STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF WELFARE AND SUPPORTIVE SERVICES
1470 College Parkway
Carson City, Nevada 89706-7924
Medicaid Estate Recovery – (775) 684-3716

MEDICAID ESTATE RECOVERY
NOTIFICATION OF PROGRAM OPERATION

If you are applying for or receiving benefits from the Medicaid Program, this document contains important information which may affect your decision about using the Medicaid Program. Recovery is not pursued until after the death of the Medicaid recipient and only after the death of the individual's surviving spouse and only at a time when there is no surviving child under age 21; or, no surviving child who is blind and/or disabled of any age. With court approval the State may place a lien against the property of a deceased Medicaid recipient for recovery when none of the exemptions are present.

Pursuant to state and federal law, the Nevada State Department of Health and Human Services administers a Medicaid Estate Recovery Program whereby Medicaid assistance is recovered from the estate of the person who received benefits after October 1, 1993. Medicaid recipients aged 55 or older (OR an inpatient of a medical facility) are affected by this program and may be required to pay, from their estate, all Medicaid benefits paid on their behalf. Medicaid payments subject to recovery include: medical assistance of home and community-based services, nursing facility services, related hospital, doctor, prescription drug services, Medicare Part A and B premiums, fees paid for Medicaid co-insurance and deductibles prior to 01/01/2010 and any other payments made by the Medicaid Program.

Federal Law (42 U.S.C. 1396p) and State law (NRS 422.054) defines undivided estate. The state defines undivided estate as all real and personal property and other assets included in the estate of a deceased recipient of Medicaid and any other real and personal property and other assets in or to which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, annuity, homestead or other arrangement. **Claims brought by the state for the recovery of correctly paid Medicaid benefits shall not be defeated by a claim of homestead exemption or by the operation of bankruptcy or insolvency law.**

Medicaid Estate Recovery may initiate property liens against the real property of Medicaid recipients if:

1. With the approval of the court, any individual prior to his death received incorrectly paid benefits.
2. A deceased Medicaid recipient aged 55 or older held an interest or legal title to real property prior to or at the time of death, action may be taken to initiate a property lien. No lien may be placed without the judgment of the court. Recovery will be delayed until the death of the surviving spouse, and only at the time, there are no children under the age of 21, or children who may be blind and/or disabled.

The following income, resources, and property are exempt from Medicaid estate recovery:

1. Certain income and resources of American Indians and Alaska Natives. Income and resources (such as interests in and income derived from Tribal land and other resources currently held in trust status and judgment funds from the Indian Claims Commission and the U.S. Claims Court) that are exempt from Medicaid estate recovery by other laws and regulations;
2. Ownership interest in trust or non-trust property, including real property and improvements:
   a. Located on a reservation (any federally recognized Indian Tribe's reservation, Pueblo, or Colony, including former reservations in Oklahoma, Alaska Native regions established by Alaska Native Claims Settlement Act and Indian allotments) or near a reservation as designated and approved by the Bureau of Indian Affairs of the U.S. Department of the Interior; or

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.

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	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: _____ (Name of Person) **Where:** _____ (City, County, State) **When:** _____ (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.

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** | OING | 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:	— —						

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

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 _____

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

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

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

2920 – EM/A (10/09)

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 nonpartisan 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? ☐ Yes ☐ No
Will you be 18 years of age or over on or before Election Day? ☐ Yes ☐ No
If you checked "no" in response to either of these questions, do not complete this form.

2 Check boxes that apply and complete items 3-14
☐ New Registration ☐ Party Affiliation Change
☐ Name Change ☐ 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
- ☐ Democratic Party
- ☐ Independent American Party
- ☐ Libertarian Party
- ☐ Nonpartisan (no party affiliation)
- ☐ Republican Party
- ☐ 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."

↓ SIGNATURE OF APPLICANT (REQUIRED) ↓

↓ DATE (REQUIRED) ↓

_____ / _____ / _____
(MM / DD / YYYY)

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

☐ AGENCY
☐ FIELD REGISTRAR
☐ MAIL
☐ OTHER

CANCELLED
INACTIVE
PRECINCT

APPLICATION NO. **HA**

RECEIVED BY:

↑ Detach Here ↑ ↑ Detach Here ↑ ↑ Detach Here ↑

NAME OF PERSON RETAINING THIS APPLICATION
(AGENCY STAMP OR NAME OF AGENT, ELECTION OFFICIAL OR PERSON RETAINING APPLICATION)

PRINT NAME OF PERSON RETAINING FORM

ELECTION OFFICIAL OR AGENCY
Contact Information, Address, Telephone, Fax

VOTER APPLICATION RECEIPT
(Please Retain Receipt)

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**