
Table of Contents

State/Territory Name: Nevada

State Plan Amendment (SPA) #: NV-13-0004

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) SPA Summary Form
- 3) Approved SPA Pages
- 4) Additional Attachments that are part of the state plan

The complete title XXI state plan for Nevada consists of the most recent state plan posted on Medicaid.gov under CHIP and State Plan Amendments. The link is provided below. The following approved templates are in addition to, or replace sections of the state's posted current state plan. The attached approval letter(s) explain how these templates fit into that state plan.

Link to state title XXI state plans and amendments: <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/CHIP-State-Program-Information.html>

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850



Children and Adults Health Programs Group

MAY 07 2015

Ms. Nova Murray
Division of Health Care Financing and Policy
1000 East William Street, Suite 200
Carson City, NV 89701

Dear Ms. Murray:

I am pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved Nevada's Children's Health Insurance Program (CHIP) state plan amendment (SPA), NV-13-0004 submitted on December 16, 2013. This SPA incorporates the Modified Adjusted Gross Income (MAGI)-based eligibility process requirements in accordance with the Affordable Care Act and implementing regulations. The effective date of this SPA is October 1, 2013.

The approval of SPA NV-13-0004 includes full approval of the state's alternative paper application. The state is using an interim alternative single streamlined online application. By August 31, 2015, the state will implement a revised alternative single streamlined online application that addresses CMS concerns outlined in the companion letter issued with this SPA approval.

Enclosed is a copy of the following state plan pages and attachments to be incorporated within a separate section at the end of Nevada's approved state plan:

- Template CS24 – Separate Child Health Insurance Program
- Attachment 1 – Statement of use with respect to the alternative single streamlined online application
- Attachment 2 – Alternative single streamlined paper application

This approval and the enclosures supercede the following sections of the current CHIP state plan:

- Section 4.3: Single Streamlined Application Screen and Enroll Process
- Section 4.4: Renewals, Screening by Other Insurance Affordability Programs

The CMS appreciates the significant amount of work your staff dedicated to preparing this State Plan Amendment. Your title XXI project officer is Ms. Joyce Jordan. She is available to answer questions concerning this amendment and other CHIP-related issues.

Page 2 – Ms. Nova Murray

Ms. Jordan's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Blvd.
Baltimore, MD 21244-1850
Telephone: (410) 786-3413
Facsimile: (410) 786-5882
E-mail: Joyce.Jordan@cms.hhs.gov

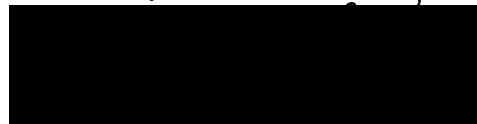
Official communications regarding program matters should be sent simultaneously to Ms. Jordan and Ms. Hye Sun Lee, Acting Associate Regional Administrator, in our San Francisco Regional Office. Ms. Lee's address is:

Ms. Hye Sun Lee
Centers for Medicare and Medicaid Services
Office of the Regional Administrator
90-7th Street, Suite 5-300
San Francisco, CA 94103-6706

If you have additional questions, please contact Ms. Kelly Whitener, Director, Division of State Coverage Programs at 410-786-0719.

We look forward to continuing to work with you and your staff.

Sincerely,



ELIOT FISHMAN
Director



Enclosure

cc:

Hye Sun Lee, Acting ARA, CMS San Francisco Region

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850



Children and Adults Health Programs Group

MAY 07 2015

Ms. Nova Murray
Division of Health Care Financing and Policy
1000 East William Street, Suite 200
Carson City, NV 89701

Dear Ms. Murray:

This letter is being sent as a companion to the Centers for Medicare & Medicaid Services (CMS) approval of Nevada's Children's Health Insurance Program (CHIP) state plan amendment (SPA), NV-13-0004, which was submitted to CMS on December 16, 2013. Our review of this submission included a review of the alternative single streamlined paper and online applications developed by the state.

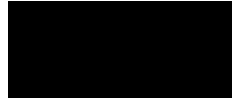
Until August 31, 2015, the state will use an interim alternative single streamlined online application. The interim alternative online application needs to be revised to reflect the following changes.

Necessary changes:	Date by which changes will be completed:
1. The state will add a solution concerning residency and citizenship along with the permanent solution concerning suppression of the PDF verification form that displays at the end of the process.	August 31, 2015
2. The state will add a permanent solution to modify the income type table and move the child support disclaimer.	August 31, 2015
3. The state will add a permanent solution to modify the household determination sequence and add ESI information.	August 31, 2015

Page 2 – Ms. Nova Murray

Please submit the revised alternative single streamlined online application to CMS for review no later than July 31, 2015 to ensure approval by August 31, 2015. We continue to be available to provide technical assistance. If you have any questions about your application, please contact Ms. Victoria Collins at Victoria.Collins@cms.hhs.gov or (410) 786-2167. We look forward to continuing to work with you and your staff.

Sincerely,



Kelly Whitener
Director
Division of State Coverage Programs

cc:

Ms. Hye Sun Lee, Acting ARA, CMS San Francisco Region

logged in as TONIABROWN(CMS CO Staff)

read only mode

application rev p01

Children's Health Insurance Program Eligibility

NV.0613.R00.00 - Oct 01, 2013

Home

Logout

Finder

Save

Validate

Print

Help

Control Panel**General Information****File Management****Tribal Input****Summary**

Children's Health Insurance Program Eligibility: Summary Page

State/Territory name: Nevada

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

Type of SPA:

- MAGI Eligibility & Methods
- XXI Medicaid Expansion
- Establish 2101(f) Group
- Eligibility Processing
- Non-Financial Eligibility

Proposed Effective Date

(mm/dd/yyyy)

Federal Statute/Regulation Citation

Federal Budget Impact
 This SPA has a budget impact.

Total budget impact:

State Funds:

\$

Federal Funds:

\$

Subject of Amendment

Please provide a brief summary of SPA changes.

Character Count: 27 out of 2000

Signature of State Agency Official

Submitted By: Robyn Heddy

Last Revision Date: Jun 2, 2015

Submit Date: Dec 16, 2013

[FAQs](#) | [Site Map](#) | [Contact](#) | [Medicaid.gov](#) | [CMS.gov](#)



CHIP Eligibility

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Separate Child Health Insurance Program General Eligibility - Eligibility Processing

CS24

2102(b)(3) & 2107(e)(1)(O) of the SSA and 42 CFR 457, subpart C

- The CHIP Agency meets all of the requirements of 42 CFR 457, subpart C for application processing, eligibility screening and enrollment.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard:

- The single, streamlined application developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act.
- An alternative single, streamlined application developed by the state and approved by the Secretary in accordance with section 1413(b)(1)(B) of the Affordable Care Act.

An attachment is submitted.

- An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

- The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in CFR 457.340(a), by telephone, via mail, in person and other commonly available electronic means.

The agency accepts applications in the following other electronic means.

- Other electronic means:

	Name of method	Description	
+	Facsimile	Will be considered an original document	X

Screen and Enroll Process

- The CHIP Agency has coordinated eligibility and enrollment screening procedures in place that are applied at time of initial application, periodic redeterminations, and follow-up eligibility determinations. The procedures ensure that only targeted low-income children are provided CHIP coverage and that enrollment is facilitated for applicants found to be potentially eligible for other insurance affordability programs.

Procedures include:



CHIP Eligibility

- Screening of application to identify all individuals eligible or potentially eligible for CHIP or other insurance affordability programs; and
- Income eligibility test, with calculation of household income consistent with 42 CFR 457.315 for individuals identified as potentially eligible for Medicaid or other insurance affordability programs based on household income; and
- Screening process for individuals who may qualify for Medicaid on a basis other than having household income at or below the applicable MAGI standard, based on information in the single streamlined application.

The CHIP agency has entered into an arrangement with the Exchange to make eligibility determinations for advanced premium tax credits in accordance with section 1943(b)(2) of the SSA.

No

Redetermination Processing

- Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 457.343:
 - Once every 12 months.
 - Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency.
- If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

Screening by Other Insurance Affordability Programs

- The CHIP Agency provides assurance that it has adopted procedures to accept and process electronic accounts of individuals screened as potentially eligible for CHIP by other insurance affordability programs in accordance with the requirements of 42 CFR 457.348(b) and to determine eligibility in accordance with 42 CFR 457.340 in the same manner as if the application had been submitted directly to, and processed by the state.
- The CHIP Agency elects the option to accept CHIP eligibility decisions made by the Exchange or other agencies administering insurance affordability programs as provided in 42 CFR 457.348 and to furnish CHIP in accordance with requirements of 42 CFR 457.340 to the same extent and in the same manner as if the applicant had been determined by the state to be eligible for CHIP.
- The CHIP Agency has entered into an agreement with agencies administering other insurance affordability programs to fulfill the requirements of 457.348(b) and will provide this agreement to the Secretary upon request.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130709

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION

Paper Application Online Application

TRANSMITTAL NUMBER:

NV-13-0004

STATE:

Nevada

Through August 30, 2015, the state is using an interim alternative single streamlined application. After August 30, 2015, the state will use a revised alternative single streamlined application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.



MAY 07 2015

Application for Health Insurance

You can use this application to:

- Apply for free or low-cost insurance from Medicaid or Nevada Check-Up.
 - You can apply for and receive Medicaid, even if you already have insurance.
- If you or your family members are determined to be ineligible for Medicaid or Nevada Check-Up, you may still qualify for help paying for health insurance from the federal government. A referral will be sent to Nevada Health Link. For additional information, visit their website at www.nevadahealthlink.com or call 855-768-5465.

Access your benefits faster.

Apply Online

Did you know that you can apply, enroll and start using your health benefits sooner by submitting your application online?

- Takes about 45 minutes for a typical household
- Follow the prompts and, when finished, click "SUBMIT"
- Once you create an account, you can check the status of your benefits online.

Go to: www.dwss.nv.gov

Get assistance with your application.

Personal Assistance

You can get personalized assistance completing your application at one of the Division's district offices or a Family Resource Center.

To find a location nearest your home:

Call 1-800-992-0900 (voice) or 1-800-326-6888 (TTY) or visit www.dwss.nv.gov

Fill out the attached paper application.

A handwritten, paper application is an option for those who must use paper.

By Mail

- Follow the instructions and complete ALL areas that apply to you and your family.
- Submit your application to the local Welfare Office or mail to: DWSS
PO Box 15400
Las Vegas, NV 89114

Contact Information (We will need to contact an adult member of the family.)				
First Name:	Middle Name:	Last Name:	Suffix	Date of Birth
Home Address:			Apartment Number:	
City:		State:	Zip Code:	
<i>If you don't have a permanent address, you still need to give a valid mailing address.</i>				
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:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Email address: _____		
Preferred language (if not English): <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____			Interpreter needed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Household Information				
Your income and family size help us decide what programs you qualify for. With this information, we can make sure everyone gets the most coverage possible.				
Who needs to be included on this application:				
<ul style="list-style-type: none"> • 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 health insurance) • 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. 				
Anyone else who lives with you will need to file their own application if they want insurance. You don't need to file taxes to apply for health insurance.				
Complete the Additional Member pages for each person in your family. Start with yourself. If you have more than 2 people in your family, you will need to make a copy of the 'Additional Member' pages and complete.				
We need Social Security Numbers (SSNs) for everyone applying for health insurance that has one. An SSN is optional for people not applying for insurance, but providing one can speed up the application process. Please ensure the name is listed the same as it is displayed on your Social Security Card.				
American Indians or Alaska Natives (AI/AN) who enroll in Medicaid, Nevada Check-Up and the Silver State Health Insurance Exchange 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 and may get special monthly enrollment periods. We will ask additional questions to make sure you and your family get the most help possible.				

Head of Household Information

First Name, MI, Last Name & Suffix	Marital Status	If married, do you live with your spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship to you? SELF
Social Security Number (OPTIONAL) _____ - _____ - _____	Date of Birth ____/____/____	Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Due Date: _____ If yes, how many babies are expected: _____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female

Do you plan to file a federal income tax return NEXT YEAR?

Yes **If yes, answer questions 1 - 3** No **If no, skip to question 3**

Note: You can still apply for health insurance even if you don't file a federal tax return.

1. Do you expect to file a joint return with a spouse/partner? Yes No

If yes, name of spouse/partner: _____

2. Will you claim any dependents on your tax return? Yes No

If yes, list name(s) of dependents: _____

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? _____

Are you applying for Medicaid, Nevada Check-Up or assistance with your health insurance premiums (Advanced Premium Tax Credit - APTC)?

Yes **If yes, answer all the questions below.** No **If no, skip to the income questions.**

Note: Marking 'Yes' means you will be evaluated for federally funded medical assistance.

Social Security Number - REQUIRED if not listed above _____ - _____ - _____	If you are a child, under the age of 19, do you have access to public employee coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	---

Are you a U.S. citizen? Yes No Have you lived in the U.S. since 1996? Yes No

If not a U.S. citizen, do you have eligible immigration status? Yes No

If yes, provide the following information: _____ **Type:** _____ **ID Number:** _____

Are you, your spouse, domestic partner or your parent (if you are a minor) an honorably discharged veteran or active duty member of the military? Yes No

Are you a full-time student? Yes No

Are you an American Indian or Alaskan Native? Yes No

If yes, what tribe? _____

If under age 26, have you ever been in foster care? Yes No **If yes, what state?** _____

Age when you left the program? _____ Did you receive health care through a state Medicaid program? Yes No

Are you the parent or primary caretaker relative of any child(ren), under the age of 19, in the household?

Yes No **If yes, who?** _____

Do you have medical bills for the past three months that you need help with? Yes No

If yes, what months? _____

Head of Household Information continued:

Are you legally blind or permanently disabled? Yes No

Are you receiving Supplemental Security Income (SSI)? Yes No

Do you need help with activities of daily living through personal assistance services or a medical facility?
 Yes No

Current Job and Income Information **Not employed - Skip to 'Other Income' section**

CURRENT JOB:

In the past 3 months, did you: Change jobs Stop working Work fewer hours None of these

Employer Name: (if self-employed, write 'SELF')	Average hours worked each week
---	--------------------------------

Employer Address:	Employer Phone Number: ()
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City:	State:	Zip Code:
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Gross wages/tips per pay period: \$	How often are you paid?	<input type="checkbox"/> Weekly	<input type="checkbox"/> Every 2 weeks
	<input type="checkbox"/> Semi-Monthly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Annually

If self-employed, please answer the following questions:

Type of work: _____

How much net income (profits once expenses are paid) will you receive this month? \$ _____

OTHER INCOME: Check all that apply and give amount and how often you receive it.

Note: You don't need to tell us about child support or veteran's disability payments. Certain money received may or may not be counted for Medicaid and Nevada Check-Up. Let us know if any money received is considered tribal income.

				Tribal Income?
<input type="checkbox"/> None				
<input type="checkbox"/> Unemployment	\$ _____	How often?	_____	
<input type="checkbox"/> Retirement	\$ _____	How often?	_____	
<input type="checkbox"/> Pensions	\$ _____	How often?	_____	
<input type="checkbox"/> Social Security (RSDI) Benefits	\$ _____	How often?	_____	
<input type="checkbox"/> Interest/Dividends	\$ _____	How often?	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Annuities	\$ _____	How often?	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Rental or Royalty Income	\$ _____	How often?	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Capital Gains	\$ _____	How often?	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Farming or Fishing Income	\$ _____	How often?	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Alimony	\$ _____	How often?	_____	
<input type="checkbox"/> Scholarships & Grants	\$ _____	How often?	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cash Advances	\$ _____	How often?	_____	
<input type="checkbox"/> Gambling Winnings	\$ _____	How often?	_____	
<input type="checkbox"/> Other	\$ _____	How often?	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Head of Household Information continued:**DEDUCTIONS (Only list deductions reported on the 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.

- | | | |
|--|----------|------------------|
| <input type="checkbox"/> Educator expenses | \$ _____ | How often? _____ |
| <input type="checkbox"/> Health savings account | \$ _____ | How often? _____ |
| <input type="checkbox"/> Moving expenses | \$ _____ | How often? _____ |
| <input type="checkbox"/> Alimony | \$ _____ | How often? _____ |
| <input type="checkbox"/> IRA deductions | \$ _____ | How often? _____ |
| <input type="checkbox"/> Business expenses of reservists, performing artists, and fee-basis government officials | \$ _____ | How often? _____ |
| <input type="checkbox"/> Penalty paid on early withdrawal of savings | \$ _____ | How often? _____ |
| <input type="checkbox"/> Student loan interest | \$ _____ | How often? _____ |
| <input type="checkbox"/> Tuition and fees | \$ _____ | How often? _____ |
| <input type="checkbox"/> Domestic production activities | \$ _____ | How often? _____ |

YEARLY INCOME:

If the income you listed on this page is not steady from month to month, please tell us what you expect the yearly income to be. **For example**, some people expect their income to change because they only work some months of the year. If you do not expect a change to your monthly income, skip this question.

Total annual income expected this year: \$ _____ Total annual income expected next year: \$ _____

RACE / ETHNICITY

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

If Hispanic/Latino (check all that apply - optional):

- Mexican Mexican American Puerto Rican Cuban Chicano/a Other

Race (optional) - check all that apply

- | | | |
|---|--------------------------------------|---|
| <input type="checkbox"/> White | <input type="checkbox"/> Filipino | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Japanese | <input type="checkbox"/> Guamanian or Chamorro |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Korean | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Other Asian | <input type="checkbox"/> Other |

Additional Member Information (If you have more than two people to include, make a copy of the Additional Member section and complete.)

First Name, MI, Last Name & Suffix	Marital Status	If married, do they live with their spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship to you?
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Social Security Number (OPTIONAL) ____ - ____ - ____	Date of Birth ____/____/____	Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Due Date: _____ If yes, how many babies are expected: _____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
---	---------------------------------	--	---

Do they plan to file a federal income tax return NEXT YEAR?

Yes **If yes, answer questions 1 - 3** No **If no, skip to question 3.**

Note: They can still apply for health insurance even if they don't file a federal tax return.

- Do they expect to file a joint return with a spouse/partner? Yes No
If yes, name of spouse/partner: _____
- Will they claim any dependents on their tax return? Yes No
If yes, list name(s) of dependents: _____
- Are they 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 they related to the tax filer? _____

Are they applying for Medicaid, Nevada Check-Up or assistance with their health insurance premiums (Advanced Premium Tax Credit - APTC)?

Yes **If yes, answer all the questions below.** No **If no, skip to the income questions.**
Note: Marking 'Yes' means they will be evaluated for federally funded medical assistance.

Social Security Number - REQUIRED if not listed above ____ - ____ - ____	If they are a child, under the age of 19, do they have access to public employee coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	---

Are they a U.S. citizen? Yes No Have they lived in the U.S. since 1996? Yes No

If not a U.S. citizen, do they have eligible immigration status? Yes No

If yes, provide the following information: **Type:** _____ **ID Number:** _____

Are they, their spouse or their parent (if they are a minor) an honorably discharged veteran or active duty member of the military? Yes No

Are they a full-time student? Yes No

Are they an American Indian or Alaskan Native? Yes No

If yes, what tribe? _____

If under age 26, have they ever been in foster care? Yes No **If yes, what state?** _____

Age when they left the program? _____ Did they receive health care through a state Medicaid program? Yes No

Are they a parent or primary caretaker relative of any child(ren), under the age of 19, in the household?
 Yes No **If yes, who?** _____

Do they have medical bills for the past three months that they need help with? Yes No

If yes, what months? _____

Additional Member Information continued:Are they legally blind or permanently disabled? Yes NoAre they receiving Supplemental Security Income (SSI)? Yes NoDo they need help with activities of daily living through personal assistance services or a medical facility?
 Yes No**Current Job and Income Information** **Not employed** - Skip to 'Other Income' section**CURRENT JOB:**In the past 3 months, did they: Change jobs Stop working Work fewer hours None of these

Employer Name: (if self-employed, write 'SELF')

Average hours worked each week

Employer Address:

Employer Phone Number:
()

City:

State:

Zip Code:

Gross wages/tips per pay period:

\$

How often are they paid?

 Weekly Every 2 weeks Semi-Monthly Monthly Annually**If self-employed, please answer the following questions:**

Type of work: _____

How much net income (profits once expenses are paid) will they receive this month? \$ _____

OTHER INCOME: Check all that apply and give amount and how often they receive it.**Note:** They don't need to tell us about child support or veteran's disability payments. Certain money received may or may not be counted for Medicaid and Nevada Check-Up. Let us know if any money received is considered tribal income.

<input type="checkbox"/> None				Tribal Income?
<input type="checkbox"/> Unemployment	\$ _____	How often?	_____	
<input type="checkbox"/> Retirement	\$ _____	How often?	_____	
<input type="checkbox"/> Pensions	\$ _____	How often?	_____	
<input type="checkbox"/> Social Security (RSDI) Benefits	\$ _____	How often?	_____	
<input type="checkbox"/> Interest/Dividends	\$ _____	How often?	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Annuities	\$ _____	How often?	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Rental or Royalty Income	\$ _____	How often?	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Capital Gains	\$ _____	How often?	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Farming or Fishing Income	\$ _____	How often?	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Alimony	\$ _____	How often?	_____	
<input type="checkbox"/> Scholarships & Grants	\$ _____	How often?	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cash Advances	\$ _____	How often?	_____	
<input type="checkbox"/> Gambling Winnings	\$ _____	How often?	_____	
<input type="checkbox"/> Other	\$ _____	How often?	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Additional Member Information continued:**DEDUCTIONS (Only list deductions reported on the IRS form 1040): Check all that apply and give amount and how often.**

If they pay for certain things that can be deducted on a federal income tax return, telling us about them could reduce their countable income. **Note:** Do not include a cost they already considered in their answer to net self-employment.

- | | | |
|--|----------|------------------|
| <input type="checkbox"/> Educator expenses | \$ _____ | How often? _____ |
| <input type="checkbox"/> Health savings account | \$ _____ | How often? _____ |
| <input type="checkbox"/> Moving expenses | \$ _____ | How often? _____ |
| <input type="checkbox"/> Alimony | \$ _____ | How often? _____ |
| <input type="checkbox"/> IRA deductions | \$ _____ | How often? _____ |
| <input type="checkbox"/> Business expenses of reservists,
performing artists, and fee-basis
government officials | \$ _____ | How often? _____ |
| <input type="checkbox"/> Penalty paid on early withdrawal of
savings | \$ _____ | How often? _____ |
| <input type="checkbox"/> Student loan interest | \$ _____ | How often? _____ |
| <input type="checkbox"/> Tuition and fees | \$ _____ | How often? _____ |
| <input type="checkbox"/> Domestic production activities | \$ _____ | How often? _____ |

YEARLY INCOME:

If the income listed on this page is not steady from month to month, please tell us what they expect their yearly income to be. **For example,** some people expect their income to change because they only work some months of the year. If they do not expect a change to their monthly income, skip this question.

Total annual income expected this year: \$ _____ Total annual income expected next year: \$ _____

RACE / ETHNICITY

Are they Hispanic, Latino or of Spanish origin? (optional) Yes No

If Hispanic/Latino (check all that apply - optional):

- Mexican Mexican American Puerto Rican Cuban Chicano/a Other

Race (optional) - check all that apply

- | | | |
|---|--------------------------------------|---|
| <input type="checkbox"/> White | <input type="checkbox"/> Filipino | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Japanese | <input type="checkbox"/> Guamanian or Chamorro |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Korean | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Other Asian | <input type="checkbox"/> Other |

HEALTH INSURANCE INFORMATION

Answer the following questions for everyone who is applying for help to pay for health insurance.

INSURANCE FROM JOBS: (This includes coverage from someone else's job, such as a parent, domestic partner or spouse, and includes private employer plans as well as TRICARE, federal or state employee plans and Peace Corps.)

Is anyone offered health coverage from a job?

Yes **If yes, answer the following questions** No **If no, skip to 'Other Health Insurance'**

We need to know about any health coverage you could get through a job. You can use this form to get information from the employer about health coverage this job offers. **If there is more than one job, copy this page.**

Employee Name:	Employee Social Security Number _____ - _____ - _____
----------------	--

Employer Name:	Employer Identification Number (EIN)	Employer Phone Number (_____) _____ - _____
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Employer Address:	City	State	ZIP Code
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Who can we contact about employee health coverage at this job?	Phone Number: (_____) _____ - _____	Email Address:
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Is the employee currently eligible for coverage offered by this employer?

Yes **If yes, will this job offer coverage NEXT year?** Yes No

No **If the employee is NOT currently eligible, will they be eligible in the NEXT 3 months?** Yes No
If yes, provide date: ___/___/___

Who in the employee's family will the health plan cover? Spouse Domestic Partner Dependent(s)

Who does this plan offer coverage to? (If you need more space, attach another sheet of paper)

Person Name (First Name, MI, Last Name)	Enrolled now, plans to enroll, or not enrolled	Changes you plan to make next year
	<input type="checkbox"/> Enrolled Now <input type="checkbox"/> Plans to Enroll Start Date: ___/___/___ <input type="checkbox"/> Not Enrolled	<input type="checkbox"/> Plans to drop coverage Date: ___/___/___ <input type="checkbox"/> Will become eligible Start Date: ___/___/___
	<input type="checkbox"/> Enrolled Now <input type="checkbox"/> Plans to Enroll Start Date: ___/___/___ <input type="checkbox"/> Not Enrolled	<input type="checkbox"/> Plans to drop coverage Date: ___/___/___ <input type="checkbox"/> Will become eligible Start Date: ___/___/___
	<input type="checkbox"/> Enrolled Now <input type="checkbox"/> Plans to Enroll Start Date: ___/___/___ <input type="checkbox"/> Not Enrolled	<input type="checkbox"/> Plans to drop coverage Date: ___/___/___ <input type="checkbox"/> Will become eligible Start Date: ___/___/___

INSURANCE FROM JOBS (continued):

Does the employer offer a health plan that meets the minimum value standard*? Yes No

For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans):

If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

- a. How much would the employee have to pay in premiums for this plan? \$ _____
- b. How often? Weekly Every 2 weeks Twice a month Once a month Quarterly Yearly

What change will the employer make for the new plan year (if known)?

- Employer won't offer health coverage
- Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard. * (Premium should reflect the discount for wellness programs.)

- a. How much would the employee have to pay in premiums for this plan? \$ _____
- b. How often? Weekly Every 2 weeks Twice a month Once a month Quarterly Yearly
- c. Date of change (mm/dd/yyyy) ____ / ____ / _____

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986.)

OTHER HEALTH INSURANCE INFORMATION

Does anyone have other health insurance, including Veterans, Medicaid/Nevada Check-Up, Medicare, COBRA, Private, or other Retiree Health Plan? 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:			

OTHER INFORMATION**Renewal of Coverage (for APTC households only)**

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow Nevada Health Link to use my income data, including information from tax returns, for the next 5 years (the maximum number of years allowed). The Nevada Health Link will send me a notice, let me make changes, and I can opt out at any time.

I give permission for tax return access at renewal time for the next:

- Yes **If yes, how many years?** 0 Years 1 Year 2 Years 3 Years 4 Years 5 Years
- No **Do not renew my eligibility for help paying for health insurance**

Authorized Representative
You can give a trusted friend or partner permission to talk about this application with us, see your information and act for you on matters related to this application. This person is called an "authorized representative."

Do you want to name someone as your authorized representative? Yes No **If no, skip this section.**

Name of Authorized Representative	Phone Number (_____) _____ - _____
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Address	City	State	ZIP Code
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By signing, you allow this person to sign your application, to get official information about this application and to act for you on all future matters with this agency.

Your Signature _____	Date _____ / _____ / _____
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Medicaid Estate Recovery Program

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 Form 6160-AF, Program Operation.)

Initial _____

Third Party Liability

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

- 1) If anyone on this application receives Medicaid benefits, I give the Medicaid agency the right to pursue and get any money from other health insurance, insurance, legal settlements, and any 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.

Initial _____

Referral Information:

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

<input type="checkbox"/> Covering Kids & Families	<input type="checkbox"/> School	<input type="checkbox"/> Tribal Resources
<input type="checkbox"/> WIC	<input type="checkbox"/> Clinic	<input type="checkbox"/> Friend / Family
<input type="checkbox"/> Other: _____		

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).

**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.

Your 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 89701.

Reviews and Investigations

By signing this application, you are authorizing the Department of Health and Human Services to make investigations concerning you, other members of your household and/or your child(ren)'s legal or natural parent(s) that may be necessary to determine eligibility for benefits you or your household receives 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 tell the program I'll be enrolled in 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 for member(s) of my household.

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.

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 information from liability, if any, resulting from the disclosure of the required information.

Your Signature

____/____/____
Date

Cooperation with Child Support Enforcement

I know I'll be required to cooperate with the agency to collect medical support and establish paternity from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency and I may not have to cooperate.

Initial _____

Does any child on this application have a parent living outside of the home? Yes No

Incarceration

Is anyone applying for health insurance on this application incarcerated (detained or jailed)? Yes No

If yes, write the name of the person incarcerated here: _____

Check here if this person is pending disposition of charges.

Privacy Policy

We keep your information private as required by law. Your answers on this application will only be used to determine eligibility for health coverage or help paying for coverage. Nevada Health Link, 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. Household members who don't want coverage won't be asked questions about citizenship or immigration status.

IMPORTANT: 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 need this information to check your eligibility for coverage and help paying for coverage if you want it and to give you the best service possible. 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. I have consent for all people I will list on the application that allows their information to be retrieved and used from the above-mentioned data sources.

Initial _____

Health Plan Selection (this section applies to Medicaid and Nevada Check-Up households only and does not apply if eligible for APTC):

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 application, we will choose a plan for you. Your choice of health plan does not guarantee acceptance into the Nevada Medicaid or Nevada Check Up program. 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 the health plan benefits and can contact the numbers below for information regarding the health plans.

Amerigroup: 1-800-600-4441
www.amerigroup.com

Health Plan of Nevada: 1-800-962-8074
www.healthplanofnevada.com

Please choose a health plan: _____

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

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
(775) 684-3651

Reno
(775) 687-1900

Las Vegas
(702) 668-4200

Elko
(775) 753-1191

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.
- I swear I have honestly reported the citizenship status of myself and anyone I am applying for.

Signature or Mark of Applicant

____/____/____
Date

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

____/____/____
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:

- ✓ Tell us about everyone in your family & household, even if they don't need insurance?
- ✓ Ask your employer about any job-related insurance?
- ✓ Sign this application?