Application for Uninsured Medical Coverage

You can use this application to:

- Apply for assistance to cover services related to testing and diagnosis of COVID-19 that are provided during the emergency period.
    - ***This application does not provide full medical coverage***. The health coverage you will get if you are found eligible, using this application will only pay for medical tests for COVID-19. It will not help you pay for other medical costs, including doctor visits, hospital care, or prescriptions.
- In order to be eligible for these services as an uninsured individual, you must meet the following criteria:
    - Not be eligible to receive coverage under a mandatory Medicaid category.
    - Not be enrolled in Medicaid coverage, except those who are enrolled in a limited-benefit Medicaid eligibility group.
    - Not be enrolled in another health care program funded by the federal government.
    - Not be enrolled in a group health insurance coverage offered by a health insurance issuer.
    -
- If you or your family members may be eligible for Medicaid or Nevada Check-Up, you are encouraged to apply for those benefits. You can apply for medical assistance through Access Nevada at https://dwss.nv.gov/.

Completing the application.

The following criteria must be met to be eligible for uninsured medical coverage.

- Resident of Nevada;
- Social Security Number (if you do not have a social security number, we can help you apply for one);
- U.S. citizen or national or legal immigration status.

This is not an application for full Medicaid benefits.

Individuals applying for uninsured medical coverage will have their coverage terminated at the end of the emergency period for COVID-19.

Contact Information *One adult should be the contact person. The contact person does not have to apply for coverage.*

First Name: **Middle Name:** **Last Name:** **Suffix**

Home Address: *(leave blank if you don't have one)* **Apartment Number:**

City: **State:** **Zip Code:**

If you don't have a permanent address, you still need to give a valid mailing address.

Mailing Address: *(if different than home address)* **Apartment Number:**

City: **State:** **Zip Code:**

Daytime Phone # Ext. Secondary Phone # Ext.

Currently, all notifications are sent in paper format. In the future, if available, would you like to receive information by:

Email: ☐ Yes ☐ No Email address: ____

Preferred language (if not English): ☐ Spanish ☐ Other: ________________________ Interpreter needed? ☐ Yes ☐ No

Applicant Information

First name:	Middle name:	Suffix:	Date of Birth (mm/dd/yy)

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Sex: ☐ Male ☐ Female

Social Security Number (SSN): __________|__________|__________

We need your SSN if you want to apply for COVID-19 testing coverage. We use SSNs to check to see who is eligible for help paying for health coverage. For more information on getting a SSN, visit www.dwss.nv.gov, or call DWSS Customer Service at 800-992-0900 (voice) or 800-326-6888 (TTY).

Are you a U.S. citizen or national? ☐ YES ☐ NO

If not a U.S. citizen, do you have eligible immigration status? ☐ YES

Enter document type and ID number

Document Type: ________________________________ **ID Number:** ________________________________

Additional information:

RACE / ETHNICITY

Are you Hispanic, Latino or of Spanish origin? *(optional)* ☐ Yes ☐ No

Race (optional) - check all that apply

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other

HEALTH INSURANCE INFORMATION

Do you currently have medical insurance? ☐ YES ☐ NO If yes, provide name: ________________________________
(Medicare, Medicaid, TRICARE, Group Health Plan)

Were you terminated from Medicaid coverage on or after March 18, 2020? ☐ YES ☐ NO ☐ DON'T KNOW
You may be eligible to get Medicaid again now.

Have you applied for and been denied Medicaid coverage on or after March 18, 2020? ☐ YES ☐ NO ☐ DON'T KNOW
You may be eligible to get Medicaid again now.

Have you already been tested for, or diagnosed with COVID-19? ☐ YES ☐ NO **If yes,** on what date:

Third Party Liability

I understand the following is an eligibility requirement to receive Medicaid benefits:

- If I receive Medicaid benefits, I give the Medicaid agency the right to pursue payment or reimbursement from other health insurance, insurance, legal settlements, and any other third party that may be liable for the medical services paid by Medicaid; and
- I agree my household members will cooperate with the Medicaid agency to obtain any money from insurance companies, legal settlements and third parties and will give DHHS notice of any settlements or legal action.

Initial ______________

Non-Discrimination

Following federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity or disability. You can file a complaint of discrimination by visiting http://www.hhs.gov/ocr/office/file; or you may write: HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Ave, S.W. Washington, D.C. 20201; or call (202) 619-0403 (voice) or (202) 619-3257(TTY).

Reviews and Investigations

By signing this application, you are authorizing the Department of Health and Human Services to make investigations concerning you that may be necessary to determine eligibility for benefits you receive under programs administered by the DWSS and Nevada Health Link. Information provided to the agency may be verified or investigated by federal, state and local officials including quality control staff.

You must cooperate in the investigation or your benefits may be denied or terminated. If you knowingly make a statement which is false or misleading; provide documents that have been altered; or conceal or withhold information that is necessary for the agency to make an accurate determination of the benefits for which you are eligible, your benefits may be denied, terminated or reduced. If you receive benefits for which you are not entitled, you must repay the agency for all money, services, and benefits you were not entitled to receive. You may also be disqualified from receiving future benefits and be criminally prosecuted or penalized according to state and federal law.

Initial ______________

Your Rights

If you think we made a mistake or have not acted timely on your application, you can appeal. That means you can ask us to look at your case again. You must request an appeal in writing within 90 days of the date of the notice. The notice will tell you how to appeal. You may appoint a representative to act for you in the appeals process. Contact us, and we can help you with your appeal.

Initial ______________

Your Responsibilities

I know that I must report if information I listed on this application changes. I know I can make changes by calling customer service and that I must report by the fifth (5th) of the following month. I understand that a change in my information could affect my eligibility.

Initial ______________

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.

____ _____|_____|______

Your Signature Date

Privacy Policy

We keep your information private as required by law. Your answers on this application will only be used to determine eligibility for assistance to cover services related to testing and diagnosis of COVID-19 that are provided during the emergency period. The Division of Welfare and Supportive Services and the Department of Health and Human Services 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.

IMPORTANT: As part of the application process, we may need to retrieve your information from Social Security and/or the Department of Homeland Security. We need this information to check your eligibility for coverage. We may also check your information at a later time to make sure your information is up to date. We'll notify you if we find something has changed.

I understand my information will be used and retrieved from data sources for this application.

Initial _____________

Please Read and Sign This Application.

- I'm signing this application under penalty of perjury, which means I've provided true answers to all of the questions to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.

____ _____|_____|_______

Signature or Mark of Applicant Date

Witness: (Use if applicant cannot read or write, or is blind.)
The information in this application has been read to the applicant and I have witnessed the above signature.

____ _____|_____|_______

Signature of Witness Date

Mail Your Completed Application.

Submit your application to the local Welfare Office or, mail your application to:

PO BOX 15400
Las Vegas, NV 89114

Did you remember to:

- ✓ Sign this application?