

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.

Non Discrimination: In accordance with Federal law and U.S. Department of Agriculture (USDA) and Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs, "To file a complaint of discrimination, contact USDA or HHS. Write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TTY). USDA and HHS are equal opportunity providers and employers."

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 <http://nevadacheckup.nv.gov> or call 1-877-543-7669.

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 – Black or African American;

I – American Indian or Alaska Native; J – American Indian or Alaskan Native and White; L – Asian and White; M – Black or African American and White; N – Native Indian/Alaskan 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	S E X	SOCIAL SECURITY NUMBER OR ALIEN REGISTRATION NUMBER <i>(optional see cover page)</i>	STATE OR COUNTRY OF BIRTH	U.S. CITIZEN? Y/N	*RACE/ETHNICITY	DATE OF BIRTH	A G E	LAST GRADE COMPLETED	YEAR COMPLETED	MARITAL STATUS	M A R R I E D	S E P A R A T E D	N E V E R M A R R I E D
	<i>self</i>													
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
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- When did the above person(s) move to Nevada? _____
- Do you intend to continue living in Nevada? YES NO
- 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.

- Does anyone wish to apply for prior medical assistance? Months Requested _____ YES NO
Who: _____
- 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: _____
- Are you (check EACH answer that applies to you) Age 65 or Older Blind Disabled
- 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 No. _____ 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
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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
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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.

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

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

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 of property/gift _____ 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
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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: — —						

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

Other: _____

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

SPOUSE INFORMATION	SHST
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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? <input type="checkbox"/> YES <input type="checkbox"/> NO	Divorced? <input type="checkbox"/> YES <input type="checkbox"/> NO	Widowed? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Claim #	Date: / /	Date: / /	
Employer name/address		Medical insurance	Are you covered? <input type="checkbox"/> YES <input type="checkbox"/> NO
Railroad, federal or local government employee?			<input type="checkbox"/> YES <input type="checkbox"/> NO
RR or gov't claim number		Years employed	

Spouse's Name			
Address			
Social Security Number		Date of birth	Date of death
Veteran? <input type="checkbox"/> YES <input type="checkbox"/> NO	Divorced? <input type="checkbox"/> YES <input type="checkbox"/> NO	Widowed? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Claim #	Date: / /	Date: / /	
Employer name/address		Medical insurance	Are you covered? <input type="checkbox"/> YES <input type="checkbox"/> NO
Railroad, federal or local government employee?			<input type="checkbox"/> YES <input type="checkbox"/> 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 2 nd) | \$ _____ | 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.	
<input type="checkbox"/> YES <input type="checkbox"/> 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 365 days from the date they became available. SNAP benefits left untouched in an EBT account for 365 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.

(CONTINUED ON NEXT PAGE)

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 assistance and services without discrimination of any kind (such as race, age, color, religion, sex, disability, handicap [including AIDS and AIDS-related conditions], political belief or national origin) according to federal rules and regulations. When the Division pays another agency, institution or person for services to clients of the Division of Welfare and Supportive Services, the vendor is not permitted to discriminate for any reason (such as race, age, color, religion, sex, disability, handicap [including AIDS and AIDS-related conditions], political belief or national origin) according to federal rules and regulations.

Violations of this provision should be promptly reported to the nearest district office, the Division of Welfare and Supportive Services Administrator, 1470 College Parkway, Carson City, Nevada 89706-7924, (775) 684-0500, the U.S. Office for Civil Rights (OCR), Department of Health and Human Services, 50 United Nations Plaza, San Francisco, California 94102, (415) 437-8310, TDD (415) 437-8311 or toll free 1-800-368-1019 or the Secretary of Agriculture, Washington, D.C. 20250.

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 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
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- 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 89710.

Non-Discrimination

“In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs.

“To file a complaint of discrimination, contact USDA or HHS. Write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TTY). USDA and HHS are equal opportunity providers and employers.”

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, extension 47200. Your Personal Identification Number (PIN) for the VRU system is _____.

You may contact your caseworker _____ at _____ between the hours of _____ to _____.

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

This is Your Copy, Keep This Page for Your Records



SECRETARY OF STATE BARBARA K. CEGAVSKE
STATE OF NEVADA
VOTER REGISTRATION APPLICATION

Application No.
HA

BOX 3 - NAME Please write your name exactly as it appears on the Nevada driver's license, ID card, or Social Security card referenced in Box 8. If you do not have any of these forms of identification, please see the instructions for Box 8.

BOX 4 - HOME ADDRESS Your home address is the street address assigned to the location at which you actually reside. If you reside at a location that has not been assigned a street address, a description of the location at which you actually reside must be provided. A P.O. Box cannot be listed as a home address.

BOX 8 - IDENTIFICATION REQUIREMENTS Federal and state law require you to provide your NV driver's license or NV ID number. If you do not have either, you must provide the last 4 digits of your social security number (SSN). If you do not have any of these three forms of identification, please contact your County Clerk/Registrar after you have completed and returned this form.

BOX 11 - PARTY REGISTRATION Mark your choice of a qualified party, "Nonpartisan" or "Other." If you mark "Other," you may print the name of an unlisted political party. If you register with a minor political party or as a nonpartisan, you will receive a non-partisan ballot for the Primary Election.

BOX 14 - ASSISTING IN THE COMPLETION OF THIS FORM If you are assisting a person to register to vote, you must complete Box 14. FAILURE TO DO SO IS A FELONY.

DEADLINES FOR SUBMITTING APPLICATION

- ★ By Mail—postmarked by Saturday, 31 days before an Election.
- ★ In Person at DMV—by Saturday, 31 days before an Election.
- ★ Online—by Tuesday, 21 days before an Election.
- ★ In Person At County Clerk's or Registrar's Office—by Tuesday, 21 days before an Election (for Municipal Elections, in person at City Clerk's).
- ★ For Special/Recall Elections—contact your County Clerk or Registrar.

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

INTERESTED IN BEING A POLL WORKER? Please contact your local County Clerk or Registrar's Office. See Reverse.

CHECK THIS BOX TO RECEIVE A SAMPLE BALLOT IN LARGER TYPE

USE BLACK INK — PLEASE PRINT CLEARLY				WARNING: GIVING FALSE INFORMATION IS A FELONY AND INCLUDES A CIVIL PENALTY OF UP TO \$20,000.			
1	Are you a citizen of the United States of America? Will you be 18 years of age or over on or before Election Day? If you checked "no" in response to either of these questions, do not complete this form.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	2	Check boxes that apply and complete items 3-14			
				<input type="checkbox"/> New Registration	<input type="checkbox"/> Party Affiliation Change		
				<input type="checkbox"/> Name Change	<input type="checkbox"/> Address Change		
3	Last Name (Only) First Name (Only)	Middle Name (Only)		Jr. Sr. II III IV			
4	Home Street Address (No P.O. Box/Business Address. See Instructions.) Apt. # City State Zip Code						
5	Mailing Address—If different from above. (P.O. Box or Mail Service Address)	6	Birth Date (M/D/YR)	7	Place of Birth (State or Country)		
8	NV Driver's License No./NV ID Card No./Last 4 of SSN	9	Telephone No. (Opt.)	10	E-mail Address (Opt.)		
11	Party Registration—Check Only One Box <input type="checkbox"/> Democratic Party <input type="checkbox"/> Independent American Party <input type="checkbox"/> Libertarian Party <input type="checkbox"/> Nonpartisan (no party affiliation) <input type="checkbox"/> Republican Party <input type="checkbox"/> Other Party – Write In Below	12	"I swear or affirm • I am a U.S. citizen • I will be at least 18 years old by the date of the next election • I will have continuously resided in Nevada at least 30 days in my county and at least 10 days in my precinct before the next election • The present address listed herein is my sole legal place of residence and I claim no other place as my legal residence • I am not laboring under any felony conviction or other loss of civil rights that would make it unlawful for me to vote. I declare under penalty of perjury that the foregoing is true and correct." <div style="display: flex; justify-content: space-between; align-items: center;"> <div style="border: 1px solid black; width: 60%; height: 40px; margin: 5px auto;"></div> <div style="text-align: center; margin: 5px auto;"> (MM / DD / YYYY) </div> </div>				
13	Your name and residence address where you were last registered to vote. (Name Used, Street, Apt. #, City, State & Zip Code of Former Residence)						
14	Important! If you are assisting a person to register to vote and you are not a field registrar appointed by a County Clerk/Registrar or an employee of a voter registration agency, you MUST complete the following. Your signature is required. Failure to do so is a felony.						
Name		Mailing Address		City/State/Zip Code		Signature	

VALIDATING AGENCY USE ONLY. DO NOT WRITE IN THE SHADED AREA BELOW.

DATE STAMP	<input type="checkbox"/> AGENCY <input type="checkbox"/> FIELD REGISTRAR <input type="checkbox"/> MAIL <input type="checkbox"/> OTHER	CANCELLED INACTIVE PRECINCT	APPLICATION NO. HA RECEIVED BY:
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↑ Detach Here ↑

↑ Detach Here ↑

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NAME OF PERSON RETAINING THIS APPLICATION <small>(AGENCY STAMP OR NAME OF AGENT, ELECTION OFFICIAL OR PERSON RETAINING APPLICATION)</small> <hr/> PRINT NAME OF PERSON RETAINING FORM	ELECTION OFFICIAL OR AGENCY Contact Information, Address, Telephone, Fax	VOTER APPLICATION RECEIPT <i>(Please Retain Receipt)</i> If you do not receive a Nevada Voter Registration Card in the mail within 10 days, please call or visit your County Election Department. APPLICATION NO. HA
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