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

Medical Assistance Addendum

Complete this addendum if requesting to add medical assistance to your current SNAP/TANF application.

CASE INFORMATION:

First Name:	Middle Name:	Last Name:	Suffix	Case Number

Who needs to be included on this addendum:

- 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 medical assistance)
- 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.**

Do you or anyone in your household plan to file a federal income tax return NEXT YEAR?

☐ Yes **If yes**, who? _____ **and** answer questions 1-3

☐ No **If no**, skip to question 3

1. Filing Status
   Check only one box.
   ☐ Single
   ☐ Married filing jointly
   ☐ Married filing separately

   Name of spouse/partner:

2. Dependents

First Name Last Name	Relationship	Resides in Household
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

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?

Please list all members requesting medical assistance:

Is anyone currently pregnant? ☐ Yes ☐ No **If yes**, who?	If pregnant, how many babies are expected:
If under age 26, has anyone ever been in foster care? ☐ Yes ☐ No **If yes**, who? Age when they left the program?	What state? Did they receive health care through a state Medicaid program? ☐ Yes ☐ No
Does anyone need help with activities of daily living through personal assistance services or a medical facility? ☐ Yes ☐ No **If yes**, who?	
Does anyone have medical bills for the past three months that you need help with? ☐ Yes ☐ No **If yes**, who?	What months?

DEDUCTIONS *(Only list deductions reported on 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.

☐	Alimony	$	How often?
☐	Student loan interest	$	How often?
☐	Other deductions Type:	$	How often?

HEALTH INSURANCE INFORMATION:

Does anyone have health insurance, such as TRICARE, federal or state employee plans, Peace Corps., Veterans, Medicaid/Nevada Check-Up, Medicare, COBRA, Private, or other Retiree Health Plan? ☐ Yes ☐ No

Does anyone have health insurance available through their employer? ☐ 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:			
Name:			
Name:			

REFERRAL INFORMATION:

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

☐	Covering Kids & Families	☐	School
☐	Tribal Resources	☐	WIC
☐	Doctor/Hospital/Clinic	☐	Other
☐	Friend/Family	☐	None

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:

NOTE: If you do not choose a health plan preference, one will be assigned to you.

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 indicate a health plan preference on your addendum, one will be assigned to you. Your choice of health plan does not guarantee acceptance into the Nevada Medicaid or Nevada Check Up programs. We might not honor your choice of plans if you or any family members have been enrolled in one of our current managed care organizations. Once enrolled, families will receive a member handbook explaining their health plan benefits. You can contact the numbers below for specific information regarding the health plans.

Please choose one of the following health plans:

☐ **Molina Healthcare** Meetmolina.com/nv-medicaid	1-833-685-2109	☐ **Silver Summit Healthplan:** silversummithealthplan.com	1-844-366-2880
☐ **Anthem Blue Cross and Blue Shield Healthcare Solutions:** mss.anthem.com/nevada-medicaid/home.html	1-844-396-2329	☐ **Health Plan of Nevada:** myHPNmedicaid.com	1-800-962-8074

For families living in the fee-for-service benefit area, services may be obtained from any Nevada Medicaid provider. If you need assistance in locating a provider, please call your local Medicaid district office:

Carson City	Reno	Las Vegas	Elko
(775) 684-3651	(775) 687-1900	(702) 668-4200	(775) 753-1191

Read and initial each statement below if anyone is applying for Health Coverage.	
	If I am determined eligible for Medicaid, the health plan I will be enrolled in depends on my individual needs and availability.
	My signature or the signature of my authorized representative as indicated on ***Appendix B***, authorizes state offices to communicate with insurance companies related to me or my child(ren)'s medical assistance. If anyone on this application receives Health Coverage Assistance benefits, I give the Medicaid agency the right to pursue and get money from any other health insurance, insurance, legal settlements, or other third party that may be liable for the medical services paid by Medicaid; and I give the Medicaid agency the right to pursue and get child and medical support from a spouse or a parent; and 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.
	If I receive Medicaid after age 55, my estate may be subject to recovery of medical expenses paid on my behalf, and that any transfer of assets may be set aside by a court if I do not receive adequate value. (*Refer to **Appendix C**).*
	I have the right to choose a primary care physician (PCP) to request referrals for services, and to change my PCP if my circumstances change.
	Nevada law mandates that "a person who is a recipient of Medicaid or insurance pursuant to the Children's Health Insurance Program may not opt out of having his or her individually identifiable health information disclosed electronically" (NRS 439.538). When a patient is no longer a Medicaid recipient, it is the patient's responsibility to change their consent choice. At any time, you may revoke your consent by signing a new consent form and giving it to your doctor. These forms are available at your doctor's office.
	I consent to the gathering and use of income data, including information from the Internal Revenue Service (IRS), for determining eligibility for help paying for health coverage in future years (up to 5 years). I will receive notice when this occurs, be able to make changes, and may opt out at any time. I have the right to revoke this consent, in writing, at any time except to the extent the Department has already used and disclosed my information in reliance on this consent. If I revoke this consent, I will not be eligible for APTC.
	If I am determined eligible to receive a tax credit (also known as APTC) and use these funds towards the purchase of a Qualified Health Plan (QHP), any discrepancies between my reported income, which was used to determine eligibility, and the amount of the tax credit, will be reconciled with the final income reported on my taxes at the end of the calendar year. The IRS will be responsible for conducting this reconciliation, and any discrepancies may result in an adjustment of the tax credit, including entitlement to additional credits or re-payment of credits received by me.
Read and initial each statement below if anyone is applying for any type of assistance.	
	My signature certifies that the information on this application is true and accurate. I could be sanctioned and required to return any benefit I receive if my information is not true. Sanctions may include administrative, civil, or criminal actions against me, including prosecution. Health Coverage benefits and all costs associated with administering the program, including capitation fees paid to managed care organizations on my behalf are part of this repayment.
	I consent to the gathering, use, and disclosure of my information, including my SSN, by the Nevada Department of Health and Human Services, Division of Welfare and Supportive Services (DWSS) or its designees. I understand the information is needed for the purpose of providing benefits or services, obtaining payment for my benefits or services, and for normal business operations of the Department. I have the right to revoke this consent, in writing, at any time, except to the extent the DWSS has already used and disclosed my information. If I revoke this consent, the DWSS will not provide further benefits or services.
	I am required to report all changes in my household circumstances, including the people who live with me, birth of a new child, school attendance, or changes in living expenses, marital status and resources which may affect my household benefits. Unreported information may affect my eligibility determination. **If I do not report or verify any of the expenses listed on this application, it will be considered that I do not want to receive a deduction for the unreported or unverified expense.** The DWSS will inform me of specific program reporting requirements in a notice of decision.
	I am required to report when my household's monthly income exceeds the gross limit for my household size.
	Information available through the Instant Eligibility Verification System (IEVS), and other online sources, is used and may be verified through a third-party contact when differences are discovered between the system and what you report. This information may affect your eligibility and level of benefits.
	I understand that all adult household members may be responsible for repaying benefits if the household received benefits, it was not entitled to receive. This applies to an over-issuance of benefits as a result of an agency error, an inadvertent household error, and intentional program violations. If a there is an overpayment of benefits to my household, the information on this application, including all adult SSNs, may be referred to federal and state agencies, as well as private claims collection agencies for collection action.

	This information may be disclosed to other federal and state agencies for official examination, and to law enforcement officials, for apprehending persons fleeing to avoid the law.
	I may be required to cooperate with federal or state reviewers who are making sure my benefits are correct. I may not be eligible to receive benefits if I do not cooperate. Making false or misleading statements, misrepresenting, concealing, or withholding facts used to determine my eligibility may also result in future program disqualification and criminal prosecution per state and federal laws.
	As part of my application, I understand that the DWSS will open a Child Support case and I must cooperate with Child Support Enforcement (CSE). Good cause for not cooperating in pursuing child support or paternity may be allowed if you think that cooperating to collect support will harm you or your children. If you do not cooperate with CSE and good cause was not established, your household will be ineligible for TANF, and Medicaid eligibility could be affected *(refer to **Appendix D**).*
	My signature indicates I have read and/or received a copy of the DWSS Privacy Policy *(refer to **Appendix E**)*.
	I will be notified of the right to appeal/request a hearing on the DWSS decisions, and I can contact the DWSS for information on the process. A request must be submitted within 90 days of the date of the notice of decision. **An appeal/hearing may be requested in person, in writing, or by phone.** I can have someone act on my behalf, but written permission must be provided to the DWSS before the appeal/hearing. If I disagree with the appeal/hearing decision, I can appeal my case to the local District Court of the State of Nevada.

Acknowledgement, Signature, and Release of Information by applicant:

I understand the questions on this application and the penalty for hiding or giving false information. I agree to notify the Division of Welfare and Supportive Services of any changes in my household circumstances that may affect my benefits. I understand failure to report changes may cause an overpayment that I will be responsible to pay back, and for which I could be prosecuted in a court of law.
I understand if I fail to initial pages 4-5 where indicated on this application, it does not release me or my household members from those requirements and obligations.
I swear I have honestly reported the citizenship of myself and anyone I am applying for.

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 release (disclosure) of the required information.

Signature or Mark of Applicant/ Authorized Representative	Date	Signature or Mark of Spouse/ Second Parent of Children/ Responsible Adult	Date
Printed Name		Printed Name	

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	Printed Name	Date

TURN IN YOUR COMPLETED ADDENDUM TO ANY DWSS OFFICE	
You can also mail your addendum to:	**Did you remember to:**
State of Nevada Division of Welfare and Supportive Services P.O. Box 15400 Las Vegas, NV 89114-5400	➢Tell us about everyone in your family & household? ➢Ask your employer about any job-related insurance benefits? ➢Sign this application?

☐ Telephone call to applicant ☐Copy of form mailed to applicant Date _____

(Page left intentionally blank)

Appendix A

DIVISION OF WELFARE AND SUPPORTIVE SERVICES
LANGUAGE ASSISTANCE SERVICES

Help is available for individuals with Limited English Proficiency (LEP) to assist in completing this application. Please contact the phone number listed in your preferred language below for more information.

Spanish
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1 866-569-1746 (TTY: 7-1-1).

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-569-1746 (TTY: 7-1-1).

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-866-569-1746 (TTY: 7-1-1).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-569-1746 (TTY: 7-1-1) 번으로 전화해 주십시오

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-569-1746 (TTY: 7-1-1).

Amharic
ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-866-569-1746 (መስማት ለተሳናቸው: 7-1-1).

Thai
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-866-569-1746 (TTY: 7-1-1).

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-569-1746 (TTY: 7-1-1) まで、お電話にてご連絡ください

Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-569-1746 (TTY: 7-1-1) رقم هاتف الصم والبكم.

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-569-1746 (телетайп: 7-1-1).

French
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-569-1746 (ATS: 7-1-1).

Persian
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-866-569-1746 (TTY: 7-1-1) تماس بگیرید.

Samoan
MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1-866-569-1746. (TTY: 7-1-1).

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-569-1746 (TTY: 7-1-1).

Ilocano
PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1-866-569-1746 (TTY: 7-1-1).

(Page left intentionally blank)

Appendix B

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF WELFARE AND SUPPORTIVE SERVICES
DESIGNATION OF AUTHORIZED REPRESENTATIVE

Applicant Name: Case No

I. DESIGNATION OF AUTHORIZED REPRESENTATIVE BY APPLICANT/RECIPIENT

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

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

☐ primary representative providing all necessary information to determine my eligibility for assistance to the Division of Welf are and Supportive Services. **Only the primary representative may sign on my behalf**.

☐ secondary representative who may provide information and will receive all notification regarding initial and ongoing eligibility.

I understand I may terminate this designation in writing at any time.

SIGNATURE OF APPLICANT DATE OF BIRTH DATE

RELATIONSHIP TO APPLICANT IF SIGNATURE IS NOT APPLICANT (MUST BE A FAMILY MEMBER) DATE

STATEMENT OF DESIGNATED 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 as representative are the same as if I were the applicant/recipient. I understand my obligations as responsible party are the same as if I were the applicant/recipient to t he extent applicant/recipient is financially able to pay.

☐ As secondary representative, I understand I will receive all notification 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 POSITION/RELATIONSHIP (PRINT NAME) DATE

ADDRESS TELEPHONE NUMBER

HOSPITAL, NURSING HOME OR COUNTY AGENCY

II. DESIGNATION OF AUTHORIZED REPRESENTATIVE BY OTHER

I, _____ , have made a good faith effort to contact family members and/or any legal guardian of the applicant/recipient. My efforts to find a family member to act as authorized representative/provide information or a legal guardian have been unsuccessful. I therefore request to be:

☐ primary representative and agree to act responsibly on behalf of the above -named applicant/recipient by providing all necessary information to determine eligibility for assistanc e. I understand my rights as representative are the same as if I were the applicant/recipient. I understand my obligations as responsible party are the same as if I were the applicant/recipient to t he extent the applicant/recipient is financially able to pay.

☐ secondary representative, and understand I will receive all notification 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 POSITION/RELATIONSHIP (PRINT NAME) DATE

ADDRESS TELEPHONE NUMBER

HOSPITAL, NURSING HOME OR COUNTY AGENCY

III. ☐ This authorization ceases upon approval for Medicaid; ☐ or ceases after newborn delivery.

(Page left intentionally blank)

Appendix C

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) 687-8414, email mer@dhcfp.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 medical institution and return home.

(Page left intentionally blank)

Appendix D

JOE LOMBARDO
Governor

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

RICHARD WHITLEY, MS
Director

ROBERT H. THOMPSON
Administrator

Non-Custodial Parent Name:	SSN:	DOB:

NON-CUSTODIAL PARENT (NCP) FORM

When applying for TANF and/or Health Coverage:

The law requires you to cooperate with Child Support Enforcement (CSE) to establish paternity to get child support and/or medical support owed to you and/or any child(ren) that you are applying for. This may include genetic testing. If the test proves the person you named is not the father, you may be required to pay the cost of the test. You are also responsible for providing all available information requested by the CSE Program such as certified copies of divorce decrees and/or support orders, birth certificates and photographs of the non-custodial parent.

The CSE Program:

Locates non-custodial parents and/or sources of income and assets, establishes and enforces financial and medical support, reviews and adjusts existing child support orders, and collects and distributes financial and medical support payments. If you are requesting medical assistance only, you may request in writing you only want medical support services.

Has sole discretion in determining which legal remedies are used in pursuing support and cannot guarantee success. CSE may request assistance of another state, and thereby, be subject to the laws of that state. CSE does not provide services involving custody, visitation, or unpaid medical bills. CSE may close your case when your case meets closure rules established by federal and state regulation.

Represents the State of Nevada when providing services and no attorney-client privilege exists. CSE is authorized to endorse and cash payments made payable to you for support payments and may collect past-due support by intercepting an IRS tax refund or other federal payment. If a tax intercept occurs, the CSE Program has the authority to hold a joint tax refund for a period of six (6) months before distributing the funds. No interest is paid on the held funds. Funds collected from a tax intercept are applied first to pay off any past due support assigned to the State of Nevada. A nonrefundable fee is deducted by the federal government of any tax or federal payment intercepted by the CSE Program.

Good Cause:

For not cooperating in pursuing child support or paternity may be allowed. If you do not cooperate with CSE and good cause has not been determined, your household will be ineligible for TANF and you will be ineligible for Medicaid. Good cause for not cooperating will be considered if you request it in writing.

Examples of good cause are:

- ***The child was conceived as a result of rape or incest.***
- ***Legal proceedings for adoption of the child are pending before a court.***
- ***You are being assisted by a public or licensed private social service agency to decide whether to keep or relinquish the child for adoption (no longer than three (3) months).***
- ***Your cooperation in establishing paternity or securing support will result in physical or emotional harm to yourself or the child(ren).***

You must provide your case manager with verification within twenty (20) days after claiming good cause. You will receive written notification of the good cause decision. If you are found to have good cause for not cooperating, CSE will NOT attempt to establish paternity or collect child support.

☐ **YES, I wish to claim good cause.** ☐ **NO, I do not wish to claim good cause at this time.**

Your Signature	Print Name	Date	Telephone Number

Case ID: _____

You Must Report Changes:

Whenever a name change occurs; you have a new address or telephone number for home or work; you hire a private attorney or collection agency; another child support or paternity legal action is filed; you file for divorce; you receive support payments directly from the non-custodial parent; you have a new address, telephone number, employment or health insurance for the non-custodial parent; a child(ren) no longer lives with you; a child(ren) is still in high school after age 18; a child(ren) becomes disabled before age 18; a child(ren) comes to live with you or you birth another child; a child marries, is adopted, joins the armed forces or is declared an adult by court order.

You Are Responsible For:

Repayment of support amounts received in error, including payments from an IRS tax refund, which are adjusted by the IRS. If you fail to enter into a repayment agreement with the CSE Program, the outstanding balance may be reported to a credit reporting agency and money collected on your behalf by the CSE Program may be withheld for repayment. Additionally, legal action may be initiated against you.

***Information on the Non-Custodial Parent (NCP) Form 2906-EG below is not required if applying for Health Coverage only.**

Non-Custodial Parent (NCP) Form*

⚠ Complete one form for each parent who does not live with the child(ren) for whom you are requesting assistance. For example, if you have two children and each have a different father / mother, you need to complete two forms. If you are not the parent of the child(ren) you are requesting assistance for, you need to complete one form for the non-custodial mother and one form for the non-custodial father. Do not leave any question blank. Write or type unknown or N/A (not applicable) for any question that does not apply to you or you do not know the answer.

Your Name:	Your SSN:	Your DOB:	Your relationship to the Child(ren):

Have You or the Children received Public Assistance in the past? ☐ Yes ☐ No If Yes, Where? (City/State)

⚠ *Fill in whatever you know about the Non-Custodial Parent. If you do not know the answer to a question, write unknown or N/A.*

Social Security Number of the Parent Who Does Not Live with You:

Last Name:	First Name:	Middle Initial:	Modifier (Jr. Sr., etc.)	Former Names (if any)

Address:	City	State	Zip Code	County

Date Last Seen or Contacted:	Phone Number:

Race:	Gender: ☐ Male ☐ Female	Hair Color:	Eye Color:	Weight:	Height:	Is He or She Disabled? ☐ Yes ☐ No

Birthplace (City and State):	Date of Birth:	Date of Death:	Zip Code	County

At any time was the Mother Married to this Non-Custodial Parent? ☐ Yes ☐ No	Date of Marriage:	Date of Divorce:

Was the mother married to someone else? ☐ Yes ☐ No	Are there other possible fathers? ☐ Yes ☐ No

Existing Child Support Court Order? ☐ Yes ☐ No If Yes, Where? (City/State)

INFORMATION ON THE CHILDREN FOR THIS NON-CUSTODIAL PARENT

Child's Social Security Number	Child's Last Name	Child's First Name	Child's Middle Initial	Child's Date of Birth (MM/DD/YY)	Did the mother have sexual relations with another man (not named above), during 30 days before or after the pregnancy began for this child?	Custody Month
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	
					☐ Yes ☐ No	

⚠ All cases for Temporary Assistance for Needy Families (TANF) and medical programs where the adult and child(ren) receive Medicaid must be referred for Child Support Enforcement. I understand if there is no adult in my family receiving medical assistance, and I would like to receive Child Support Enforcement services, I must submit an application for assistance with the appropriate state or county child support agency.

This information is correct to the best of my knowledge. I have read the "Important Child Support Information" section found on the eligibility application. I understand if I have intentionally withheld or misrepresented information, I could be disqualified from receiving public assistance.

I declare under penalty of perjury that the information I have provided on this document is true to the best of my knowledge and belief and that the statements contained herein are made for the purposes stated herein, including but not limited to, obtaining assistance in establishing parentage and/or an order for child support along with the collection of child support.

Your Signature: **Date:**

Appendix E

DWSS Privacy Policy

The Nevada Division of Welfare and Supportive Services (DWSS) is committed to protecting the privacy of its customers and potential customers. All data provided to DWSS will be used to determine eligibility for public assistance; assistance purchasing medical insurance; investigations of misuse of public assistance benefits and repayment; quality control reviews of casework; and internal, state, and federal audits.

Per Section 5 of the U.S. Code (5 USC) § 552a(e)(1), when applying for the public assistance programs offered by DWSS, you must provide DWSS with your personal information. In doing so, you are consenting for DWSS to collect, use, disseminate, and maintain this information for the purpose of determining eligibility for public assistance programs and the ancillary uses as mentioned above, on an as needed basis.

Per Section 7 of the Code of Federal Regulations (CFR), Chapter 273.2(b) for the Supplemental Nutrition Assistance Program (SNAP); 45CFR 206.10a for the Temporary Assistance for Needy Families (TANF) Program; 42CFR 435.600a for the Medical Assistance Program; and 5USC § 552a(e)(1) of the Privacy Act, DWSS requires applicants to submit an application for public assistance containing personal information to determine if the applicant is eligible for public assistance.

Information obtained by DWSS from individuals will be used for internal purposes only. DWSS will not knowingly disclose or sell your personal information to any third party. DWSS will take all reasonable measures to protect your information.

DWSS keeps your information private, as required by law. Your answers on this application will only be used to determine eligibility for the public assistance program(s) for which you are applying. The DWSS and the Department of Health and Human Services (DHHS) will check your eligibility using the Division's electronic databases and the databases of federal agencies. If the information does not match, you may be asked to send in proof.
DWSS will collect and store all information you provide through the Access Nevada site. This includes:

- your name
- address
- contact information
- usernames
- passwords
- PINs
- social security number
- financial and similar information
- along with copies of any documents you upload like:
  - rent receipts
  - pay stubs and
  - pictures of your driver's license

The State of Nevada's Privacy Policy can be found at nv.gov/privacy-policy.