Joe Lombardo
Governor

Laura Rich
Director

DEPARTMENT OF HUMAN SERVICES
DIVISION OF SOCIAL SERVICES
Helping people. It's who we are and what we do.

Robert H. Thompson
Administrator

Medicaid Application for Justice Involved Individuals

This application can be used for Justice Involved Individuals to request a Medicaid determination of eligibility for one of the following programs:

Re-Entry Medicaid Coverage	Suspended Medicaid
Individuals must meet specific program requirements to be considered for this program. *Carceral facilities must attest to the individual meeting these requirements by submitting a completed DSS Form 2971, Justice Involved Medicaid Transition Request to DSS.*	*Individuals currently not on a Medicaid program may apply and have DSS evaluate them for a Medicaid or CHIP program.* *If determined eligible, the individual will have their eligibility suspended until their release from the carceral facility or their circumstances change, and they no longer qualify for Medicaid or CHIP.*

Applicant Information

First Name: Middle Name: Last Name: Suffix: Date of Birth:

Currently incarcerated? Yes No Expected release date: _____

Facility Name: Facility Address: City: State: Zip Code:

List the current Physical and Mailing address below.

Physical Address:	Apartment Number:	Mailing Address:	Apartment Number:
City: State:	Zip Code:	City: State:	Zip Code:

Daytime Phone #: Ext.: Secondary Phone #: Ext.:

Preferred language (if not English): Spanish Other: _____ Interpreter needed? Yes No

Currently, notifications are sent by mail. In the future, if available, would you like to receive information by:

Email: Yes No Email address:

Social Security Number:

DSS needs Social Security Numbers (SSNs) (if one has been assigned) for individuals applying for health insurance.

Please ensure the name is listed the same as it is displayed on your Social Security Card.

Social Security Number/Tax ID (**REQUIRED**):	Marital Status:	Pregnant? Yes No Due Date: _____ If yes, how many babies are expected: _____	**Sex:** Male Female
_____			

Are you legally blind or permanently disabled? Yes No

Do you plan to file a federal income tax return NEXT YEAR? Yes No

If **no**, are you being claimed as a dependent on someone else's federal income tax return? Yes No

If **yes**, name of tax filer: Relationship to You:

Are you a U.S. citizen? Yes No Have you lived in the U.S. since 1996? Yes No

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

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

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? Yes No

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

Did you receive health care through a state Medicaid program? Yes No

Age when you left the program? _____

Current Income Information ☐ Not employed

Are you currently receiving income? Yes No

If yes, what type: Gross amount: $

How often are you paid? Weekly Every 2 weeks Semi-Monthly Monthly Annually

Racial and Ethnicity Information

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

Race (optional) - check all that apply

White	Native Hawaiian	Asian Indian
African American or Black	American Indian or Alaska Native	Middle Eastern or North African
Other Pacific Islander	Other Asian	Other:_____

American Indians or Alaska Natives (AI/AN) Tribal members who enroll in Medicaid, Nevada Check Up and through the Nevada Health Link 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. We will ask additional questions to make sure you and your family get the most help possible. Tribal Affiliation Cards are required.

Are you an American Indian or Alaska Native? Yes No

If yes, what tribe?

Health Insurance Information

Do you currently have health insurance? Yes No

If yes, what type? Insurance Company Name:

Non-Discrimination

Following federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, 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: ocrmail@hhs.gov

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.)

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.

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.

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.

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 Human Services (DHS) Division and Managed Care Organization (MCO) to which you are assigned. Consent authorizes calls and/or texts from DHS, 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 healthcare needs and treatment, wellness services, plan benefits, eligibility, renewal and/or redetermination, and for any other communication relating to your relationship with DHS or the MCO concerning 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 _____

I do not consent to receive text messaging as described above. Initials:_____

AMERICAN INDIAN OR ALASKAN NATIVE:

Tribal members who enroll in Medicaid, Nevada Check Up and through the Nevada Health Link 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. We will ask additional questions to make sure you and your family get the most help possible. Tribal Affiliation Cards are required.

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	Available Region	Contact Phone	Website *(Visit for more information)*
Anthem Blue Cross and Blue Shield Healthcare Solutions	Urban Clark Urban Washoe	1-844-396-2329	mss.anthem.com/nevada-medicaid/home.htm
CareSource	Rurals Urban Clark Urban Washoe	1-833-230-2058	caresource.com/nv/plans/medicaid/
Health Plan of Nevada	Urban Clark	1-800-962-8074	myHPNmedicaid.com/Member
Molina Healthcare	Urban Clark Urban Washoe	1-833-685-2109	meetmolina.com/nv-medicaid
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://dhcfp.nv.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	TTY	Carson City	Reno	Las Vegas	Elko
(800) 992-0900	(800) 326-6888	(775) 684-3651	(775) 687-1900	(702) 668-4200	(775) 753-1191

Your Rights

If you think we made a mistake or have not acted timely on your application, you can appeal. This 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.

Your Responsibilities

I know that I must tell the program I'll be enrolled in if 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.

of 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.

- 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.

Signature or Mark of Applicant:	Date:	**Signature or Witness*:** (Use if applicant cannot read, write, is blind.) **The information in this application has been read to the applicant and I have witnessed their signature or mark.*	Date:

Submit This Application by:

Email to justicemed@dss.nv.gov, or; Fax to 702-631-3387	**Did you remember to:** ✓ Sign this application?

Disclaimer:

Upon release from the public institution, you must provide the address of where you intend to reside. All important documents, such as eligibility determinations, Medicaid card, etc., will be mailed to the last address you provided

Designation of Authorized Representative

Applicants may designate an individual or facility to act responsibly on their behalf. This includes assisting with the individual's application for assistance, renewals of eligibility and other ongoing communications with the agency. This designation must include the applicant's signature. For a valid designation, the designated authorized representative must also agree in writing to act responsibly on behalf of the applicant/recipient.
The rights and obligations of an authorized representative are the same as if they were the applicant/recipient to the extent of the applicant/recipient's financial ability to pay.

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

Name of Authorized Representative:	Phone Number:

Mailing Address: *(Required)* City: State: ZIP Code:

By signing, you agree to allow this person to act and speak on your behalf with all DSS matters regarding your Medicaid eligibility. This individual will receive copies of all official notifications about your case with DSS. NOTE: This authorization is only valid for the current Medicaid eligibility period unless you inform DSS to terminate the authorization sooner.

Your Signature: Date:

If you wish to designate a facility as your Authorized Representative, the section below must be completed and signed by the applicant and facility staff member:

I, _____, request the following person/agency:
(PRINT NAME OF APPLICANT/ RECIPIENT) (CECK ONE)

_____ to be my:
(PRINT NAME OF PERSON OR AGENCY)

Primary representative (Receives all requests for information along with any attachments plus all notices. They hold the same responsibility as the customer in securing information for determining eligibility, reporting responsibilities and they are the only one authorized to sign on behalf of the customer. Primary representatives have the same access to case information as a customer.)

Secondary representative (Receives the same requests for information and notices as the customer but are not responsible for securing or reporting information; however, if they choose to, they may secure and report the requested information to the DSS. A secondary representative has the same access to case information as a customer, but cannot sign on behalf of the customer.)

I understand I may terminate this designation in writing at any time and that the authorization for the facility to act as an authorized representative ceases upon release from the public institution.

SIGNATURE OF APPLICANT DATE OF BIRTH DATE

STATEMENT OF DESIGNATED FACILITY REPRESENTATIVE

I believe the above-named applicant/recipient understands the nature and consequences of his/her acts and is able to exercise his/her own will. I certify the above-named applicant/recipient made the decision to designate me as his/her representative under no threat or duress of any kind.

As primary representative, I agree to act responsibly on behalf of the above-named applicant/recipient by providing all necessary information to determine eligibility for assistance. I understand my rights and obligations are the same as if I were the applicant/recipient to the extent of the applicant/recipient's financial ability to pay.

As secondary representative, I understand I will receive all notifications regarding the above-named applicant/recipient's initial and ongoing eligibility and may provide any information to assist in the eligibility process. **I understand I have no authority to sign on behalf of the above-named applicant/recipient.**

I certify under penalty of perjury; the information I provide is correct and complete to the best of my knowledge.

SIGNATURE OF REPRESENTATIVE (PRINT NAME) POSITION/RELATIONSHIP DATE

ADDRESS TELEPHONE NUMBER

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 institutions[1] 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."

[1]Certain 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.

STATE OF NEVADA VOTER REGISTRATION APPLICATION

Application No.

USE BLACK OR BLUE INK ONLY – PLEASE PRINT CLEARLY

WARNING: GIVING FALSE INFORMATION IS A FELONY AND INCLUDES A CIVIL PENALTY OF UP TO $20,000.

All fields are required unless marked Optional. If you do not provide all of the required information, your application to register to vote will not be complete.

1. Are you a citizen of the United States? Yes No

If you checked "No" to the above question, do not complete this form.

Will you be at least 18 years of age on or before election day? Yes No

If you checked "No" to the above question but are at least 17 years of age, do you wish to preregister to vote? Yes No

If you checked "No" to both of the prior questions, do not complete this form.

2. Last Name | First Name | Middle Name | Suffix

3. Nevada Residential Address – See Instructions on Back (No P.O. Box/Business Address) | Apt. # | City | State (NV) | Zip Code

4. Mailing Address – If Different From Above (P.O. Box or Mail Service Address Acceptable) | Apt. # | City | State | Zip Code

5. Birth Date (MM/DD/YYYY)

6. Place of Birth (State or Country)

7. Telephone Number (Optional)

8.

☐ I have a valid NV Driver's License or ID Card and that number is: ___ ___ ___ ___ ___ ___ ___ ___ ___

☐ I have not been issued a NV Driver's License or ID Card. The last 4 digits of my Social Security Number are: XXX – XX - ___ ___ ___ ___

☐ I have not been issued a NV Driver's License or ID Card, and I do not have a Social Security Number. If you select this option, you will be contacted by your County Election Department for more information once your application is received.

Note: ID numbers provided above are confidential and not available for public inspection.

9. If applicable, check one of the following:

☐ Military Domestic (or military spouse or dependent) – Only check if you are on active duty and will be absent from your place of registration

☐ Military Overseas (or military spouse or dependent)

☐ U.S. Citizen Overseas

10. Email Address (Optional) – Email Address is Confidential

11. ☐ **CHECK THIS BOX TO RECEIVE A SAMPLE BALLOT IN LARGER TYPE**

12. Party Registration – Check Only One Box

☐ Democratic Party

☐ Independent American Party

☐ Libertarian Party of Nevada

☐ Nonpartisan (No Political Party)

☐ Republican Party

☐ Other Party – Write in below

_____

13. I swear or affirm I am a U.S. citizen. I will be at least 18 years old by the date of the next election, or if I indicated in Box 1 above that I am preregistering to vote, I am at least 17 years old. I will have continuously resided in Nevada at least 30 days in my county and at least 10 days in my precinct before the next election at which I intend to vote. The residential address listed herein is my sole legal place of residence, and I claim no other place as my legal residence. If I am preregistering to vote, I understand and acknowledge that I will be deemed to have registered to vote as of the date of my 18th birthday unless my preregistration is canceled by any of the means or for any of the reasons for canceling voter registration pursuant to Chapter 293 of the *Nevada Revised Statutes*. I am not currently serving a term of imprisonment for a felony conviction. I declare under penalty of perjury that the foregoing is true and correct.

SIGNATURE OF APPLICANT (REQUIRED)

____/____/____
(MM / DD / YYYY)

14. Your name and residential address where you were last registered to vote (Name Used, Address, State, etc.)

15. Important! If you are assisting a person to register to vote and you are not a Field Registrar appointed by a County Clerk / Registrar of Voters or an employee of a voter registration agency, you MUST complete the following. Your signature is required. Failure to do so may be a felony.

Full Name | Mailing Address | City/State/Zip Code | Signature

OFFICIAL USE ONLY. DO NOT WRITE IN THE SHADED AREA BELOW.

DATE STAMP	☐ AGENCY ☐ FIELD REGISTRAR ☐ MAIL ☐ IN PERSON ☐ OTHER	CANCELLED INACTIVE PRECINCT	**APPLICATION NO.** RECEIVED BY:

✂ Detach Here ✂ ✂ Detach Here ✂ ✂ Detach Here ✂

NAME OF PERSON RETAINING THIS APPLICATION
(Agency Stamp or Name of Agent, Election Official or Person Retaining Application)

ELECTION OFFICIAL OR AGENCY
(Contact Information, Address, Telephone, Fax)

VOTER APPLICATION RECEIPT
(Please Retain Receipt)

Your voter registration information has been transmitted to your County Election Office for processing. Within 10 days after receiving your information, your County Election Office will mail your Nevada Voter Registration Card or a notice that additional information is required to complete your registration.

APPLICATION NO.

INSTRUCTIONS

Box 1 – PREREGISTRATION: Every citizen of the United States who is 17 years of age or older but less than 18 years of age and has continuously resided in this state for 30 days or longer may preregister to vote by any of the means available for a person to register to vote pursuant to Nevada law. If a person preregisters to vote, he or she shall be deemed to be a registered voter on his or her 18th birthday unless the person's preregistration has been cancelled or he or she does not satisfy the voter eligibility requirements.

Box 2 – NAME: Required. Please write your name exactly as it appears on your Nevada Driver's License, ID Card, or Social Security Card.

Box 3 – ADDRESS WHERE YOU LIVE: Required. Your home address is the street address assigned to the location at which you actually reside. If you reside at a location that has not been assigned a street address, a description of the location at which you actually reside must be provided. A P.O. Box or business address cannot be listed as a home address.

Box 4 – ADDRESS WHERE YOU RECEIVE MAIL: Optional. Include your mailing address if it is different than your physical address. Include P.O. Boxes and Mail Service Addresses, if applicable.

Box 8 – IDENTIFICATION: Required. Include your Nevada Driver's License or Nevada Identification Card number. If you do not have a driver's license or identification card issued by a Nevada DMV, include the last four digits of your Social Security Number. If you do not have a Nevada Driver's License or Social Security Number, you will be contacted by your County Election Department for more information once your application is received.

Box 9 – MILITARY: Required, if applicable. Mark the applicable box.

Box 12 – POLITICAL PARTY AFFILIATION: Required. Mark your choice of a qualified political party, "Nonpartisan" or "Other." If you mark "Other," you may print the name of an unlisted political party. If you register with a minor political party or as a nonpartisan, you will receive a nonpartisan ballot for the Primary Election.

Box 13 – DECLARATION: Required. Sign and date. Voting Rights are immediately restored for all felony convictions upon release from prison.

Box 14 – UPDATING INFORMATION: Optional. You may include the last address where you were registered to vote. This helps the County Clerk/Registrar of Voters identify you as the applicant.

Box 15 – ASSISTANCE: Required, if applicable. If you are assisting a person to preregister or register to vote, you must complete Box 15. *FAILURE TO DO SO MAY BE A FELONY.*

DEADLINES FOR SUBMITTING APPLICATION:

- By Mail – Postmarked by the fourth Tuesday preceding the primary or general election.
- In-Person at your local County Clerk's or Registrar of Voters Office – By the fourth Tuesday preceding the primary or general election.
- Online – By the Thursday preceding the primary or general election. Online Registration available at: www.RegisterToVoteNV.gov
- For Special / Recall Elections – Contact your County Clerk or Registrar of Voters.

SAME-DAY VOTER REGISTRATION: Eligible Nevada voters can register to vote or update existing voter registration information in person at the polling place either during early voting or on Election Day.

INTERESTED IN BEING A POLL WORKER? Please contact your local County Clerk or Registrar of Voters Office.

NOTICE: You are urged to return your application to the County Clerk or Registrar of Voters in person or by mail. If you choose to give your completed application to another person to return to the County Clerk or Registrar of Voters on your behalf, and the person fails to deliver the application to the County Clerk or Registrar of Voters, you will not be preregistered or registered to vote, as applicable. Please retain the duplicate copy or receipt from your application to preregister or register to vote.

COUNTY	ELECTION DEPARTMENT ADDRESS	COUNTY	ELECTION DEPARTMENT ADDRESS
Carson City Clerk (775) 887-2087	885 East Musser Street, Suite 1025, Carson City, NV 89701	**Lincoln Clerk** (775) 962-8077	181 North Main Street, Suite 201, Pioche, NV 89043 P.O. Box 90, Pioche, NV 89043
Churchill Clerk (775) 423-6028	155 North Taylor Street, Suite 110, Fallon, NV 89406	**Lyon Clerk** (775) 463-6501	27 South Main Street, Yerington, NV 89447
Clark Registrar (702) 455-8683	965 Trade Drive, Suite A, North Las Vegas, NV 89030 P.O. Box 3909, Las Vegas, NV 89127	**Mineral Clerk** (775) 945-2446	105 South A Street, Suite 1, Hawthorne, NV 89415 P.O. Box 1450, Hawthorne, NV 89415
Douglas Clerk (775) 782-9014	1616 8th Street, 2nd Floor, Minden, NV 89423 P.O. Box 218, Minden, NV 89423	**Nye Clerk** (775) 482-8127	101 Radar Road, Tonopah, NV 89049 P.O. Box 1031, Tonopah, NV 89049
Elko Clerk (775) 753-4600	550 Court Street, 3rd Floor, Elko, NV 89801	**Pershing Clerk** (775) 273-2208	398 Main Street, Lovelock, NV 89419 P.O. Box 820, Lovelock, NV 89419
Esmeralda Clerk (775) 485-6309	233 Crook Avenue, Goldfield, NV 89013 P.O. Box 547, Goldfield, NV 89013	**Storey Clerk** (775) 847-0969	26 South B Street, Drawer D, Virginia City, NV 89440
Eureka Clerk (775) 237-5263	10 South Main Street, Eureka, NV 89316 P.O. Box 540, Eureka, NV 89316	**Washoe Registrar** (775) 328-3670	1001 E. 9th St., Reno, NV, 89512
Humboldt Clerk (775) 623-6343	50 West 5th Street, #207, Winnemucca, NV 89445	**White Pine Clerk** (775) 293-6509	1786 Great Basin, Blvd., Suite 3, Ely, NV 89301
Lander Clerk (775) 635-5738	50 State Route 305, Battle Mountain, NV 89820		

OFFICIAL ELECTION MAIL
Authorized by the U.S. Postal Service

FIRST CLASS
STAMP
NECESSARY
FOR MAILING