STEVE SISOLAK
Governor

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

RICHARD WHITLEY, MS
Director

STEVE H. FISHER
Administrator

Medical Assistance Addendum

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

Case Information

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

Who needs to be included on this addendum:

- your spouse, if married
- your children who live with you
- your partner who lives with you (but only if you have children together who need medical assistance)
- anyone you include on your federal tax return, **whether they live with you or not**
- **If you don't file a tax return, remember to still add family members who live with you.**

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

☐ Yes **If yes**, who? _____ **and** answer questions 1-3
☐ No **If no**, skip to question 3

1. Filing Status
Check only one box.

☐ Single
☐ Married filing jointly
☐ Married filing separately

Name of spouse/partner:

2. Dependents

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

3. Are you being claimed as a dependent on someone else's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer:
How are you related to the tax filer?

Please list all members requesting medical assistance:

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

Deductions (Only list deductions reported on IRS form 1040): Check all that apply and give amount and how often.

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could reduce your countable income. **Note:** You shouldn't include a cost that you already considered in your answer to net self-employment.

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

Health Insurance Information

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

Does anyone have health insurance available through their employer? ☐ Yes ☐ No

If yes, provide the following information:

Who has other health insurance?	What type do they have?	Name of Plan	Policy Number
Name:			
Name:			
Name:			
Name:			

Third Party Liability

I understand the following is an eligibility requirement to receive medical assistance:

1) If anyone on this addendum receives medical assistance, I give the Medicaid agency the right to pursue and get any money from other health insurance, insurance, legal settlements, or other third party that may be liable for the medical services paid by Medicaid; and
2) I give the Medicaid agency the right to pursue and get child and medical support from a spouse or a parent; and
3) I agree my household members will cooperate with the Medicaid agency to obtain any money from insurance companies, legal settlements and third parties and will give DHHS notice of any settlements or legal action.

Referral Information:

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

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

Health Plan Selection:

NOTE: If you do not choose a health plan preference, we will choose a plan for you.

Families who live in urban Washoe County or urban Clark County are covered by a managed care organization (MCO). You are being asked to choose one of the following health plans. If you do not indicate a health plan preference on your addendum, we will choose a plan for you. Your choice of health plan does not guarantee acceptance into the Nevada Medicaid or Nevada Check Up programs. We might not honor your choice of plans if you or any family members have been enrolled in one of our current managed care organizations. Once enrolled, families will receive a member handbook explaining their health plan benefits. You can contact the numbers below for specific information regarding the health plans.

Please choose one of the following health plans:

☐ **Anthem Blue Cross and Blue Shield Healthcare Solutions:** 1-844-396-2329
mss.anthem.com/nevada-medicaid/home.html

☐ **Health Plan of Nevada:** 1-800-962-8074
myHPNmedicaid.com

☐ **Silver Summit Healthplan:** 1-844-366-2880
silversummithealthplan.com

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

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

Privacy Policy

We keep your information private as required by law. Your answers on this addendum will only be used to determine eligibility for medical assistance or help paying for coverage. Nevada Health Link, the Division of Welfare and Supportive Services (DWSS) and the Department of Health and Human Services (DHHS) will check your eligibility using our electronic databases and the databases of other federal agencies. If the information does not match, we may ask you to send us proof. We won't ask any questions about your medical history. Household members who don't want coverage won't be asked questions about citizenship or immigration status.

DWSS needs this information to check your eligibility for medical assistance and help paying for coverage if you want it and to give you the best service possible. DWSS may also check your information at a later time to make sure your information is up to date. DWSS will notify you if we find out that something has changed.

As part of the application process, we may need to retrieve your information from the **Internal Revenue Service (IRS)**, **Social Security**, the **Department of Homeland Security** and/or a consumer reporting agency. We will verify this information through computer matching programs, including the **Income and Earnings Verification System (IEVS)**. This information will also be used to monitor compliance with program regulations and for program management.

I agree to allow my information to be used and retrieved from data sources for this addendum. I have consent for all people I will list on the addendum, allowing their information to be retrieved and used from the above-mentioned data sources.

Your Responsibilities

You must report to the DWSS if information on your SNAP/TANF application or this addendum changes. You must report any changes by contacting the DWSS customer service by the 5th of the following month; individuals approved under the aged, blind, or disabled Medicaid program have until the 10th of the following month to report changes. Changes may affect your household's eligibility.

Nevada law mandates that "a person who is a recipient of Medicaid or insurance pursuant to the Children's Health Insurance Program may not opt out of having his or her individually identifiable health information disclosed electronically" (NRS 439.538). When a patient is no longer a Medicaid recipient, it is the patient's responsibility to change their consent choice. At any time, you may revoke your consent by signing a new consent form and giving it to your doctor. These forms are available at your doctor's office.

American Indian or Alaska Native

Tribal members who enroll in Medicaid, Nevada Check Up and through the Nevada Health Link can also get services from the Indian Health Services, Tribal Health Programs or Urban Indian Health Programs.

If you or your family members are American Indian or Alaska Native, you may not have to pay premiums or cost sharing. We will ask additional questions to make sure you and your family get the most help possible. Tribal Affiliation Cards are required.

Medicaid Estate Recovery

Medicaid recipients who are 55 years or older or inpatients of a medical facility may be responsible for repayment of Medicaid expenses paid for them. Recovery of these payments made from the Medicaid Program would be pursued from the estate of the recipient after their death or after the death of their surviving spouse.
(See DWSS Form 6160-AF, Program Operation.)

Important Child Support Information

By signing this addendum and by receiving Medicaid benefits, you agree to assign your child support rights to the State of Nevada, Division of Welfare and Supportive Services (DWSS). This is a condition of eligibility for parents or adult caretakers to receive Medicaid. If you are receiving Medicaid, any court ordered or stipulated child support paid directly to you are required to be reported to the DWSS or Child Support Enforcement (CSE).

When applying for Medicaid benefits, the law requires you to cooperate with CSE to establish paternity to get child support and medical support owed to you and any children for which you are applying. Good cause for not cooperating in pursuing child support or paternity may be allowed if you think that cooperating to collect support will harm you or your children. If you do not cooperate with CSE and good cause was not established, the medical assistance eligibility for the parents or adult caretakers in your household could be affected.

Your Right to a Hearing

You can request a conference or a hearing if you disagree with our decision or think we have not acted timely on your addendum. **You may ask for a hearing in person, in writing, or by phone**. A request must be submitted within 90 days of the date of the notice of decision. The notice will have more information about the hearings process. If you need help, you can have someone else act on your behalf, but written permission must be received by DWSS before the conference/hearing. If you disagree with the hearing decision, you can appeal your case to your local District Court of the State of Nevada.

Overpayments, Case Reviews and Investigations

By signing this addendum, you authorize the Department of Health and Human Services to investigate your household's circumstances used to determine eligibility for Medicaid benefits. Information provided by the applicant, beneficiary, or authorized representative in connection with this addendum will be subject to verification by Federal, State or local officials to determine if the information is factual. If the information is determined to be incorrect, your Medicaid benefits may be denied, terminated, or reduced if you do not cooperate with an investigation.

Making false or misleading statements, misrepresenting, concealing or withholding facts used to determine eligibility may also result in future program disqualification and criminal prosecution per state and federal laws.

You are responsible for repayment of all benefits you were not entitled to receive. Medicaid benefits and all costs associated with administering the program, including capitation fees paid to managed care organizations on your behalf are part of this repayment.

Please read and sign this addendum

- I declare under penalty of perjury, information I gave in this addendum is true, correct, and complete to the best of my knowledge.
- I understand the questions on this addendum and the penalty for hiding or giving false information.
- I agree to notify the Division of Welfare and Supportive Services of any changes in my household circumstances that may affect my benefits.
- I understand failure to report changes may cause an overpayment that I will be responsible to pay back, and for which I could even be prosecuted in a court of law.
- I swear I have honestly reported the citizenship status of myself and anyone I am applying for.

Release of Information

- I hereby authorize and consent to the release of all information concerning me or my household members to the Department of Health and Human Services by the holder of the information such as, but not limited to, wage information, information made confidential by law, as well as patient information privileged under NRS 49.225, or any other provision of law. I hereby release the holder of the information from liability, if any, resulting from the release (disclosure) of the required information.
- If I am 60 years of age or older, I hereby consent to the disclosure of my identity and waive my rights as an older person to have my identity kept confidential. I hereby release the holder of information from liability, if any, resulting from the release (disclosure) of the required information.

_____ _____/_____/_____
Signature or Mark of Applicant Date

_____ _____/_____/_____
Signature or Mark of Spouse/Partner (Second Parent of Children) Date

Witness: (Required if applicant cannot read or write or is blind.)

The information in this addendum has been read to the applicant and I have witnessed the above signature.

_____ _____/_____/_____
Signature of Witness Date

_____ _____/_____/_____
Signature of Case Manager Date

Mail Your Completed Addendum.

Submit your addendum to the local DWSS District Office, or mail your addendum to:

DWSS
PO Box 15400
Las Vegas, NV 89114

Did you remember to:

- ✓ Tell us about everyone in the family & household, even if they don't need insurance?
- ✓ Attach verification of current monthly income?
- ✓ Attach copy of insurance card (front & back)?
- ✓ Sign this addendum?

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