JOE LOMBARDO
Governor

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF WELFARE AND SUPPORTIVE SERVICES

RICHARD WHITLEY, MS
Director

ROBERT THOMPSON
Administrator

☐ MEDICAID

Date: _____
Case Name: _____
Case ID: _____

PARENTAL REIMBURSEMENT QUESTIONNAIRE

OVERVIEW

The Nevada State Division of Welfare and Supportive Services requires parental financial responsibility for services provided to disabled children. The Division is seeking a monthly reimbursement of Medicaid costs from parents who meet certain financial thresholds. Consideration is given to family size and annual income. Credit is given when the child is cared for at home and for private comprehensive health insurance premium payments. There is a family deduction amount and a deduction for paid child support.

This form must be completed by the parents of undefined undefined, a disabled child receiving Medicaid services through the Division as a resident in a medical facility or as a recipient of home care services. The information is used to determine how much, if anything, the parents of this child are required to pay.

The completed form should be returned to the address above. Questions may be addressed to undefined at (702) 486-1646; (775) 684-7200; (800) 992-0900 ext 47200. Failure to return this form within fifteen days from the date it was mailed to you may result in your being assessed $1,900 per month.

Remember, you are certifying to the correctness of your answers. The Division verifies the answers you provide on this form. If you make a false or misleading statement, misrepresent, conceal or withhold facts to avoid financial responsibility for your child's Medicaid expenses, you will be assessed $1,900 per month.

HOUSEHOLD INFORMATION

1. Home Address:

(Number & Street) (Apt.)

(City) (State) (Zip)

Mailing Address: (***If different from the Home Address, if you have a box number, or if you live in a rural area or area difficult to find, give directions.)***

(Number & Street) (Apt.)

(City) (State) (Zip)

(Home Telephone No.) (Cell Telephone No.) (Work Telephone No.)

2. List all persons living in your home; include yourself, your spouse and all children.

LEGAL NAME FIRST	MI	LAST	RELATIONSHIP TO DISABLED CHILD	SOCIAL SECURITY NO.	DATE OF BIRTH

INCOME

3. You must provide proof of income by submitting copies of last year's income tax return, including all attachments. *(If your current source of income is different from last year, submit proof of current income.)*

RECEIVED BY	NAME AND ADDRESS OF EMPLOYER, COMPANY OR TRAINING FACILITY	DATE WORK BEGAN OR WILL BEGIN	DATES PAY IS RECEIVED OR EXPECTED TO BE RECEIVED	HOURLY PAY RATE	HOURS PER PAY-CHECK	PAY FREQUENCY (WK/BI-WK/ MO/SEMI-MO)	GROSS PAY (BEFORE DEDUCTIONS)PER PAY-CHECK (WK/BI-WK/ SEMI-MO)	TIPS
				$			$	$
				$			$	$
				$			$	$

OTHER MONEY INFORMATION

4. You must provide proof of income. *(If you are self-employed, you must provide copies of your last two (2) Income Tax returns, with all attachments.)*

		RECEIVING? NO	YES	RECEIVED BY WHOM?	CLAIM NUMBER (IF YOU HAVE ONE)	AMOUNT (WK/ MO/SEMI-MO)	
1)	SUPPLEMENTAL SECURITY INCOME (SSI)	☐	☐			$	per
2)	SOCIAL SECURITY INCOME	☐	☐			$	per
3)	VETERAN BENEFITS	☐	☐			$	per
4)	RETIREMENT PENSIONS (CIVIL SERVICE, RAILROAD, MILITARY, PUBLIC EMPLOYEE-INCLUDE PRIVATE OR UNION ETC.) SOURCE:	☐	☐			$	per
5)	DISABILITY PAYMENTS FROM ANY SOURCE (SIIS, REHAB OR OTHER) SOURCE:	☐	☐			$	per
6)	UNEMPLOYMENT BENEFITS	☐	☐			$	per
7)	BOARDERS/ROOMERS	☐	☐			$	per
8)	INDIAN GENERAL ASSISTANCE	☐	☐			$	per
9)	MILITARY ALLOTMENT	☐	☐			$	per
10)	UNION ANNUITIES	☐	☐			$	per
11)	INTEREST OR PAYMENTS (STOCKS, BONDS, TRUSTS, OIL LEASES, ETC.) SOURCE:	☐	☐			$	per
12)	MONEY FROM PROPERTY RENTALS, LEASES, MORTGAGES	☐	☐			$	per
13)	MONEY FROM RELATIVES OR OTHERS NAME:	☐	☐			$	per
14)	STRIKE BENEFITS	☐	☐			$	per
15)	MONEY RECEIVED FOR EDUCATION (BEOG/PELL, SEOG, NDSL, USAF, NSIG, VA, STUDENT LOAN, ETC.) SOURCE: PERIOD COVERED: FROM: TO:	☐	☐			$	per
16)	INCOME GRANTS OR ASSISTANCE (COUNTY WELFARE, TANF OR FOSTER CARE, ETC.)	☐	☐			$	per
17)	ALIMONY PAID DIRECTLY TO YOU RECEIVED FROM:	☐	☐			$	per
18)	ANY OTHER INCOME NOT STATED ABOVE TYPE:	☐	☐			$	per

CHILD SUPPORT OBLIGATIONS

5. Complete each item below for child support payments made last year using last year's income. *(If your current child support obligation is different from last year, submit proof.)*

CUSTODIAL PARENT NAME	CHILDREN'S NAME(s)	DISTRICT ATTORNEY CASE#	CUSTODIAL PARENT SOCIAL SECURITY NO.	ANNUAL AMOUNT PAID
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$

MEDICAL INSURANCE

6. My disabled child has hospital/medical/dental/school and/or accident insurance *(Include group insurance programs through your past or present employer or union and policies held by an absent parent or stepparent).*

☐ YES ☐ NO

Premium Amount $ _____ ☐ Monthly ☐ Quarterly

Policy No. _____ Group Policy No. _____

Name of Insurance Company _____

Insurance Company Address _____

Policy Holder _____ Social Security No. _____

Coverage Effective Date _____

List other individuals covered under this policy.

_____

_____

7. I am or my spouse is a Veteran ☐ YES ☐ NO

Branch of Service	VA Claim No.	VA Serial No.

8. Are any medical costs paid by another agency (SIIS or other)? ☐ YES ☐ NO

If YES, by whom? _____

OTHER PARENT

9. Is there an absent, deceased or disabled parent of the disabled child?

NAME	SOCIAL SECURITY NO.	DATE OF BIRTH	ABSENT	DISABLED	DECEASED
			☐	☐	☐
			☐	☐	☐

I/we certify that I/we gave complete and accurate information and I/we acknowledge willful concealment of income and household information could result in criminal prosecution.

I/we acknowledge if false or misleading statements are made, misrepresentation, concealment or facts are withheld to avoid financial responsibility, I/we will be assessed a monthly reimbursement of $1,900.

(*All parents living in the household must sign*.)

Client Signature	Print Name	Date	Telephone Number
		/ /	

Client Signature	Print Name	Date	Telephone Number
		/ /	