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.

Apply Online

Access your benefits faster.

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: dwss.nv.gov

Personal Assistance

Get assistance with your application.

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 dwss.nv.gov

By Mail

Fill out the attached paper application.

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

• Follow the instructions and complete ALL areas that apply to you and your family.
• Submit your application to the local Welfare Office or mail to: DWSS
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:**

If you don't have a permanent address, you still need to give a valid mailing address.

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: ☐ Yes ☐ No Email address: _____

Preferred language (if not English): ☐ Spanish ☐ Other: _____ Interpreter needed? ☐ Yes ☐ 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.

Head of Household Information

First Name, MI, Last Name & Suffix	Marital Status	If married, do you live with your spouse? ☐ Yes ☐ No	Relationship to you? **SELF**

Social Security Number (**OPTIONAL**)	Date of Birth	Pregnant? ☐ Yes ☐ No Due Date: _____ If yes, how many babies are expected: _____	**Sex** ☐ Male ☐ Female
_____-_____-_____	___/___/_____		

Do you 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: You can still apply for health insurance even if you don't file a federal tax return.

1. Do you expect to file a joint return with a spouse/partner? ☐ Yes ☐ No
   If yes, name of spouse/partner: _____
2. Will you claim any dependents on your tax return? ☐ Yes ☐ No
   If yes, list name(s) of dependents: _____
3. Are you 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 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)?

☐ Yes **If yes**, answer all the questions below. ☐ 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? ☐ Yes ☐ No
_____-_____-_____	

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

Are you a full-time student? ☐ Yes ☐ No

Are you an American Indian or Alaska Native? ☐ Yes ☐ No

If yes, what tribe? _____

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

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

Are you the parent or primary caretaker relative of any child(ren), under the age of 19, in the household?

☐ Yes ☐ No **If yes**, who? _____

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

If yes, what months? _____

Head of Household Information continued:

Are you legally blind or permanently disabled? ☐ Yes ☐ No

Are you receiving Supplemental Security Income (SSI)? ☐ Yes ☐ No

Do 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.

				Tribal Income?
☐	None			
☐	Unemployment	$	How often?	
☐	Retirement	$	How often?	
☐	Pensions	$	How often?	
☐	Social Security (RSDI) Benefits	$	How often?	
☐	Interest/Dividends	$	How often?	☐ Yes ☐ No
☐	Annuities	$	How often?	☐ Yes ☐ No
☐	Rental or Royalty Income	$	How often?	☐ Yes ☐ No
☐	Capital Gains	$	How often?	☐ Yes ☐ No
☐	Farming or Fishing Income	$	How often?	☐ Yes ☐ No
☐	Alimony	$	How often?	
☐	Scholarships & Grants	$	How often?	☐ Yes ☐ No
☐	Cash Advances	$	How often?	
☐	Gambling Winnings	$	How often?	
☐	Other	$	How often?	☐ Yes ☐ No

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.

☐	Educator expenses	$	How often?	
☐	Health savings	$	How often?	
☐	Moving expenses	$	How often?	
☐	Alimony	$	How often?	
☐	IRA deductions	$	How often?	
☐	Business expenses of reservists,	$	How often?	
☐	Penalty paid on early withdrawal of savings	$	How often?	
☐	Student loan interest	$	How often?	
☐	Tuition and fees	$	How often?	
☐	Domestic production	$	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 $

RACE / ETHNICITY

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

If Hispanic/Latino (check all that apply - optional):

☐ Mexican ☐ Mexican American ☐ Puerto Rican ☐ Cuban ☐ Chicano/a ☐ Other

Race (optional) - check all that apply

☐	White	☐	Native Hawaiian	☐	Asian Indian	☐	Korean
☐	African American or Black	☐	Guamanian or Chamorro	☐	Chinese	☐	Other Asian
☐	American Indian or Alaska Native	☐	Samoan	☐	Filipino	☐	Vietnamese
☐	Middle Eastern or North African	☐	Other Pacific Islander	☐	Japanese	☐	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? ☐ Yes ☐ No	Relationship to you?

Social Security Number (**OPTIONAL**)	Date of Birth	Pregnant? ☐ Yes ☐ No Due Date: _____ If yes, how many babies are expected: _____	**Se** ☐ Male ☐ 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.

1. Do they expect to file a joint return with a spouse/partner? ☐ Yes ☐ No
   If yes, name of spouse/partner: _____
2. Will they claim any dependents on their tax return? ☐ Yes ☐ No
   If yes, list name(s) of dependents: _____
3. 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? ☐ Yes ☐ No
_____-_____-_____	

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~~n~~ 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
Employer Address:	Employer Phone Number: ( )
City: State:	Zip Code:
Gross wages/tips per pay period: $	How often are they 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 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?
☐	None			
☐	Unemployment	$ _____	How often? _____	
☐	Retirement	$ _____	How often? _____	
☐	Pensions	$ _____	How often? _____	
☐	Social Security (RSDI) Benefits	$ _____	How often? _____	
☐	Interest/Dividends	$ _____	How often? _____	☐ Yes ☐ No
☐	Annuities	$ _____	How often? _____	☐ Yes ☐ No
☐	Rental or Royalty Income	$ _____	How often? _____	☐ Yes ☐ No
☐	Capital Gains	$ _____	How often? _____	☐ Yes ☐ No
☐	Farming or Fishing Income	$ _____	How often? _____	☐ Yes ☐ No
☐	Alimony	$ _____	How often? _____	
☐	Scholarships & Grants	$ _____	How often? _____	☐ Yes ☐ No
☐	Cash Advances	$ _____	How often? _____	
☐	Gambling Winnings	$ _____	How often? _____	
☐	Other	$	How often?	☐ Yes ☐ 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.

☐	Educator expenses	$	How often?	
☐	Health savings account	$	How often?	
☐	Moving expenses	$	How often?	
☐	Alimony	$	How often?	
☐	IRA deductions	$	How often?	
☐	Business expenses of reservists, performing artists, and fee-basis government officials	$	How often?	
☐	Penalty paid on early withdrawal of savings	$	How often?	
☐	Student loan interest	$	How often?	
☐	Tuition and fees	$	How often?	
☐	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

If Hispanic/Latino (check all that apply - optional):

☐ Mexican ☐ Mexican American ☐ Puerto Rican ☐ Cuban ☐ Chicano/a ☐ Other

Race (optional) - check all that apply

☐ White	☐ Native Hawaiian	☐ Asian Indian	☐ Korean
☐ African American or Black	☐ Guamanian or Chamorro	☐ Chinese	☐ Other Asian
☐ American Indian or Alaska Native	☐ Samoan	☐ Filipino	☐ Vietnamese
☐ Middle Eastern or North African	☐ Other Pacific Islander	☐ Japanese	☐ 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:____/___/______

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 DHHS notice of any settlements or legal action.

Initial

Referral Information:

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

☐ Covering Kids & Families	☐ School	☐ Tribal Resources
☐ WIC	☐ Clinic	☐ Friend / Family
☐ 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

(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, Carson City, Nevada 89701.

Reviews and Investigations

By signing this application, you are authorizing the Department of Health and 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 DWSS 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

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 (5^{th}) of the following month. I understand that a change in my information could affect my eligibility for member(s) of my household.

Initial

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 Welfare and Supportive Services and the Department of Health and 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

Families who live in urban Washoe County or urban Clark County 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?	Contact Phone	Website *(Visit for more information)*
☐ **Anthem Blue Cross and Blue Shield Healthcare Solutions**	1-844-396-2329	mss.anthem.com/nevada-medicaid/home.html
☐ **Molina Healthcare**	1-844-327-7136	meetmolina.com/nv-medicaid
☐ **SilverSummit Healthplan**	1-844-366-2880	silversummithealthplan.com
☐ **UnitedHealthcare Health Plan of Nevada Medicaid**	1-800-962-8074	myHPNmedicaid.com/Member

☐ **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

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 Welfare Office or, mail your application to:
DWSS
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 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 HMS at (800) 293-3973 or (303) 837-8293, email nvestaterecovery@gainwelltechnologies.com or visit the Medicaid Estate Recovery 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 medical institution and return home.