State of Nevada
Department of Health and Human Services
Division of Welfare and Supportive Services

APPLICATION FOR ASSISTANCE

MEDICAID - MEDICAL ASSISTANCE TO THE AGED, BLIND AND DISABLED (MAABD)
SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

IF YOU NEED HELP COMPLETING ANY PART OF THIS FORM, LET US KNOW.

Public Assistance Programs you may apply for:

* **MEDICAID - Medical Assistance to the Aged, Blind and Disabled (MAABD)**
  Medical assistance for low-income individuals who are eligible under the following programs:

  - Over Age 65
  - Blind
  - Disabled
  - Hospital Stay, Nursing Home Stay, Home Care Waiver Application
  - Non-citizens Who Meet Specific Program Requirements
  - Qualified Medicare Beneficiaries

* **SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)**
  Food assistance (formerly known as Food Stamps) for low-income households to help supplement the purchase of food.

READ THIS PAGE CAREFULLY BEFORE FILLING OUT THE APPLICATION

1. Read each page carefully and **answer every question**. If the answer is "none," then write in "NONE."

2. If you need help filling out the form, you may want to ask your family, a friend, or a case manager from the Division of Welfare and Supportive Services (DWSS).

3. Remember, you are certifying to the correctness of your answers whether you are completing the form yourself or acting for another person who is unable to complete the form.

   The Division of Welfare and Supportive Services will verify the answers you give on this form. Willful concealment of income and assets could result in criminal prosecution.

4. Your Rights and Obligations as a recipient are attached to the back of this application.

5. If you are applying for someone other than yourself, check boxes or complete blank spaces as it applies to the person for whom the application is made.

If you are also applying for SNAP, we must verify information you provide and take action on your SNAP application within 30 days from the date you submit your application. If you are eligible, SNAP benefits will be provided from the date you give us the first page.

If you qualify to get SNAP right away, we must take action on your SNAP application within 7 days from the date you give us the first page. You may get SNAP right away if:

- Monthly rent/mortgage and utilities are more than your household's gross monthly income; or
- Gross monthly income is less than $150 and your household's resources, such as cash or checking/savings accounts, are $100 or less; or

Disclosure of Social Security Numbers: Pursuant to Title 42 USC 1320b-7, Social Security Numbers (SSN) are required for individuals receiving or seeking to receive assistance for themselves. If you or an individual in your household is applying for assistance and do not wish to provide or apply for an SSN, only this person's request for assistance will be denied. Undocumented or ineligible non-qualified citizens and other non-applicants or ineligible persons are not required to provide or apply for an SSN. Individuals who do not wish to pursue an SSN are considered non-applicants, but their income and resources may still be countable to other household members seeking assistance such as dependent children and/or a spouse. However, if you or an individual in your household is seeking assistance for themselves and meet "good cause" for not providing or pursuing an SSN, assistance may be granted if otherwise eligible.

Social Security Numbers are used to verify your family's income and resources and to conduct computer matching with other agencies such as the Social Security Administration, Employment Security Division, Child Support Enforcement Programs and the Internal Revenue Service. It is also used to gather workforce information, investigations, recover overpaid benefits and to ensure duplicate benefits are not issued.

Disclosure of Citizenship and/or Immigration Status: You will be required to provide proof of citizenship and/or immigration status. If you or another member of your family or household do not want SNAP benefits, then you/they DO NOT have to give us information about citizenship or immigration status. If you are applying for TANF-cash assistance, Medicaid or SNAP, we may decide that certain members of your family are ineligible for benefits because they do not have the right immigration status. If that happens, other family members may still be able to get benefits if they are otherwise eligible. If you want us to decide whether other family members are eligible for benefits, you will still need to tell us about their citizenship and/or immigration status. You will also need to tell us about your family's income and answer the other questions on this form.

Do Not Send Applications Here

Non Discrimination: In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

mail: Food and Nutrition Service, USDA
1320 Braddock Place, Room 334
Alexandria, VA 22314; or
fax: (833) 256-1665 or (202) 690-7442; or
email: FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

Do Not Send Applications Here

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS),

write: Centralized Case Management Operations
US Department of Health and Human Services
200 Independence Avenue, S.W. Room 509F, HHH Building
Washington, D.C. 20201

or call: (202) 619-0403, (800) 368-1019 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

Important Notice: If you are applying for a child not eligible for Medicaid assistance on this application, the Nevada Check Up Program provides low-cost, comprehensive health care coverage to uninsured children 0-18 years of age who are not covered by private insurance or Medicaid. To find out the eligibility requirements for this medical program or to request an application, go to https://dwss.nv.gov/Medical/NCUMAIN/.

Medical benefits start from the first day of the month eligibility is approved, with the exception of some Medicare beneficiaries.

Division of Welfare and Supportive Services

Complete the application questions as they pertain to the person in need of assistance.

If you need more space to answer, write on a separate sheet of paper.

Race (optional) – please check one of the boxes Hispanic/Latino or Non-Hispanic or Latino.
Please list below the ethnicity* code for each household member: A – Asian; B – African American or Black; G – Middle Eastern or North African; I – American Indian or Alaska Native; J – American Indian or Alaska Native and White; L – Asian and White; M – Black or African American and White; N – Native Indian/Alaska Native and Black/African American; U – Native Hawaiian or other Pacific Islander; W – White; Z – 2 or more combinations not listed above.
Please list marital status for each household member: D – Divorced; L – Legally Separated; M – Married; N – Never Married; P – Separated; W – Widowed

NAME LAST NAME, FIRST	RELATION TO YOU	SEX	SOCIAL SECURITY NUMBER OR ALIEN REGISTRATION NUMBER *(optional, see cover page)*	STATE OR COUNTRY OF BIRTH	U.S. CITIZEN? Y/N	*RACE/ETHNICITY	DATE OF BIRTH	AGE	LAST GRADE COMPLETED	YEAR COMPLETED	MARITAL STATUS	MAABD	SNAP	NONE
	self													

Facility Address	City	State Zip
Home Address	City	State Zip
Mailing Address	City	State Zip
Home Phone	Day/Message Phone	Date of Death (If applicable)

MEMB	SPEC	APPLICANT INFORMATION	AREP	INFC

1. **When did the above person(s) move to Nevada?** _____
2. **Do you intend to continue living in Nevada?** **YES** **NO**
3. **Has anyone, applying for assistance, RECEIVED any type of public assistance in the past 90 days?** **YES** **NO**

   If YES, Who: _____ **Where:** _____ **When:** _____
   Name of Person City County State Mo/Yr

If you are applying for Medicaid, you may request payment for any medical expenses you had in the three months prior to this medical application. This is known as PRIOR MEDICAL ASSISTANCE.

4. **Does anyone wish to apply for prior medical assistance? Months Requested** _____ **YES** **NO**

   Who: _____
5. **Has anyone, applying for assistance, been in a hospital, nursing home or other medical institution during the past 3 months?** **YES** **NO**

   Are you currently in a hospital, nursing home, or other medical facility? **YES** **NO**

   If YES, Who: _____ Date Entered: _____ Date Left: _____

   Facility Name/Address: _____
6. **Are you (check EACH answer that applies to you)** **Age 65 or Older** **Blind** **Disabled**
7. **If disabled, date most recent disability began:** _____

   What is your disability? _____

Under penalty of perjury, I swear the statements on this application are true and correct.

_____

Your Signature **Date**

PHOTOCOPY AND DATE STAMP PAGE 1 TO ESTABLISH APPLICATION DATE.

8. Is any household member a veteran?

Name	Branch of Service	VA Claim Number	Serial Number	Dates of Service
				— —
				— —

9. Have you worked for a railroad company or for federal, state, county or city government? **YES** **NO**
If YES, complete below.

Name of employer		
Address of employer		
Dates you were employed	Claim Number	Identification Number

10. Does any household member have medical benefits through either Medicare (Part A or B) or Railroad Retirement Coverage? Who _____ Claim # _____ ☐ **YES** ☐ **NO**

11. Does anyone have any health/dental insurance or is it available to you from any source? ☐ **YES** ☐ **NO**
Who: _____
Insurance company name and address: _____
Policy in name of _____ Policy owner's Social Security No. __
Group or Policy _____ Effective date of coverage _____

12. Has any household member been injured in an accident? ☐ **YES** ☐ **NO**
Who: _____ When: _____

13. Do you want someone other than yourself to apply for benefits or act on your behalf? ☐ **YES** ☐ **NO**
(This would include obtaining and using SNAP for you. This person must be at least 18 and have I.D.) If YES, complete below.

Who: _____
Name **Address**
Telephone Number _____ Age _____

RESIDENCE INFORMATION	PROP

14. If you or your spouse reside in a medical facility regardless of medical condition, do you or your spouse intend to return to your home? ☐ **YES** ☐ **NO**

15. Is this residence occupied by a community spouse, dependent relative or other person? ☐ **YES** ☐ **NO**

16. Do you receive rental income from your home? ☐ **YES** ☐ **NO**

17. What is the fair market value of your home? $ _____

18. What amount is owed on your home? 1st Mortgage _____ 2nd Mortgage _____

BANK	CARS	RESO	RESOURCES	LIFE	PROP	TRAN

19. List all resources you or a member of your household have, such as: bank/credit union accounts, stocks and bonds, property, life and burial insurance, etc.

- ☐ Available Trust Funds _____
- ☐ Burial Funds/Plans
- ☐ Business Checking Accounts
- ☐ Business Equipment/Inventory
- ☐ Cash on hand $_____
- ☐ Certificates of Deposit (CD)
- ☐ Checking Accounts
- ☐ Christmas Club
- ☐ Credit Union Accounts
- ☐ Individual Indian Money Accounts (IIM)
- ☐ Individual Retirement Accounts (IRA)
- ☐ Keogh Accounts (401K)
- ☐ Land/Mineral Rights
- ☐ Life Estates/Life Leases
- ☐ Life Insurance Policies
- ☐ Livestock/Horses
- ☐ Mining Claims
- ☐ None
- ☐ Other Account Types
- ☐ Other Houses, Land or Buildings
- ☐ Promissory Notes or Contracts
- ☐ Safe Deposit Box
- ☐ Savings Account
- ☐ Savings Bonds
- ☐ Stocks/Bonds
- ☐ The Home You Live In
- ☐ Unavailable Trust Funds

Owner(s)	Resource Type	Account/Policy Number	Amount Value	Amount Owed

Other _____

20. Are any of the resources, in question 19, MONEY FOR BURIAL? ☐ **YES** ☐ **NO**

If YES, which item(s): _____

21. List all cars, trucks, recreational vehicles, trailers, etc., for all persons applying for assistance. INCLUDE VEHICLES THAT DO NOT RUN.

☐ Car ☐ Motorcycle ☐ Motor Home ☐ Trailer/Camper ☐ None
☐ Truck/Van ☐ Snowmobile ☐ Boats/Motors ☐ Other Vehicle (dune buggy, ATV, etc.)

_____

Owner(s)	Year, Make & Model	Value	Check if Registered	Owner(s)	Year, Make & Model	Value	Check if Registered
			☐				☐
			☐				☐

22. Has anyone sold, traded, or given away money, vehicles, property or other resources, closed any bank accounts, or purchased any annuities in the last 60 months? **YES** **NO**

If YES, give date _____ Value of property and/or cash gift _____
Description _____ Total sale price _____

23. Have either you or your spouse executed a trust, annuity, court order and/or purchased a Promissory Note, loan or Life Estate? **YES** **NO**

Be aware that by virtue of the provision of medical assistance for institutional care, annuities purchased on or after February 8, 2006 must name the State of Nevada as the remainder beneficiary.
If YES, attach a copy(ies) of the document(s) with the application.

JINC	SELF	INCOME INFORMATION	OINC	QUIT

24. List current AND last employer for ALL household members.

Employment Dates MM/YY		Name, Address of Employer or Training	How Often Paid	Hours Worked	Hourly Wage	Tips Per Pay Period	Reason for Leaving
Name:							
Start:	— —						
End:	— —						
Name:							
Start:	— —						
End:	— —						
Name:							
Start:	— —						
End:	— —						
Name:							
Start:	— —						
End:	— —						

RINC	RBIN	EDIN	UNEARNED INCOME	LSUM	GAGA	UNIN

25. Has anyone in the household applied for or currently receiving any money other than from a job? **YES NO**

If YES, complete boxes below.

- ☐ Child Support/Alimony (Absent Parent)
- ☐ Contributions/Gifts
- ☐ County Assistance/General Assistance
- ☐ Educational Assistance
- ☐ Foster Care Payments
- ☐ Insurance Settlements
- ☐ Interest/Dividends
- ☐ Loans
- ☐ Lump Sum Payments
- ☐ Military Allotment
- ☐ Mining Claims
- ☐ Native TANF
- ☐ Pan Handling
- ☐ Pensions/Retirement
- ☐ Railroad Retirement
- ☐ Royalties
- ☐ Social Security Disability
- ☐ Social Security Retirement
- ☐ Social Security Survivor's
- ☐ Strike Benefits
- ☐ Supplemental Security Income (SSI)
- ☐ TANF Assistance
- ☐ Temporary Disability Insurance
- ☐ Tribal Assistance/IGA
- ☐ Trust Income
- ☐ Unemployment Insurance
- ☐ Utility Allowance From Housing
- ☐ Utility Rebate Check
- ☐ Veterans Benefits
- ☐ Winnings
- ☐ Worker's Compensation

Other: _____

Income Type	Who Receives	Amount	How Often	Income Type	Who Receives	Amount	How Often

SPOUSE INFORMATION	SHST

26. Complete the following on your current and most recent spouse. If spouse is deceased, all possible information must still be completed.

Spouse's Name			
Address			
Social Security Number	Date of birth	Date of death	
Veteran? ☐ YES ☐ NO Claim #	Divorced? ☐ YES ☐ NO Date: / /	Widowed? ☐ YES ☐ NO Date: / /	
Employer name/address	Medical insurance	Are you covered? ☐ YES ☐ NO	
Railroad, federal or local government employee? ☐ YES ☐ NO			
RR or gov't claim number	Years employed		

Spouse's Name			
Address			
Social Security Number	Date of birth	Date of death	
Veteran? ☐ YES ☐ NO Claim #	Divorced? ☐ YES ☐ NO Date: / /	Widowed? ☐ YES ☐ NO Date: / /	
Employer name/address	Medical insurance	Are you covered? ☐ YES ☐ NO	
Railroad, federal or local government employee? ☐ YES ☐ NO			
RR or gov't claim number	Years employed		

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM APPLICATION

COMPLETE THIS PAGE ONLY IF APPLYING FOR SNAP AS HOME BASED WAIVER APPLICANT OR SPOUSE OF APPLICANT REQUESTING HOSPITAL OR NURSING HOME ASSISTANCE.

27. **Do you usually buy and prepare your food with the other people in your home?** ☐ **YES** ☐ **NO**

28. **What is the TOTAL gross amount of money your household expects to receive this month from any source?** **$** _____

29. **How much do all persons have in cash, checking and savings accounts?** **$** _____

30. **How much is your current monthly cost for housing (rent/mortgage) and utilities?** **$** _____

31. **Has anyone in the household received benefits in another state?** ☐ **YES** ☐ **NO**

When? _ _ _ _ _ _ **City/County/State?** _____

32. **Is any household member on strike?** If YES, complete below. ☐ **YES** ☐ **NO**

Name of Person on Strike	Date Strike Began and Ended		Employer's Name, Address and Phone No.
	_ _	_ _	
	_ _	_ _	

33. **Are there non-citizen members living in the house?** ☐ **YES** ☐ **NO**

34. **Is any member in the household applying for assistance currently wanted by any law enforcement agency for any reason (including questioning)?** ☐ **YES** ☐ **NO**

35 **Has any member in the household applying for assistance ever been convicted of any drug-related offenses?** ☐ **YES** ☐ **NO**

36. **Is anyone in the household applying for assistance currently sanctioned for an intentional program violation?** ☐ **YES** ☐ **NO**

RENT	HOME	SUDE	MEDI	EXPENSES	MINS	UTIL	DCEX	MEDX

If you claim **and** provide proof of shelter, utility, dependent care and/or medical expenses, your SNAP amount may be more. **If you have any of these expenses and do not claim them and/or do not provide proof, your SNAP benefits may be less than you would receive if expenses were claimed. Failure to claim or provide proof of expenses will be seen as a statement by your household you do not want to receive a deduction from income for the unreported expense.**

37. **Does anyone in the household pay court ordered child support to someone not living with you?** ☐ **YES** ☐ **NO /Do not wish to claim**

38. **Is anyone paying for or being charged for the case of a dependent child or disabled adult so someone in the household can work, attend training, school, or look for work?** ☐ **YES** ☐ **NO Amount $**_____

39. **Does anyone in the household expect any changes in income, expenses or work hours?** ☐ **YES** ☐ **NO**

40. **Were you billed for or expect to pay medical costs (doctor/hospital bills, prescriptions, dental bills, etc.) for anyone in your home who is disabled or age 60 or older?** ☐ **YES** ☐ **NO**

41. **List the monthly shelter expenses for your household.**

Rent or Space Rent	$ _____	Electricity	$ _____	Water	$_____
Mortgage (including 2nd)	$ _____	Natural Gas	$ _____	Garbage	$_____
Property Taxes	$ _____	Propane	$ _____	Sewer	$_____
Home Insurance	$ _____	Heating Oil	$ _____	Telephone$	_____
Association Fees	$ _____	Wood	$ _____	Other	$_____

42. **Does anyone else pay a portion of your rent or utilities?** ☐ **YES** ☐ **NO**

Who? _____ How much? _____

43. **Is the rent government subsidized (HUD, Section 8, Federal Public Housing, etc.)?** ☐ **YES** ☐ **NO**

44. **List landlord's/rental company's name, address and phone number.**

_____

Landlord's Name Address Telephone

FOR OFFICE USE ONLY - EXPEDITED SERVICE SCREEN - Household eligible for expedited service.

☐ **YES** ☐ **NO** **Expedited Service Screener's Signature:** **Date:**

SIGNATURE AND AFFIRMATION

Information provided on this form is subject to verification and investigation by federal, state, and local officials. If you make a false or misleading statement, misrepresent, conceal or withhold facts to establish or maintain program eligibility, your benefits may be reduced/denied/terminated. You will be responsible for repayment of all monies, services and benefits for which you were not legitimately entitled.

Individuals found guilty of intentional program violation of SNAP are barred from program participation for twelve (12) months for the first violation, twenty-four (24) months for a second violation and PERMANENTLY for a third violation.

The unlawful use, transfer, acquisition, alteration, or possession of SNAP is punishable by a fine up to $250,000, imprisonment for up to 20 years, or both. You are liable for any over issuance resulting from erroneous information. A court can also bar an individual from the program for an additional 18 months. The person may also be subject to further prosecution under the federal laws.

Qualified non-citizen status will be verified with the Bureau of Citizenship and Immigration Services (BCIS) for eligibility purposes.

I wish payments under the medical insurance program (Part B of Title XVIII) to be made directly to physicians and medical suppliers on any future unpaid bills for medical and other health services furnished me while eligible for welfare assistance.

Eligibility and income information is regularly requested from the Nevada State Employment Security Department, the Social Security Administration and Internal Revenue Service, and is used to determine your eligibility for and amount of assistance.

I hereby assign to the Division of Welfare and Supportive Services, as a condition of eligibility, all rights to medical support or other payments for medical care for myself and all persons for whom I am applying/receiving assistance. I will cooperate with the Division in obtaining third party benefits and/or payments for medical care.

I understand that I have a duty to inform the Division of Welfare and Supportive Services if I, or anyone on my behalf, commence a legal action against someone for recovery of money as reimbursement for medical care and treatment paid by the Medicaid program AND that I must further advise the Division of Welfare and Supportive Services should I, or anyone on my behalf, solicit or receive any offer of settlement of money as reimbursement for medical care and treatment paid for by the Medicaid program. I understand I must surrender any such monies received to the Division of Welfare and Supportive Services.

Medicaid recipients who are: 1) 55 years of age or older; OR 2) inpatients of a medical facility may be responsible for repayment of Medicaid expenditures paid on their behalf. Recovery would be accomplished from the estate of recipient after their death or after the death of their surviving spouse. (See attached Form 6160-AF, Program Operation.)

Any person who signs an application for assistance to the medically indigent and fails to report the following may be personally liable for any money incorrectly paid to the recipient:

1) any required information to the Division of Welfare and Supportive Services which the individual knew at the time they signed the application; or
2) within the period allowed by the Division of Welfare and Supportive Services, any required information to the Division of Welfare and Supportive Services which the individual obtained after filing the application.

I understand, that as a parent of a disabled minor child who receives services under the Medicaid program:

1) I am responsible to contribute to the support of my child by reimbursing the State of Nevada, Division of Welfare and Supportive Services for said services pursuant to NRS 125B.020; and NRS 422.310.
2) I agree to cooperate with the Division of Welfare and Supportive Services and provide to the Division of Welfare and Supportive Services, Medicaid program, all information regarding income, resource and medical insurance, necessary to determine the amount of the reimbursement.
3) I understand if I fail to cooperate or fail to provide the requested information, I will be responsible for a monthly reimbursement payment in the amount of $1,900.

I understand the "period of intended use" for SNAP benefits deposited into an EBT account is 274 days from the date they became available. SNAP benefits left untouched in an EBT account for 274 days will be removed from the account and returned to Food and Nutrition Services (FNS) as required by federal regulations. Federal regulations do allow unused benefits to be applied (credited) to any outstanding SNAP claim (debt) the household may have incurred prior to being returned to FNS. I hereby give the Division of Welfare and Supportive Services permission to apply any unused EBT SNAP benefits to any unpaid or outstanding SNAP debt I or any other adult member of my household owes to the SNAP Program.

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.

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.htm
☐ Molina Healthcare	1-833-685-2109	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

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 such information from liability, if any, resulting from the disclosure of the required information.

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 circumstances that may affect my eligibility for assistance. I understand failure to report changes in circumstances may result in overpayment collection/criminal prosecution.

I understand Social Security Numbers (SSNs) are used to verify income and resources, to see what benefits are available, as case numbers in the computer, gather workforce information for research which helps lawmakers and agencies improve services to Nevadans, investigate fraud, recover overpaid benefits, make sure nobody gets benefits in more than one household (double benefits) or while they are in jail or prison or deceased and match against other federal and state records. For example: Child Support Enforcement Program (CSEP), Unemployment Insurance Benefits (UIB), Internal Revenue Service (IRS), Medicaid and Social Security Administration (SSA), law enforcement/prison records. By signing this application, I allow the agency to use my SSN for the purposes explained on this form. This includes anyone under age 18 I am applying for.

I hereby authorize the Nevada Department of Health and Human Services to make any investigation concerning me or other members of my household which is necessary to determine eligibility for any benefits I have received or will receive under programs administered by the Division of Welfare and Supportive Services. I hereby authorize and consent to the release of all information concerning me and/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. This information may also include education records (including IEP records) maintained at the local school district that are necessary for Medicaid reimbursement purposes for health services provided to my child. I hereby release the holder of the information from liability, if any, resulting from the release (disclosure) of the required information. **A REPRODUCED COPY OF THIS AUTHORIZATION LEGALLY CONSTITUTES AN ORIGINAL COPY.**

I realize that I must give complete and accurate information, and that willful concealment of income and assets could result in criminal prosecution. I certify under penalty of perjury; my answers are correct and complete to the best of my knowledge and ability.

If you are applying for someone else and they are unable to sign, sign your name for them on the applicant's signature line (e.g., John Doe for Mary Doe).

Signature or Mark of Applicant Date Signature or Mark of Applicant's SPOUSE Date

WITNESS: (USE IF APPLICANT CANNOT READ OR WRITE OR IS BLIND)
The Information Contained in This Application Has Been Read To The Applicant And I Have Witnessed The Above Signature

Signature Of Witness Address Date

IN CASE OF EMERGENCY, NOTIFY:

Name Relationship Address Telephone #

The person applying for assistance MUST SIGN below.

I certify under penalty of perjury, by signing my name below, that I have reported the correct citizenship status for all household members.	U.S. Citizen or National	Non-citizen Lawfully Admitted	Other	Date
1.				
2.				

FOR OFFICE USE ONLY

Case Manager Signature Date

RECIPIENT'S RIGHTS AND OBLIGATIONS

AS AN APPLICANT/RECIPIENT FOR WELFARE BENEFITS FROM THE STATE OF NEVADA, YOU ARE HEREBY ADVISED THAT:

You have the following RIGHTS:

1. You have the right to a hearing if your application for assistance or services is denied, reduced, terminated, or not acted on with reasonable promptness unless state or federal law requires such action. You may obtain a hearing by mailing in a written request to the Division of Welfare and Supportive Services. You may be represented by legal counsel or by a relative, friend or other spokesperson, or you may represent yourself.

2. The Division of Welfare and Supportive Services provides medical and food assistance and services without discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity according to federal rules and regulations. When the Division pays another agency, institution or person for services to customers of the Division of Welfare and Supportive Services, the vendor is not permitted to discriminate for any reason according to federal rules and regulations.

3. If you are married and living separate and apart from your spouse, you have the right to enter into a written agreement which equally splits your community income and/or resources between you. If this is done, only the income or resources the agreement specifies as yours will be counted in determining eligibility, unless your spouse makes a portion of his/her income or resources available to you. The portion made available to you will be counted when determining/continuing your eligibility. The written agreement must be specific as to what assets are being divided and how they will be divided between you. It is suggested you consult legal assistance if you decide to enter into such an agreement.

4. When there is a court order dividing community resources, excluding income, between you and your spouse under provisions of 1987 Statutes of Nevada Chapter 123, only these resources awarded to you will be counted in determining/continuing your eligibility unless your spouse makes a portion of his/her resources available to you. The portion made available to you will be counted in determining/continuing your eligibility.

You have the following OBLIGATIONS:

1. Institutionalized persons or persons receiving nursing care at home (includes SSI and non-SSI recipients) may be responsible for paying a portion of their income toward the cost of their care. **This is called patient liability**. The division district office must be notified immediately of any income changes.

2. All household members must provide proof of their Social Security Number, or their application to obtain a number. The Division of Welfare and Supportive Services' authority to require Social Security Numbers is Section 1137 of the Social Security Act. The Social Security Number is used to determine and verify eligibility for benefits through such means as computer matching and to prevent and detect fraud and abuse.

3. If you are applying for/receiving Supplemental Security Income (SSI), you must inform your Case Manager immediately of the following:

    a. Written proof of your application for SSI (Supplemental Security Income);
    b. Proof of your SSI eligibility determination;
    c. Termination of SSI;
    d. **ANY CHANGES IN ADDRESS**;
    e. Income (if you are institutionalized);
    f. Any other changes/information that may affect your eligibility for assistance.

4. If you are **NOT** receiving Supplemental Security Income (SSI), you must inform your caseworker immediately of the following:

    a. **ANY CHANGES IN ADDRESS;**
    b. Any change in assets or property;
    c. Any change of income for yourself affecting eligibility must be reported. This includes any receipt of, increase, reduction or termination of any form of income, including earnings, unemployment, Social Security benefits, veteran's benefits, railroad retirement, income, Employers Insurance Company of Nevada (EICON), child support and contributions from relatives and friends other than income;
    d. Any changes/information that may affect your eligibility for assistance.

5. If you are applying for Supplemental Nutrition Assistance Program (SNAP)
   You are required to report all changes in your household from the date you submit your application to the day of your interview. Once SNAP benefits are approved, you will receive a notice informing you of your specific reporting requirement.
   If your household is designated as a *Change Status Reporting Household* you will be required to report changes within 10 days from the date the change happened.
   If your household is designated as a *Simplified Reporting Household,* you will only need to report if you move out of state or your household's income exceeds 130% of the federal poverty level for your household size.

6. The SNAP Program allows certain household expenses like rent, mortgage, property taxes, homeowner's insurance, utility expense, child/dependent care and child support paid by the household as a deduction to determine the amount of SNAP your household is eligible for as long as the expense is reported and verified. Medical expenses over $35.00 are allowed if there is an elderly or disabled person applying for benefits. If you do not report or verify any of the expenses listed on the application, this will be considered that you do not want to receive a deduction for the unreported or unverified expense.

7. Your case may be reviewed by a quality control unit as to the accuracy of benefits paid or allotted. You are required to cooperate with the review.

8. You must assist the Child Support Enforcement Program or district attorney in establishing parentage of a child born out-of-wedlock and assist in obtaining medical care support and payments for all persons applying for or receiving assistance.

SPECIAL NOTICE:

1. Failure or refusal to comply with above may result in your termination from the welfare program. The above information must be reported to your caseworker; reporting to other governmental agencies such as Social Security does not meet your obligation as a welfare recipient. Periodically this agency may mail to you correspondence which requires you to respond by a certain date. If you are away from home, you are not excused from your responsibility to respond by the designated date. You may wish to make arrangements for your mail during your absence.

2. Eligibility and income information will be regularly requested from Nevada State Employment Security Department, the Social Security Administration, and the Internal Revenue Service, and will be used in determining your eligibility for assistance.

3. Changes must be reported immediately after you apply and before you are approved benefits. Once your SNAP benefits are approved, you must report within 10 days from the date the change happened, and once your Medicaid benefits are approved, proof of the change must be postmarked by the 5th of the following month. Your case manager may request additional proof of the change. You will be required to provide the proof by a certain date in order to continue your eligibility or to avoid an overpayment or underpayment of benefits.

Applicant/Recipient	Date	Case Manager Signature	Date

- If you have problems understanding or completing these forms, ask a relative, friend or contact your local Division of Welfare and Supportive Services office.

IF YOU ARE NOT REGISTERED TO VOTE WHERE YOU LIVE NOW,
would you like to register to vote here today?
(Please check one)

☐ YES ☐ NO

If you do not check either box, you will be considered to have decided not to register to vote at this time.

The **NATIONAL VOTER REGISTRATION ACT** provides you with the opportunity to register to vote at this location. If you would like help in filling out a voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

IMPORTANT NOTICE: Applying to register or declining to register to vote WILL NOT AFFECT the amount of assistance you will be provided by this agency.

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.

Do Not Send Applications Here

Non-Discrimination

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, age, or disability. Under the USDA policy, discrimination is further prohibited on the basis of political beliefs or reprisal or retaliation for civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

1. mail:
   Food and Nutrition Service, USDA
   1320 Braddock Place, Room 334
   Alexandria, VA 22314; or

2. fax:
   (833) 256-1665 or (202) 690-7442; or

3. email:
   FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

Do Not Send Applications Here

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS),

write: Centralized Case Management Operations
US Department of Health and Human Services
200 Independence Avenue, S.W. Room 509F, HHH Building
Washington, D.C. 20201

or call: (202) 619-0403, (800) 368-1019 (voice) or (800) 537-7697 (TTY).

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Your Rights

Anyone whose application for assistance has been denied, not acted on within a reasonable time frame, or whose benefits have been reduced or terminated, may request a conference or hearing. You may request a conference or hearing by writing your local district DWSS office or the administration office. For SNAP, you may request a hearing by calling your local district DWSS office. You may also request a hearing for assistance programs such as SNAP or Medicaid within 90 days of the notice date. For Social Service programs, you must request a hearing within 13 days from the notice date.

You will be notified in writing 10 days prior to the hearing date, the time and location of the hearing. You may be represented at a conference/hearing by anyone you have given written authorization to which must be given to the DWSS office prior to the conference/hearing. You may request information on the various legal services which may be available in your community at no cost, please contact us for information. If you are dissatisfied with the hearing decision, you may appeal your case to your local District Court of the State of Nevada.

Your Responsibilities

If you are applying for Medicaid:

You must report changes in your mailing address immediately. Additional changes must be reported immediately after you apply and before you are approved benefits. Once your benefits are approved you must report the following changes and the change must be reported by the 5th of the following month. You must report changes such as your physical address, living expenses, subsidized housing value, marital status, employment status, any money you receive or income from any source, assets/resources, absent parent's address, number of people in the home, birth of a child in your home, school attendance, absence of any household member even if it is temporary (if more than 30 days), and any other change which may affect your household benefits.

If you are applying for Supplemental Nutrition Assistance (SNAP):

You are required to report all changes in your household from the date you submit your application to the day of your interview. Once SNAP benefits are approved, you must report required changes within 10 days from the date the change happened based on your household's specific reporting requirements. You will receive a notice informing you of your specific requirement.

If your household is designated as a *Change Status Reporting Household,* you will be required to report the same changes listed under the request for TANF and Medicaid.

If your household is designated as a *Simplified Reporting Household,* you will only need to report if you move out of state or your household's income exceeds 130% of the federal poverty level for your household size.

Your caseworker may request additional proof of the change. You will be required to provide the proof by a certain date in order to continue your eligibility or to avoid an overpayment or underpayment of benefits.

The Supplemental Nutrition Assistance Program allows certain household expenses like rent, mortgage, property taxes, homeowner's insurance, utility expenses, child/dependent care and child support paid by the household as a deduction to determine the amount of SNAP benefits your household is eligible for as long as the expense is reported and verified. Medical expenses over $35.00 are allowed if there is an elderly or disabled person applying for benefits. **If you do not report or verify any of the expenses listed on the application, it may be considered that you do not want to receive a deduction for the unreported or unverified expense.**

Utilizing TANF funds, DWSS through the Nevada Public Health Foundation (NPHF), has developed a class to target pregnant and parenting teens receiving TANF cash assistance. Teen parents receiving TANF benefits and services are known as STARS (Supporting Teens Achieving Real-life Success) participants. This class has been expanded to include other pregnant and parenting teens receiving other forms of assistance such as SNAP and Child Welfare. This one-day class places emphasis on employment, success in the workplace, decision-making, money management and health, such as birth control and sexually transmitted diseases.

In addition, Community Action Teams, an entity of the Nevada Public Health Foundation, conduct community assessments of teen pregnancy and its prevention and identify potential methods for reducing teen pregnancy through abstinence-based programs. Youths, parents, business, churches, health care providers, law enforcement, schools and other organizations are encouraged to serve on the Community Action Teams. Men of all ages are also encouraged to serve as positive role models, reinforcing the postponement of sexual involvement message.

After you submit your application, you may call our Voice Response Unit (VRU) system to find out if your case has been approved, denied, terminated or is still pending. The VRU system will also let you know when your benefits have been issued and the amount.
For Southern Nevada, call (702) 486-1646; Northern Nevada, call (775) 684-7200; Rural Nevada, call (800) 992-0900.
Your Personal Identification Number (PIN) for the VRU system is _____.

Visit our website at http://dwss.nv.gov/

This is Your Copy, Keep This Page for Your Records