



STEVE SISOOOLAK
Governor

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

RICHARD WHITLEY, MS
Director

STEVE H. FISHER
Administrator

MEDICAID



Date: _____
Case Name: _____
Case ID: _____

MAABD ADDENDUM

Please complete the following questions so your application for medical assistance can be evaluated properly.

Have you or your spouse been in a hospital, nursing home or other medical institution during the past 3 months? Self Spouse

Are you or your spouse currently in a hospital, nursing home or other medical facility? Yes No

If yes, who: _____ Date Entered: _____ Date Left: _____

Facility Name/Address: _____

Have you or your spouse been injured in an accident? Yes No Who: _____ When: _____

If you or your spouse resides in a medical facility, regardless of medical condition, do you intend to return home? Yes No

Please check the box for all resources you or a member of your household have:

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

If you have checked any boxes above, please provide details below.

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

Are any of the resources listed above designated for burial? Yes No Which one? _____



List all cars, trucks, recreational vehicles, trailers, etc. you own or are purchasing. Include vehicles that are not currently running.

Owner(s)	Year, Make and Model	Value	Registered?	Owner(s)	Year, Make and Model	Value	Registered?

Has anyone transferred, sold, traded or given away money, vehicles, property or other resources, closed any bank accounts or purchased annuities in the last 60 months? Yes No

If yes, list date: _____ What was given: _____ Value: _____ Total Sale Price: _____

Have you or your spouse executed a trust, annuity, court order and/or purchased a promissory note, loan or life estate?

Yes No If yes, attach a copy(ies) of the document(s) with this application.

Be aware that by virtue of the provisions of medical assistance for institutional care, amenities purchased on or after February 8, 2006 must name the State of Nevada as remainder beneficiary.

INCOME INFORMATION

Do you or your spouse receive income from any source other than Social Security? Yes No

Person	Frequency	Amount



SPOUSE INFORMATION

Please complete the following about your current and previous spouse, even if you are separated, but not divorced. If your spouse is deceased, all possible information must still be completed.

Spouse Name:			
Address:			
Social Security #:		Date of Birth:	
Are you divorced? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you separated? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Divorce:		Date separated:	
		Are you widowed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Date Widowed:	
Employer Name/Address:		Medical Insurance Information:	
		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			Years employed:
Railroad or government Claim #:			
Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No		Claim #:	

Spouse Name:			
Address:			
Social Security #:		Date of Birth:	
Are you divorced? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you separated? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Divorce:		Date separated:	
		Are you widowed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Date Widowed:	
Employer Name/Address:		Medical Insurance Information:	
		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			Years employed:
Railroad or government Claim #:			
Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No		Claim #:	

In order to assist us in processing your application timely, please provide verification of any income and resources you have listed on this form. Provide copies of the most current bank statement for all accounts, value of life insurance policies, and vehicle registration.

Client Signature	Print Name	Date	Telephone Number
Spouse Signature	Print Name	Date	Telephone Number

For Office Use Only

Telephone call to applicant (Date): _____ Copy of form mailed to applicant (Date): _____

