & Grants	\$ _____	How often?	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cash Advances	\$ _____	How often?	_____	
<input type="checkbox"/> Gambling Winnings	\$ _____	How often?	_____	
<input type="checkbox"/> Other	\$ _____	How often?	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Additional Member Information continued:**DEDUCTIONS (Only list deductions reported on the IRS form 1040): Check all that apply and give amount and how often.**

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could reduce your countable income. **Note:** You shouldn't include a cost that you already considered in your answer to net self-employment.

<input type="checkbox"/> Educator expenses	\$ _____	How often? _____
<input type="checkbox"/> Health savings account	\$ _____	How often? _____
<input type="checkbox"/> Moving expenses	\$ _____	How often? _____
<input type="checkbox"/> Alimony	\$ _____	How often? _____
<input type="checkbox"/> IRA deductions	\$ _____	How often? _____
<input type="checkbox"/> Business expenses of reservists, performing artists, and fee-basis government officials	\$ _____	How often? _____
<input type="checkbox"/> Penalty paid on early withdrawal of savings	\$ _____	How often? _____
<input type="checkbox"/> Student loan interest	\$ _____	How often? _____
<input type="checkbox"/> Tuition and fees	\$ _____	How often? _____
<input type="checkbox"/> Domestic production activities	\$ _____	How often? _____

YEARLY INCOME:

If the income you listed on this page is not steady from month to month, please tell us what you expect the yearly income to be. **For example**, some people expect their income to change because they only work some months of the year. If you do not expect a change to your monthly income, skip this question.

Total annual income expected this year: \$ _____ Total annual income expected next year: \$ _____

RACE / ETHNICITY

Are they Hispanic, Latino or of Spanish origin? (optional) Yes No

Race (optional) - check all that apply

<input type="checkbox"/> White	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Asian Indian
<input type="checkbox"/> African American or Black	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Middle Eastern or North African
<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> Other Asian	Other: _____

HEALTH INSURANCE INFORMATION

Answer the following questions for everyone who is applying for help to pay for health insurance.

INSURANCE FROM JOBS: (This includes coverage from someone else's job, such as a parent, domestic partner or spouse, and includes private employer plans as well as TRICARE, federal or state employee plans and Peace Corps.)

Is anyone offered health coverage from a job?

Yes **If yes**, answer the following questions No **If no**, skip to 'Other Health Insurance'

We need to know about any health coverage you could get through a job. You can use this form to get information from the employer about health coverage this job offers. **If there is more than one job, copy this page.**

Employee Name:

Employee Social Security Number

_____-_____-_____

Employer Name:

Employer Identification Number
(EIN)

Employer Phone Number

Employer Address:

City

State

ZIP Code

Who can we contact about employee health coverage at this job?

Phone Number:

Email Address:

Is the employee currently eligible for coverage offered by this employer?

Yes **If yes**, will this job offer coverage NEXT year? Yes No

No If the employee is NOT currently eligible, will they be eligible in the NEXT 3 months? Yes No

If yes, provide date:

Who in the employee's family will the health plan cover? Spouse Domestic Partner Dependent(s)

Who does this plan offer coverage to? (If you need more space, attach another sheet of paper)

Person Name

(First Name, MI, Last Name)

Enrolled now, plans to enroll, or not enrolled

Changes you plan to make next year

- Enrolled Now
 Plans to Enroll
 Start Date: ____/____/____
 Not Enrolled

- Plans to drop coverage
 Date: ____/____/____
 Will become eligible
 Start Date: ____/____/____

- Enrolled Now
 Plans to Enroll
 Start Date: ____/____/____
 Not Enrolled

- Plans to drop coverage
 Date: ____/____/____
 Will become eligible
 Start Date: ____/____/____

- Enrolled Now
 Plans to Enroll
 Start Date: ____/____/____
 Not Enrolled

- Plans to drop coverage
 Date: ____/____/____
 Will become eligible
 Start Date: ____/____/____

Need help with your application?

Call 1-800-992-0900 (voice) or 1-800-326-6888 (TTY) or visit us online at dss.nv.gov

INSURANCE FROM JOBS (continued):

Does the employer offer a health plan that meets the minimum value standard*? Yes No

For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans):

If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

- a. How much would the employee have to pay in premiums for this plan? \$ _____
- b. How often? Weekly Every 2 weeks Twice a month Once a month Quarterly Yearly

What change will the employer make for the new plan year (if known)?

- Employer won't offer health coverage
- Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard. * (Premium should reflect the discount for wellness programs.)

- a. How much would the employee have to pay in premiums for this plan? \$ _____
- b. How often? Weekly Every 2 weeks Twice a month Once a month Quarterly Yearly
- c. Date of change (mm/dd/yyyy) _____/_____/_____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986.)

OTHER HEALTH INSURANCE INFORMATION

Does anyone have other health insurance, including Veterans, Medicaid/Nevada Check-Up, Medicare, COBRA, Private, or other Retiree Health Plan? Yes No

If yes, provide the following information:

Who has other health insurance?	What type do they have?	Name of Plan	Policy Number
Name:			
Name:			

OTHER INFORMATION**Renewal of Coverage (for APTC households only)**

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow Nevada Health Link to use my income data, including information from tax returns, for the next 5 years (the maximum number of years allowed). The Nevada Health Link will send me a notice, let me make changes, and I can opt out at any time.

I give permission for tax return access at renewal time for the next:

- Yes **If yes, how many years?** 0 Years 1 Year 2 Years 3 Years 4 Years 5 Years
- No **Do not renew my eligibility for help paying for health insurance**

Authorized Representative

You can give a trusted friend or partner permission to talk about this application with us, see your information and act for you on matters related to this application. This person is called an "authorized representative."

Do you want to name someone as your authorized representative? Yes No **If no, skip this section.**

Name of Authorized Representative

Phone Number

(____)____-____

Address

City

State

ZIP Code

By signing, you allow this person to sign your application, to get official information about this application and to act for you on all future matters with this agency.

Your Signature

____/____/____
Date

Medicaid Estate Recovery Program

Medicaid recipients who are 55 years or older or inpatients of a medical facility may be responsible for repayment of Medicaid expenses paid for them. Recovery of these payments made from the Medicaid Program would be pursued from the estate of the recipient after their death or after the death of their surviving spouse. (See Form 6160-AF, Program Operation.)

Initial

Third Party Liability

I understand the following is an eligibility requirement to receive Medicaid benefits:

- 1) If anyone on this application receives Medicaid benefits, I give the Medicaid agency the right to pursue and get any money from other health insurance, insurance, legal settlements, and any other third party that may be liable for the medical services paid by Medicaid; and
- 2) I give the Medicaid agency the right to pursue and get child and medical support from a spouse or a parent; and
- 3) I agree my household members will cooperate with the Medicaid agency to obtain any money from insurance companies, legal settlements and third parties and will give DHS notice of any settlements or legal action.

Initial

Referral Information:

How did you hear about these programs? Check ONLY one:

- | | | |
|---|---------------------------------|---|
| <input type="checkbox"/> WIC | <input type="checkbox"/> School | <input type="checkbox"/> Tribal Resources |
| <input type="checkbox"/> Family/ Friend | <input type="checkbox"/> Clinic | <input type="checkbox"/> Other |

Non-Discrimination

Following federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity or disability. You can file a complaint either:

online at: <https://www.hhs.gov/civil-rights/filing-a-complaint/index.html>;

by mail: Director, U.S. Department of Health and Human Services, Office for Civil Rights, Centralized Case Management Operations, 200 Independence Ave, S.W. Room 509F, HHH Building, Washington, D.C. 20201;

by phone: Customer Response Center: (800) 368-1019, Fax: (202) 619-3818, TDD: (800) 537-7697;

by email: ocrcomplaint@hhs.gov

Need help with your application?

Call 1-800-992-0900 (voice) or 1-800-326-6888 (TTY) or visit us online at dss.nv.gov

**IF YOU ARE NOT REGISTERED TO VOTE WHERE YOU LIVE NOW,
WOULD YOU LIKE TO REGISTER TO VOTE HERE TODAY?**

(Please check 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.

Your 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, 101 N. Carson Street, Suite 3, Carson City, Nevada 89701.

Reviews and Investigations

By signing this application, you are authorizing the Department of Human Services to make investigations concerning you, other members of your household and/or your child(ren)'s legal or natural parent(s) that may be necessary to determine eligibility for benefits you or your household receives under programs administered by the DSS and Nevada Health Link. Information provided to the agency may be verified or investigated by federal, state and local officials including quality control staff.

You must cooperate in the investigation, or your benefits may be denied or terminated. If you knowingly make a statement which is false or misleading; provide documents that have been altered; or conceal or withhold information that is necessary for the agency to make an accurate determination of the benefits for which you are eligible your benefits may be denied, terminated or reduced. If you receive benefits for which you are not entitled, you must repay the agency for all money, services, and benefits you were not entitled to receive. You may also be disqualified from receiving future benefits and be criminally prosecuted or penalized according to state and federal law.

Initial

Your Rights

If you think we made a mistake or have not acted timely on your application, you can appeal. That means you can ask us to look at your case again. You must request an appeal in writing within 90 days of the date of the notice. The notice will tell you how to appeal. You may appoint a representative to act for you in the appeals process. Contact us, and we can help you with your appeal.

Initial

Your Responsibilities

I know that I must tell the program I'll be enrolled in if the information I listed on this application changes. I know I can make changes by calling customer service and that I must report by the fifth (5th) of the following month. I understand that a change in my information could affect my eligibility for member(s) of my household.

Initial

Release of Information

I hereby authorize and consent to the release of all information concerning me or my household members to the Department of Health and Human Services by the holder of the information such as, but not limited to, wage information, information made confidential by law, as well as patient information privileged under NRS 49.225, or any other provision of law. I hereby release the holder of the information from liability, if any, resulting from the release (disclosure) of the required information.

If I am 60 years of age or older, I hereby consent to the disclosure of my identity and waive my right as an older person to have my identity kept confidential. I hereby release the holder of information from liability, if any, resulting from the disclosure of the required information.

Your Signature

____/____/____
Date

Cooperation with Child Support Enforcement

I know I'll be required to cooperate with the agency to collect medical support and establish paternity from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency and I may not have to cooperate.

Initial _____

Does any child on this application have a parent living outside of the home? Yes No

Incarceration

Is anyone applying for health insurance on this application incarcerated (detained or jailed)? Yes No

If yes, write the name of the person incarcerated here: _____

Check here if this person is pending disposition of charges.

Privacy Policy

We keep your information private as required by law. Your answers on this application will only be used to determine eligibility for health coverage and to provide information on additional healthcare services available to your household. Nevada Health Link, Division of Social Services and the Department of Human Services will check your eligibility using our electronic databases and the databases of other federal agencies. If the information does not match, we may ask you to send us proof. We won't ask any questions about your medical history. Household members who don't want coverage won't be asked questions about citizenship or immigration status.

IMPORTANT: As part of the application process, we may need to retrieve your information from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security and/or a consumer reporting agency.

We need this information to check your eligibility for coverage and help paying for coverage if you want it and to give you the best service possible. We may also check your information at a later time to make sure your information is up to date. We'll notify you if we find something has changed.

I understand my information will be used and retrieved from data sources for this application. I have consent for all people I will list on the application that allows their information to be retrieved and used from the above-mentioned data sources.

Initial _____

Health Plan Selection / Managed Care Organization Preference

Nevada households are covered by a managed care organization (MCO). You are being asked to choose one of the following health plans. If you do not select a preference, you will be assigned a plan randomly. Your choice does not guarantee enrollment into the Nevada Medicaid or Nevada Check Up programs. If you or any family members are already enrolled in one of the current MCOs, you might not be able to switch at this time. Enrolled families will receive a member handbook explaining their benefits.

Which Managed Care Option Would You Like?	Available Region	Contact Phone	Website <i>(Visit for more information)</i>
<input type="checkbox"/> Anthem Blue Cross and Blue Shield Healthcare Solutions	Urban Clark Urban Washoe	1-844-396-2329	mss.anthem.com/nevada-medicaid/home.html
<input type="checkbox"/> CareSource	Rurals Urban Clark Urban Washoe	1-8332302058	caresource.com/nv/plans/medicaid/
<input type="checkbox"/> Health Plan of Nevada	Urban Clark	1-800-962-8074	myHPNmedicaid.com/Member
<input type="checkbox"/> Molina Healthcare	Urban Clark Urban Washoe	1-844-327-7136	meetmolina.com/nv-medicaid
<input type="checkbox"/> SilverSummit Healthplan	Rurals Urban Clark Urban Washoe	1-844-366-2880	silversummithealthplan.com

No Preference

(Note: If you do not choose a Managed Care option, you will be randomly assigned to one by Medicaid)

For more information on the different MCO plans, visit <https://dhcfnv.gov/Members/BLU/MCOMain/>. If you need to find a provider, visit <https://www.medicaid.nv.gov/hcp/provider/Home/tabid/135/Default.aspx>, and search for a provider or you can call one of the local Medicaid district offices below:

Statewide Toll Free (800) 992-0900	TTY (800) 326-6888	Carson City (775) 684-3651	Reno (775) 687-1900	Las Vegas (702) 668-4200	Elko (775) 753-1191
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Optional Text Messaging Opt-In/Opt-Out

The information provided on this application, including your phone number(s), will be shared with any Department of Health and Human Services (DHHS) Division and Managed Care Organization (MCO) to which you are assigned. Consent authorizes calls and/or texts from DHHS, MCO, or any contractors acting on their behalf, at any phone number(s) you provide on this application, now or in the future, including information regarding your healthcare needs and treatment, wellness services, plan benefits, eligibility, renewal and/or redetermination, and for any other communication relating to your relationship with DHHS or the MCO concerning your health coverage. These calls/texts may be made using automated technology, such as with an automatic telephone dialing system or artificial or prerecorded voice message. Standard message and data rates may apply.

(Check one of the following):

- I consent to receive text messaging as described above. Preferred Phone (____) ____ - ____ Initial _____
- I do not consent to receive text messaging as described above.

Please read and sign this application.

- I'm signing this application under penalty of perjury, which means I've provided true answers to all of the questions to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.
- I swear I have honestly reported the citizenship status of myself and anyone I am applying for.

Signature or Mark of Applicant Date Signature or Mark of Spouse/Partner (Second Parent of Children) Date

Witness: (Use if applicant cannot read or write or is blind.)

The information in this application has been read to the applicant and I have witnessed the above signature.

Signature of Witness Date

Mail Your Completed Application.

Submit your application to the local Social Service Office or, mail your application to:
DSS
PO BOX 15400
Las Vegas, NV 89114

Did you remember to:

- ✓ Tell us about everyone in your family & household, even if they don't need insurance?
- ✓ Ask your employer about any job-related insurance?
- ✓ Sign this application?



Medicaid Estate Recovery Notification of Program Operation

Please be advised that if you are applying for or receiving benefits from the Medicaid Program, this is important information that could affect your decision to receive benefits from Medicaid.

Pursuant to State and Federal law, the State of Nevada administers a Medicaid Estate Recovery Program whereby correctly paid Medicaid assistance is recovered from the undivided estate of the person who received Medicaid benefits. Medicaid recipients aged 55 or older and certain inpatients in nursing facilities or institutions¹ are affected by this program. When those individuals pass away, Medicaid requires that the undivided estates of those individuals pay back any benefits paid by Medicaid.

“Undivided estate” is defined broadly in Nevada. It includes all real and personal property and other assets in or to which an individual had any interest or legal title at the time of death. This includes assets conveyed to someone else through joint tenancy, life estate, living trust, annuity, homestead or other arrangement. A Medicaid claim cannot be defeated by a homestead exemption or by the operation of bankruptcy or insolvency law.

Certain individuals are protected from Medicaid recovery. Medicaid cannot recover if the Medicaid recipient has a surviving spouse, a child under the age of 21 or a blind and/or disabled child of any age. If Medicaid is prevented from recovering because of a surviving spouse, blind or disabled child or a child under the age of 21, Medicaid may place a lien on the deceased recipient’s interest in real and/or personal property.

However, Medicaid must release the lien if the spouse, blind or disabled child or child under the age of 21 sells the property to a bona fide purchaser for fair market value. If the exempted individual chooses to refinance the property, Medicaid will subordinate its lien.

In addition, certain income, resources and property of American Indians and Alaska Natives are exempt from Medicaid estate recovery. Please reference the Medicaid Operations Manual at www.dhcfp.nv.gov for a detailed explanation of the property exempt from recovery for these groups.

The above language refers to benefits that are correctly paid to eligible Medicaid recipients. When benefits are paid to persons who are not otherwise eligible, those benefits are considered as incorrectly paid. Medicaid may recover incorrectly paid benefits immediately upon discovery and without the restrictions that apply to correctly paid benefits.

Medicaid recovery may be waived, compromised or delayed if it would cause undue hardship for the heirs. Heirs may submit a hardship waiver request at the time of Medicaid recovery. The denial of a hardship waiver or compromise may be appealed through the appropriate legal system. Medicaid will provide hardship waiver application information to the known heirs at the time of recovery.

Please share this form with all family members and potential heirs.

If you have questions or need additional clarification, please contact the Medicaid Estate Recovery Program at (775) 687-8416, email mer@nvha.nv.gov or visit its website at www.dhcfp.nv.gov under “Programs.”

¹Certain inpatients in nursing Facilities or institutions refers to individuals with respect to whom the State determines, after notice and opportunity for hearing, that the inpatient cannot reasonably be expected to be discharged from the medial institution and return home.