Table of Contents

State/Territory Name: Nevada

State Plan Amendment (SPA) #: NV-13-0026-MM

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

Division of Medicaid & Children's Health Operations

August 22, 2014

Laurie Squartsoff, Administator
Department of Health and Human Services
Division of Health Care Financing and Policy
1100 East William Street, Suite 101
Carson City, NV 89710

Dear Ms. Squartsoff:

On June 6, 2014, the Centers for Medicare & Medicaid Services (CMS) approved Nevada's State Plan Amendment (SPA) 13-0026-MM with an effective date of October 1, 2013. This SPA included approval for the State to use an interim alternative single streamlined paper application until September 30, 2014.

The CMS has reviewed the changes submitted with respect to Nevada's alternative single streamlined paper application. The revised application addresses the concerns outlined in the companion letter that was issued with the SPA approval. This letter serves as official approval of Nevada's alternative single streamlined paper application.

Enclosed is a copy of the approved alternative single streamlined paper application. Please incorporate these pages into the State Plan following the attachment to S94 entitled "Use of the Alternative Single Streamlined Application."

If you have any additional questions or require any further assistance, please contact Brian Zolynas at (415) 744-3601 or Brian.Zolynas@cms.hhs.gov.

Sincerely,

/s/

Hye Sun Lee
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

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.

Apply Online

Access your benefits faster.

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

Personal Assistance

Get assistance with your application.

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

By Mail

Fill out the attached paper application.

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

• 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:**

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

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:

- 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? ☐ Yes ☐ No	Relationship to you? **SELF**

Social Security Number (**OPTIONAL**)	Date of Birth	Pregnant? ☐ Yes ☐ No Due Date: _____ If yes, how many babies are expected: _____	**Sex** ☐ Male ☐ 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? ☐ Yes ☐ 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: ( )
City: State:	Zip Code:
Gross wages/tips per pay period: $	How often are you 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 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?
☐ None				
☐ Unemployment	$ _____	How often?	_____	
☐ Retirement	$ _____	How often?	_____	
☐ Pensions	$ _____	How often?	_____	
☐ Social Security (RSDI) Benefits	$ _____	How often?	_____	
☐ Interest/Dividends	$ _____	How often?	_____	☐ Yes ☐ No
☐ Annuities	$ _____	How often?	_____	☐ Yes ☐ No
☐ Rental or Royalty Income	$ _____	How often?	_____	☐ Yes ☐ No
☐ Capital Gains	$ _____	How often?	_____	☐ Yes ☐ No
☐ Farming or Fishing Income	$ _____	How often?	_____	☐ Yes ☐ No
☐ Alimony	$ _____	How often?	_____	
☐ Scholarships & Grants	$ _____	How often?	_____	☐ Yes ☐ No
☐ Cash Advances	$ _____	How often?	_____	
☐ Gambling Winnings	$ _____	How often?	_____	
☐ Other	$ _____	How often?	_____	☐ Yes ☐ 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.

☐	Educator expenses	$ _____	How often?	_____
☐	Health savings account	$ _____	How often?	_____
☐	Moving expenses	$ _____	How often?	_____
☐	Alimony	$ _____	How often?	_____
☐	IRA deductions	$ _____	How often?	_____
☐	Business expenses of reservists, performing artists, and fee-basis government officials	$ _____	How often?	_____
☐	Penalty paid on early withdrawal of savings	$ _____	How often?	_____
☐	Student loan interest	$ _____	How often?	_____
☐	Tuition and fees	$ _____	How often?	_____
☐	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

☐	White	☐	Filipino	☐	Native Hawaiian
☐	Black or African American	☐	Japanese	☐	Guamanian or Chamorro
☐	American Indian or Alaska Native	☐	Korean	☐	Samoan
☐	Asian Indian	☐	Vietnamese	☐	Other Pacific Islander
☐	Chinese	☐	Other Asian	☐	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? ☐ Yes ☐ No	Relationship to you?

Social Security Number (**OPTIONAL**)	Date of Birth	Pregnant? ☐ Yes ☐ No Due Date: _____ If yes, how many babies are expected: _____	**Sex** ☐ Male ☐ 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.

1. Do they expect to file a joint return with a spouse/partner? ☐ Yes ☐ No
   If yes, name of spouse/partner: _____
2. Will they claim any dependents on their tax return? ☐ Yes ☐ No
   If yes, list name(s) of dependents: _____
3. 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? ☐ Yes ☐ 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 ☐ No

Are they receiving Supplemental Security Income (SSI)? ☐ Yes ☐ No

Do 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.

				Tribal Income?
☐ None				
☐ Unemployment	$ _____	How often?	_____	
☐ Retirement	$ _____	How often?	_____	
☐ Pensions	$ _____	How often?	_____	
☐ Social Security (RSDI) Benefits	$ _____	How often?	_____	
☐ Interest/Dividends	$ _____	How often?	_____	☐ Yes ☐ No
☐ Annuities	$ _____	How often?	_____	☐ Yes ☐ No
☐ Rental or Royalty Income	$ _____	How often?	_____	☐ Yes ☐ No
☐ Capital Gains	$ _____	How often?	_____	☐ Yes ☐ No
☐ Farming or Fishing Income	$ _____	How often?	_____	☐ Yes ☐ No
☐ Alimony	$ _____	How often?	_____	
☐ Scholarships & Grants	$ _____	How often?	_____	☐ Yes ☐ No
☐ Cash Advances	$ _____	How often?	_____	
☐ Gambling Winnings	$ _____	How often?	_____	
☐ Other	$ _____	How often?	_____	☐ Yes ☐ 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.

☐	Educator expenses	$ _____	How often?	_____
☐	Health savings account	$ _____	How often?	_____
☐	Moving expenses	$ _____	How often?	_____
☐	Alimony	$ _____	How often?	_____
☐	IRA deductions	$ _____	How often?	_____
☐	Business expenses of reservists, performing artists, and fee-basis government officials	$ _____	How often?	_____
☐	Penalty paid on early withdrawal of savings	$ _____	How often?	_____
☐	Student loan interest	$ _____	How often?	_____
☐	Tuition and fees	$ _____	How often?	_____
☐	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

☐	White	☐	Filipino	☐	Native Hawaiian
☐	Black or African American	☐	Japanese	☐	Guamanian or Chamorro
☐	American Indian or Alaska Native	☐	Korean	☐	Samoan
☐	Asian Indian	☐	Vietnamese	☐	Other Pacific Islander
☐	Chinese	☐	Other Asian	☐	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 (______) ______- _________
Employer Address:	City	State ZIP Code
Who can we contact about employee health coverage at this job?	Phone Number: (______) ______- ________	Email Address:

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
	☐ Enrolled Now ☐ Plans to Enroll Start Date: ___/___/_____ ☐ Not Enrolled	☐ Plans to drop coverage Date: ___/___/_____ ☐ Will become eligible Start Date: ___/___/_____
	☐ Enrolled Now ☐ Plans to Enroll Start Date: ___/___/_____ ☐ Not Enrolled	☐ Plans to drop coverage Date: ___/___/_____ ☐ Will become eligible Start Date: ___/___/_____
	☐ Enrolled Now ☐ Plans to Enroll Start Date: ___/___/_____ ☐ Not Enrolled	☐ Plans to drop coverage Date: ___/___/_____ ☐ 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 (_____) _____- _____

Address	City	State	ZIP Code

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

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:

☐ Covering Kids & Families	☐ School	☐ Tribal Resources
☐ WIC	☐ Clinic	☐ Friend / Family
☐ 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 (5^{th}) 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	Reno	Las Vegas	Elko
(775) 684-3651	(775) 687-1900	(702) 668-4200	(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?

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

JUN 0 6 2014

Michael J. Willden, Director
Department of Health and Human Services
4126 Technology Way, Suite 100
Carson City, NV 89706

Dear Mr. Willden:

Enclosed is an approved copy of Nevada's State Plan Amendment (SPA) 13-0026-MM, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on October 9, 2013. SPA 13-0026-MM incorporates the MAGI-based eligibility process requirements, including the single streamlined application, into Nevada's state plan in accordance with the Affordable Care Act.

The effective date of this SPA is October 1, 2013.

The approval of 13-0026-MM includes full approval of your state's alternative paper application used to apply for multiple human service programs. Until September 30, 2014, the state will use interim alternative single streamlined paper and online applications. By September 30, 2014, the state will implement revised alternative paper and online applications that addresses CMS concerns outlined in the companion letter issued with this SPA approval.

Enclosed is a copy of the following S94 state plan pages and attachments to be incorporated within a separate section at the end of Nevada's approved state plan:

- S94, pages S94-1, S94-2
- Attachment 1 – Nevada's alternative paper application used to apply for multiple human service programs
- Attachment 2 – Statement of use with respect to the alternative single streamlined online application
- Attachment 3 – Statement of use with respect to the alternative single streamlined paper application

In addition, enclosed is a summary of state plan pages which are superseded by SPA 13-0026-MM, which should also be incorporated into a separate section in the front of the state plan.

- Superseding Pages of State Plan Material, 13-0026-MM

CMS appreciates the significant amount of work your staff dedicated to preparing this State Plan Amendment. If you have any questions concerning this SPA, please contact Brian Zolynas by phone at (415) 744-3601 or by email at Brian.Zolynas@cms.hhs.gov.

Sincerely,

[redacted]

Gloria Nagle, Ph.D., MPA
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

cc: Laurie Squartsoff, Administrator, DHCFP
Marta Stagliano, Chief, Compliance, DHCFP

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

JUN 0 6 2014

Michael J. Willden, Director
Department of Health and Human Services
4126 Technology Way, Suite 100
Carson City, NV 89706

Dear Mr. Willden:

This letter is being sent as a companion to Centers for Medicare & Medicaid Services (CMS) approval of state plan amendment (SPA) 13-0026-MM, which was submitted to CMS on October 9, 2013. Our review of this submission included a review of the state's alternative single streamlined paper and online applications and the state's alternative paper application used to apply for multiple human service programs.

Until September 30 2014, the state will use interim alternative single streamlined paper and online applications. The interim alternative paper and online applications need to be revised to reflect the following changes.

Necessary changes:	**Date by which changes will be completed:**
1. The state will remove the tobacco question on the alternative single streamlined paper application. On the alternative single streamlined online application, the state will only ask the tobacco question to individuals who appear ineligible for Medicaid/CHIP.	September 30, 2014
2. The state will remove the question regarding income from inheritances on both the alternative single streamlined paper and online applications.	September 30, 2014

Please submit the revised alternative single streamlined paper and online applications to CMS for review no later than September 1, 2014 to ensure approval by September 30, 2014. We continue to be available to provide technical assistance. If you have any questions about your application, please contact Dena Greenblum at Dena.Greenblum@cms.hhs.gov or (410) 786-8684. If you

have any questions about this letter or need any additional information, please contact Brian Zolynas by phone at (415) 744-3601 or by email at Brian.Zolynas@cms.hhs.gov.

Sincerely,

[redacted]

Gloria Nagle, Ph.D., MPA
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Laurie Squartsoff, Administrator, DHCFP
Marta Stagliano, Chief, Compliance, DHCFP

Medicaid State Plan Eligibility: Summary Page (CMS 179)

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.

13-0026-MM

Proposed Effective Date

10/01/2013 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

42 CFR 435, Subpart J and Subpart M

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$ 0.00
Second Year	2015	$ 0.00

Subject of Amendment

Defines the application process and indicates the states election to use an alternative single streamlined application as well as an alternative application for multiple programs.

Governor's Office Review

Governor's office reported no comment

Comments of Governor's office received

Describe:

No reply received within 45 days of submittal

Other, as specified

Describe:

The Governor's Office does not wish to review the State Plan Amendment.

Signature of State Agency Official

Submitted By:	**Robyn Heddy**
Last Revision Date:	**Jun 6, 2014**
Submit Date:	**Oct 9, 2013**

SUPERSEDING PAGES OF STATE PLAN MATERIAL	
TRANSMITTAL NUMBER: 13-0026-MM	**STATE:** Nevada
PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: S94 Eligibility Process, Page S94-1, S94-2	**PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:** Section 2, Page 10, section 2.1(a), 91-22 Section 2, Page 11a, section 2.1(d), 92-6

Division of Welfare and Supportive Services

Application for Assistance

"Working for the Welfare of ALL Nevadans"

Programs You May Apply For:

Food Assistance from the Supplemental Nutrition Assistance Program **(SNAP)** helps people buy food.
Temporary Assistance for Needy Families (TANF) helps families with children meet their basic needs with cash assistance.

Time Frames

- **SNAP** benefits are processed within 30 days from the date of the application. If your household has little or no income, you could receive SNAP benefits within 7 days from the date of your application. SNAP benefits are paid from the date of the application.
- **TANF** benefits are paid from the date of approval or 30 days from the date of the application, whichever is sooner. TANF applications are processed within 45 days from the application date unless there are unusual circumstances.

Denial of benefits for one program does not automatically affect the decision on another program you may be applying for.

Social Security Numbers

You will be asked to provide Social Security Numbers (SSN) for all persons (including yourself) **who are applying for assistance,** pursuant to Title 42 USC 1320b-7. Providing or applying for a SSN is voluntary. For SNAP, any person who wants assistance but does not want to give information about his or her SSN will not be eligible for benefits. Other family or household members may still get benefits if they are otherwise eligible. For TANF, if a required household member fails or refuses to provide an SSN without good cause, the entire household will be ineligible for TANF benefits. This includes all individuals who income and needs are used to determine eligibility for the TANF program.

SSNs are used to verify your household's income and resources and to conduct computer matching with other agencies such as the Social Security Administration, Employment Security Division, Child Support Enforcement Programs and the Internal Revenue Service. It is also used to gather workforce information, investigations, recover overpaid benefits and to ensure duplicate benefits are not received.

Citizenship/Immigration Status

You will be required to provide information about the citizenship and/or immigration status for all persons (including yourself) **who are applying for assistance**. For SNAP, if any of these persons do not want to give us information about his/her citizenship and/or immigration status, he/she will not be eligible for benefits. Other family or household members may still receive benefits if they are otherwise eligible. For TANF, if a required household member fails or refuses to provide verification of their status, the entire household will be ineligible for TANF benefits. Qualified Non-Citizen status is verified with the United States Citizenship and Immigration Service (USCIS) for eligibility purposes. Information on non-applicants or non-qualified non-citizens will not be shared with USCIS.

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."

Special Accommodations

To get SNAP (food assistance) and/or TANF (cash assistance), most people have to come into the office for a face-to-face interview; you need to bring identification with you.

Do you have a physical or mental condition that requires special accommodations during your interview? ☐ YES ☐ NO

If YES, what do you need? _____ (Most services are free to you.)

Do you speak English? ☐ YES ☐ NO If NO, what language do you speak? _____

Do you need an interpreter for your interview? ☐ YES ☐ NO (This service is free to you.)

HOUSEHOLD INFORMATION

Please list everyone who lives in the home with you, whether you consider them household members or not. If someone is pregnant please list the unborn child(ren) as household members as well. Please list the head of household first; you may choose who this individual will be. The person chosen as the head of household will be the case name. Fill out as much of the application as you can; you may ask for help if you need it.

Last Name	First Name	Middle Initial	Modifier Jr. Sr.	Relation to You	Gender	Date of Birth	Age	Marital Status **	Social Security Number	State or Country of Birth	U.S. Citizen Y/N	*Race/Ethnicity	Last Grade Completed	Month/Year Completed	FOOD	TANF	NONE
				SELF											☐	☐	☐
															☐	☐	☐
															☐	☐	☐
															☐	☐	☐
															☐	☐	☐
															☐	☐	☐
															☐	☐	☐

Are there additional people in your home? ☐ YES ☐ NO If "YES", list them on a separate sheet of paper.

Race - Please check one of the boxes that best describes your household - ☐ Hispanic/Latino or ☐ Non-Hispanic or Latino

***Ethnicity (Optional)** - Please choose one of the following ethnicity codes for each household member: A-Asian; B-Black or African American; I-American Indian or Alaska Native; J-American Indian or Alaska Native and White; L-Asian and White; M-Black or African American and White; N-American Indian or Alaska Native and Black or African American; U-Native Hawaiian or Other Pacific Islander; W-White; Z-2 or more combinations not listed above.*

****Marital Status** – Please choose one of the following marital status codes for each household member: D-Divorced; L-Legally Separated; M-Married; N-Never Married; P-Separated; W-Widowed*

Home Address (Give Directions if you do not have an address.)	City	State	Zip Code
Mailing Address (If *different from your home address.*)	City	State	Zip Code

Home Phone	Cell/Message/Daytime Phone	E-mail Address

If you are applying for Food Assistance, please answer questions 1 through 6 about your household. A Food Assistance household includes all people who live and share food with you. Based on your answers below, you may qualify for expedited service. You may complete, sign and submit the first page in order to start the application process.

1. Do you usually buy, prepare and eat with others you live with? ☐ YES ☐ NO
   If "NO", list who buys their food separately _____
2. List the total gross amount of money your household received or expects to receive this month. $_____
3. How much do all persons have in cash, checking and savings accounts? $_____
4. How much is your current monthly cost for housing (rent/mortgage) and utilities. $_____
5. Are you or any person(s) in your household a migrant or seasonal farm worker? ☐ YES ☐ NO
6. Have you or any person in your household received TANF, Food Assistance or Indian Commodities in Nevada or any other state? ☐ YES ☐ NO
   If "YES", Who? _____ What Benefits? _____
   Where? _____ Last month and year benefits were received _____ /

I certify under penalty of perjury, my answers are correct and complete to the best of my knowledge and ability. I swear I have honestly reported the citizenship of myself and anyone I am applying for.

Your Signature _____ Date _____

FOR OFFICE USE ONLY – EXPEDITED SERVICE SCREENING: HOUSEHOLD ELIGIBLE FOR EXPEDITED SERVICE?
☐ YES ☐ NO Expedited service screener signature: _____ DATE: _____

AUTHORIZED REPRESENTATIVE — AREP

7. Do you want someone other than yourself, age 18 or older, to apply for benefits or act on your behalf? ☐ YES ☐ NO
   If "YES" Who? _____ Age? _____ Telephone # ( ) _____ - _____
   Address _____
8. In case of emergency, who would you like us to contact? Name _____ Relationship _____
   Daytime Telephone # ( ) - Address

ADDITIONAL HOUSEHOLD INFORMATION

9. Do you plan to continue living in Nevada? ☐ YES ☐ NO
   If "NO", Explain: _____
10. List the most recent date you started living in Nevada. _____ / _____ (MM/YYYY)
11. Are you or any person(s) in your household a member of an American Indian or Alaskan Native Tribe? ☐ YES ☐ NO
    If "YES," Who? _____ What Tribe? _____
12. Are you or any person(s) in your household currently disqualified for an Intentional Program Violation (IPV)? ☐ YES ☐ NO
    If "YES", Who? _____ What State? _____
13. Have you or any person(s) in your household been convicted of a felony drug offense on or after August 22, 1996? ☐ YES ☐ NO
    If "YES", Who? _____ When? _____ Where? _____
14. Are you or any person(s) in your household currently participating in or have participated in a Drug Addiction or Alcohol Treatment Program? ☐ YES ☐ NO
    If "YES", Who? _____ Date Entered / / Date Completed / /
    Facility Name: _____ Facility Address _____
15. Are you or any person(s) in your household currently wanted by Law Enforcement? ☐ YES ☐ NO
    If "YES", Who? Why?

PREGNANCY — PREG

16. Are you or any person(s) in your household pregnant? ☐ YES ☐ NO
    If "YES" Who? Expected Due Date? / / (MM/DD/YYYY)

DISABILITY — DISA

17. Are you or any person(s) in your household blind, disabled or unable to work due to illness or injury? ☐ YES ☐ NO
    If "YES", Who? _____ When did this condition begin? _____ / _____ / _____ (MM/DD/YYYY)
    What is the disability?

NON-CITIZEN INFORMATION — ALIE

18. Are you or any person(s) in your household **NOT** a U.S. Citizen? ☐ YES ☐ NO
    If "YES" Who? _____ Alien Registration # _____
    When did this person enter the United States? _____ / _____ / _____ (MM/DD/YYYY)
    If "YES" Who? _____ Alien Registration # _____
    When did this person enter the United States? / / (MM/DD/YYYY)

SCHOOL ATTENDANCE — SCHL

19. Are you or any person(s) in your household between the ages of 7 and 11 or over 16 attending school? ☐ YES ☐ NO
    If "YES" Who? _____ School Name? _____
    If additional persons "YES" Who? School Name?

EARNED INCOME/WORK HISTORY — JINC/SELF/OINC/QUIT/STRK

20. Are you or any person(s) in your household **currently** working, including self-employment? ☐ YES ☐ NO
    If "YES", Who is employed? _____ Hourly Wage? $ _____ Hours worked per week? _____
    How often are they paid? _____ Tips paid per month? $ _____
    Start Date? _____ /
    Employer's Name? _____ Employer's Telephone _____
    Employer's Address? _____

EARNED INCOME/WORK HISTORY (CONT) | **JINC/SELF/OINC/QUIT/STRK**

If "YES", for additional household members:
Who is employed? _____ Hourly Wage? $ _____ Hours worked per week? _____
How often are they paid? _____ Tips paid per month? $ _____
Start Date? ___/___/___
Employer's Name? _____ Employer's Telephone? _____
Employer's Address? _____

If more than two persons are currently working, please attach an additional sheet of paper.

21. Have you or any persons(s) in your household had a job that ended in the **last three months**? ☐ YES ☐ NO
Who was employed? _____ Hourly Wage? $ _____ Hours worked per week? _____
How often where they paid? _____ Tips received per month? $ _____
Employer's Name? _____ Start Date? ___/___/___ When did the job end? ___/___/___
Employer's Address _____ Employer's Telephone? (___) ___-____
Reason for leaving? ☐ Quit ☐ Fired ☐ Leave of Absence ☐ Applied Worker's Compensation ☐ Other
If "YES" for additional household members:
Who was employed? _____ Hourly Wage? $ _____ Hours worked per week? _____
How often where they paid? _____ Tips received per month? $ _____
Employer's Name? _____ Start Date? ___/___/___ When did the job end? ___/___/___
Employer's Address _____ Employer's Telephone? (___) ___-____
Reason for leaving? ☐ Quit ☐ Fired ☐ Leave of Absence ☐ Applied Worker's Compensation ☐ Other

22. Are you or any person(s) in your household currently registered with or working for a Temporary Employment Service/Agency? ☐ YES ☐ NO
If "YES", Who? _____ Which Service/Agency? _____

23. Are you or any person(s) in your household currently on strike? ☐ YES ☐ NO
If "YES", Who? _____

24. Do you or any person(s) in your household work in exchange for food, shelter or something else? ☐ YES ☐ NO
If "YES", Who? _____ What do they receive for their work? _____
What is the value of this exchange? $ _____ When did this begin?

UNEARNED/OTHER INCOME | **UNIN/GAGA/LSUM/RINC/RBIN/EDIN**

25. Please check the "YES" box for each of the types of the unearned income you or any person(s) in your household receives or has applied for. If you do not check the "yes" box for any of the unearned income below you are acknowledging neither you or any person(s) in your household have any unearned or other income.

YES	SOURCE	Person Applied/Receiving	Gross Amount Per Month
☐	Alimony		$
☐	Boarder/Roomer Income		$
☐	Child Support (Voluntary or Court Ordered)		$
☐	Contributions/Gifts		$
☐	Educational Assistance/Student Loans		$
☐	Foster Care		$
☐	General Assistance		$
☐	Insurance Settlements		$
☐	Interest/Dividends		$
☐	Loans		$
☐	Military Allotment		$
☐	Mining Claims		$
☐	Pan Handling		$
☐	Pensions/Retirement		$
☐	Property Rentals		$
☐	Railroad Retirement		$
☐	Royalties		$
☐	Social Security Benefits (RSDI)		$

UNEARNED/OTHER INCOME (CONT)			UNIN/GAGA/LSUM/RINC/RBIN/EDIN
☐	Strike Benefits		$
☐	Subsidized Housing		$
☐	Supplemental Security Income (SSI)		$
☐	Supported Living Arrangement (SLA)		$
☐	TANF Assistance		$
☐	Trust Income		$
☐	Unemployment Insurance		$
☐	Utility Allowance/Rebate Check		$
☐	Veteran's Benefits		$
☐	Gambling Winnings		$
☐	Worker's Compensation or Temporary Disability		$
☐	Other: (please list)_____		$

INCOME MANAGEMENT

26. If you do not have any income, please explain how you are paying your bills and buying personal items for your household?

RESOURCES — BANK/LIFE/PROP

27. Please mark the "YES" box for each types of resources you or any person(s) in your household has, even if jointly owned with someone outside the household. If you do not check the "YES" box for any of the resources below you are acknowledging neither you or any person(s) in your household have any resources:

BANK ACCOUNTS

YES	TYPE OF ACCOUNT	OWNER(S)	NAME OF BANK	VALUE	ACCOUNT NUMBER (Please list the last 4 numbers only)
☐	Savings Account			$	
☐	Checking Account			$	
☐	Credit Union Account			$	
☐	Minor Savings			$	
☐	Business Account			$	
☐	Christmas Club Account			$	
☐	Educational Savings Account			$	
☐	Patient Trust Fund			$	
☐	Individual Indian Money Account			$	

LIFE INSURANCE/TRUSTS/BURIALS

YES	TYPE OF ACCOUNT	OWNER(S)	NAME OF COMPANY OR BANK	FACE VALUE	POLICY OR ACCOUNT NUMBER (Please list the last 4 numbers only)
☐	Life Insurance			$ /CSV$	
☐	Available Trusts			$	
☐	Unavailable Trusts			$	
☐	Burial Funds/Plans			$ /CSV$	
☐	Life Estates				

RESOURCES (CONT) — BANK/LIFE/PROP

INVESTMENT & RETIREMENT ACCOUNTS

YES	TYPE OF ACCOUNT	OWNER(S)	NAME OF BANK OR COMPANY	VALUE	ACCOUNT NUMBER (Please list the last 4 numbers only)
☐	Savings Bonds				
☐	Stocks or Bonds				
☐	Certificates of Deposit				
☐	Individual Retirement Accounts (IRA)				
☐	Keogh Account (401K)				
☐	Annuities				

PERSONAL PROPERTY

YES	TYPE OF PROPERTY	OWNER(S)	LOCATION	CONTENTS OR TYPE OF RESOURCE	CURRENT OR MARKET VALUE
☐	Safe Deposit Box				$
☐	Livestock				$
☐	Land Mineral Rights				$
☐	Mining Claims				$
☐	Business Equipment/ Inventory				$
☐	Houses/Land or Buildings			*Is this property currently for sale?* ☐ Yes ☐ No	$

MISCELLANEOUS

YES	TYPE OF RESOURCE	OWNER(S)	CURRENT VALUE
☐	Promissory Notes		$
☐	Cash on Hand		$
☐	Other: (please list)		$

28. Are any of the resources in question 27 designated as money for burial? ☐ YES ☐ NO
If "YES" Which resources?

VEHICLES — CARS

29. Do you or any person(s) in your household own, or are they buying, a car, motorcycle, trailer, truck, camper, boat, motorcycle, ATV, etc.? (Please include any vehicles that are not currently working.) ☐ YES ☐ NO
If "YES", Please complete the information below.

OWNER	TYPE OF VEHICLE	YEAR, MAKE & MODEL	IS THE VEHICLE REGISTERED	FAIR MARKET VALUE	AMOUNT OWED
			☐ YES ☐ NO	$	$
			☐ YES ☐ NO	$	$
			☐ YES ☐ NO	$	$

TRANSFERRED RESOURCE — TRAN

30. Have you or any person(s) in your household sold, traded or given away any money, vehicles, property or other resources, or closed any bank accounts in the last 3 months? ☐ YES ☐ NO
If "YES", Who? _____ What resource was transferred? _____
When? ____/____ (MM/YYYY) What was the value of this resource when it was transferred? $ _____
Who was the resource transferred to? _____ Relationship to you? _____
Why was the resource transferred?

HOUSING EXPENSES — RENT/HOME/UTIL

31. Please choose which of the following housing costs that you or any person(s) in your household pays.
☐ RENT ☐ MORTGAGE/RELATED EXPENSES ☐ NONE

32. If you are **renting** your home, how much is the monthly rent? (Including space/lot rent) $_____

33. What is your landlord's Name? _____ Landlord's Telephone Number ( ) -

34. What is your landlord's address? _____

35. Is your rent subsidized by any agency? ☐ YES ☐ NO

36. If "YES," by which agency? _____ How much is subsidized? $ _____

37. If you are **buying** your home, please complete the areas with the current expenses:

Mortgage Amount (including second)	$		How Often Paid?	
Taxes (if paid separately)	$		How Often Paid?	
Homeowners Insurance (if paid separately)	$		How Often Paid?	
Association Fees (if paid separately)	$		How Often Paid?	
Lot/Space Rent	$		How Often Paid?	

38. Does anyone outside the home pay any of your rent or mortgage expenses? ☐ YES ☐ NO
If "YES", Who? _____ Telephone _____ How Much? $ _____ How Often? _____

39. Are you or any person(s) in your household responsible for paying any utility expenses? ☐ YES ☐ NO
If "YES", does this utility expense include costs for heating or cooling? ☐ YES ☐ NO
If "NO", please choose the utilities your household is responsible for paying:

Electricity	☐	Wood	☐	Water	☐	Sewer	☐	Other	☐
Natural Gas	☐	Propane	☐	Garbage	☐	Telephone	☐		

40. Does anyone outside your household pay a portion of your utility expenses? ☐ YES ☐ NO
If "YES", Who? Telephone How Much? $ How Often?

OTHER EXPENSES — SUDE/MEDX/DCEX

41. Do you or any person(s) in your household pay court ordered Child Support to someone outside the household? ☐ YES ☐ NO
If "YES", Who? _____ How much do they pay per month? $ _____

42. Do you or any person(s) in your household pay child care or for the care of a disabled adult? ☐ YES ☐ NO
If "YES", Who? _____ For Whom? _____
How much per month?
$ _____

43. Does any agency or anyone outside your home pay a portion of your daycare costs? ☐ YES ☐ NO
If "YES," Who? _____ How much per month? $ _____

44. Does anyone age 60 or over, or any person(s) who is disabled have out-of-pocket medical expenses including costs for Medicare or medical insurance? ☐ YES ☐ NO
If "YES", Who? _____ How much per month? $ _____

45. Does anyone outside the household pay for any of these medical expenses? ☐ YES ☐ NO
If "YES", Who? How much per month? $

INJURIES/ACCIDENTS — SETT

46. Have you or anyone in your household been injured or in an accident in the last 12 months? ☐ YES ☐ NO
If "YES", Who? _____ When? _____

47. Is there a pending lawsuit because of the injury or accident? ☐ YES ☐ NO
If "YES", What is the attorney's name? _____
Attorney's Address _____

48. Have you or anyone in your household received or expect to receive an insurance reimbursement, payment or legal settlement? ☐ YES ☐ NO
If "YES", Who? When? How Much $ From Where?

ABSENT PARENT INFORMATION — NCPM

49. Is the father/mother of the child(ren) you are applying for : (Check one) ☐ living somewhere else ☐ disabled or ☐ deceased

50. If anyone in your home is pregnant, is the father of the unborn in the home? ☐ YES ☐ NO
If "YES", Who is thefather?

Complete the following form with information about the absent parent of your child(ren) who is not living with you (including the parent of an unborn child). If there is more than one possible parent, complete a form for each one. Please provide as much information as possible.
***Please make copies or request additional copies of this page for additional parents.**

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

NON-CUSTODIAL PARENT (NCP) FORM

When applying for TANF the law requires you to cooperate with Child Support Enforcement (CSE) to establish paternity to get child support owed to you and/or any child(ren) that you are applying for. This may include genetic testing. If the test proves the person you named is not the father, you may be required to pay the cost of the test. You are also responsible for providing all available information requested by the CSE Program such as certified copies of divorce decrees and/or support orders, birth certificates and photographs of the absent parent.

The CSE Program locates absent parents and/or sources of income and assets, establishes and enforces financial support, reviews and adjusts existing child support orders, and collects and distributes financial payments.

The CSE Program has sole discretion in determining which legal remedies are used in pursuing support and cannot guarantee success. CSE may request assistance of another state, and thereby, be subject to the laws of that state. CSE does not provide services involving custody or visitation. CSE may close your case when your case meets closure rules established by federal and state regulation.

The CSE Program represents the State of Nevada when providing services and no attorney-client privilege exists. CSE is authorized to endorse and cash payments made payable to you for support payments and may collect past-due support by intercepting an IRS tax refund or other federal payment. If a tax intercept occurs, the CSE Program has the authority to hold a joint tax refund for a period of six (6) months before distributing the funds. No interest is paid on the held funds. Funds collected from a tax intercept are applied first to pay off any past-due support assigned to the State of Nevada. A nonrefundable fee is deducted by the federal government of any tax or federal payment intercepted by the CSE Program.

Good cause for not cooperating in pursuing child support or paternity may be allowed. If you do not cooperate with CSE and good cause has not been determined, your household will be ineligible for TANF. Good cause for not cooperating will be considered if you request it in writing. Examples of good cause are as follows:

- ***The child was conceived as a result of rape or incest.***
- ***Legal proceedings for adoption of the child are pending before a court.***
- ***You are being assisted by a public or licensed private social service agency to decide whether to keep or relinquish the child for adoption (no longer than three (3) months).***
- ***Your cooperation in establishing paternity or securing support will result in physical or emotional harm to yourself or the child(ren).***

You must provide your case manager with verification within twenty (20) days after claiming good cause. You will receive written notification of the good cause decision. If you are found to have good cause for not cooperating, CSE will NOT attempt to establish paternity or collect child support.

☐ **YES, I wish to claim good cause.** ☐ **NO, I am not claiming good cause at this time.**

_____
Signature

You must report changes whenever a name change occurs; you have a new address or telephone number for home or work; you hire a private attorney or collection agency; another child support or paternity legal action is filed; you file for divorce; you receive support payments directly from the absent parent; you have a new address, telephone number, employment for the absent parent; a child(ren) no longer lives with you; a child(ren) is still in high school after age 18; a child(ren) becomes disabled before age 18; a child(ren) comes to live with you or you birth another child; a child marries, is adopted, joins the armed forces or is declared an adult by court order.

You are responsible for repayment of support amounts received in error, including payments from an IRS tax refund, which are adjusted by the IRS. If you fail to enter into a repayment agreement with the CSE Program, the outstanding balance may be reported to a credit reporting agency and money collected on your behalf by the CSE Program may be withheld for repayment. Additionally, legal action may be initiated against you.

NEVADA STATE DIVISION OF WELFARE AND SUPPORTIVE SERVICES
NON-CUSTODIAL PARENT (NCP) FORM

Complete one form for each parent who does not live with the child(ren) for whom you are requesting assistance. For example, if you have two children and each have a different father / mother, you need to complete two forms. If you are not the parent of the child(ren) you are requesting assistance for, you need to complete one form for the absent mother and one form for the absent father. Do not leave any question blank. Write or type unknown or N/A (not applicable) for any question that does not apply or you do not know the answer.

YOUR NAME:	YOUR SSN:	YOUR DOB:	YOUR RELATIONSHIP TO THE CHILD(REN):

Have you or the children received public assistance in the past? ☐ **YES** ☐ **NO**	**If YES, where?** **(City, State)**

Fill in whatever you know about the Non-Custodial Parent. If you do not know the answer to the question, write unknown or N/A.

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	MODIFIER (Jr., Sr., etc.):

ADDRESS:		
CITY:	STATE:	ZIP:

SOCIAL SECURITY NUMBER:	TELEPHONE / CELL PHONE:
DATE OF BIRTH:	BIRTH CITY AND STATE:
IF DECEASED, DATE OF DEATH:	IF DECEASED, PLACE OF DEATH:
DATE LAST SEEN OR CONTACTED:	IS HE OR SHE DISABLED? ☐ YES ☐ NO

RACE:	SEX:	HAIR COLOR:	EYE COLOR:	WEIGHT:	HEIGHT:

AT ANY TIME WAS THE MOTHER MARRIED TO THIS NON-CUSTODIAL PARENT? ☐ YES ☐ NO	DATE OF MARRIAGE:	PLACE OF MARRIAGE:
IF MARRIED ARE THEY DIVORCED? ☐ YES ☐ NO	DATE OF DIVORCE:	PLACE DIVORCE FILED:
WAS THE MOTHER MARRIED TO SOMEONE ELSE? ☐ YES ☐ NO	ARE THERE OTHER POSSIBLE FATHERS? ☐ YES ☐ NO	
EXISTING CHILD SUPPORT COURT ORDER? ☐ YES ☐ NO	CITY AND STATE	

INFORMATION ON THE CHILDREN FOR THIS ABSENT PARENT:

Child's Social Security Number	Child's Last Name	Child's First Name	Child's Middle Initial	Child's date of birth (MM/DD/YY)	Did the mother have sexual relations with another man (not named above), during 30 days before or after when pregnancy began for this child?	Custody Month
					☐ YES ☐ NO	
					☐ YES ☐ NO	
					☐ YES ☐ NO	

All cases for Temporary Assistance for Needy Families (TANF) must be referred for Child Support Enforcement. This information is correct to the best of my knowledge. I have read the "Important Child Support Information" section found on the eligibility application. I understand if I have intentionally withheld or misrepresented information, I could be disqualified from receiving public assistance.

I declare under penalty of perjury that the information I have provided on this document is true to the best of my knowledge and belief and that the statements contained herein are made for the purposes stated here, including but not limited to, obtaining assistance in establishing parentage and/or an order for child support along with the collection of child support.

Your Signature:	Date Signed:

Electronic Benefits Transfer (EBT)

Federal law states the intended period of use for SNAP benefits is 12 months from the date of issuance. DWSS is required to remove any unused SNAP benefits from an account 365 days after the benefit was issued and return them to the Federal government. Unused benefits are frozen 360 days after their issuance. If the client, or any adult member of the client's household, has any outstanding SNAP debt, the frozen benefit will be applied towards the SNAP debt.

Unused TANF benefits are removed from a client's EBT account 180 days after the benefit was issued.

Per Federal Law, TANF EBT benefits cannot be accessed from ATM machines or used to purchase items in the following locations: casinos, gaming establishments, liquor stores or retail establishments which provide adult entertainment.

*Initials*_____

Work Requirements

If you are approved for TANF and/or SNAP, you may be required to cooperate with certain work requirements. Failure to comply with certain work requirements could disqualify you and/or other members of your household from participating in either program. For SNAP, if you or any other household member voluntarily quits a job or reduces work hours without good cause, this may be considered failure to comply with work requirements. The SNAP disqualification period for failure to comply with work requirements is one month and until compliance for the first violation, three months and until compliance for the second violation, and six months and until compliance for the third violation. For TANF, failure to cooperate with work requirements agreed to in their Personal Responsibility Plan may result in the household losing their TANF benefits for three full months.

Important Child Support Information

By signing this application and by receiving TANF benefits, you agree to assign your child support rights to the State of Nevada Division of Welfare and Supportive Services (DWSS). This is a condition of eligibility for your household to receive TANF benefits. If you are receiving TANF, any court ordered or stipulated child support paid directly to you is required by law to be surrendered immediately to DWSS or Child Support Enforcement (CSE). By signing this application, you are authorizing DWSS to transfer all or part of the support collected each month to pay back the TANF benefits your household received.

When applying for TANF, the law requires you to cooperate with CSE to establish paternity to get child support owed to you and/or any child(ren) for which you are applying. Good cause for not cooperating in pursuing child support or paternity may be allowed. If you do not cooperate with Child Support Enforcement and good cause is not established, your household will be ineligible for TANF.

If TANF is terminated and child support is collected, any portion due to you will be made as a direct deposit onto a Nevada Debit Card or into your bank account. A Nevada Debit Card will be issued to you unless you request payments by direct deposit into your bank account. Visit our website: dwss.nv.gov for more information.

You are responsible for repayment of child support amounts received in error, including child support payments from an IRS tax refund which are adjusted by the IRS. If you fail to enter into a repayment agreement with the CSE program, money collected on your behalf by the CSE program may be withheld for repayment and the outstanding balance may be reported to a collection agency.

DWSS may charge a $25.00 fee for child support services provided to clients who have never received public assistance.

Do you wish to pursue child support if your household is found ineligible for TANF?
☐ Yes ☐ No

Initials _____

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 or will receive under programs administered by the DWSS, including childcare assistance. Information provided to the DWSS may be verified or investigated by federal, state and local officials including Quality Control staff. If you do not cooperate in the investigation, your benefits may be denied or terminated. If you make false or misleading statements, misrepresent, conceal or withhold facts necessary for the DWSS to make an accurate determination on your benefits or alter any document, your benefits may be denied, terminated or reduced. You are responsible for repayment of all monies, services and benefits (including childcare assistance) for which you were not entitled to. Additionally, you may be disqualified from receiving benefits in the future and criminally prosecuted or otherwise penalized according to state and federal law.

Individuals found guilty of an intentional program violation in TANF and/or SNAP are barred from program benefits for twelve (12) months for the first violation, twenty-four (24) months for a second violation and PERMANENTLY for the third violation. The unlawful use of SNAP is punishable by a fine up to $250,000, imprisonment for up to 20 years or both.

Initials _____ *Initials* _____

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 office or the administration office. For SNAP, you may request a hearing by calling your local district office. You may also request a hearing by signing and returning the Notice of Decision you receive. You must request a hearing for TANF or SNAP within 90 days of the notice date.

You will be notified of the hearing date, time and location in writing ten (10) days prior to the scheduled hearing. You may be represented at a conference/hearing by anyone whom you have given written authorization. This written authorization must be given to the DWSS office prior to the conference/hearing. You may request information on the various legal services that 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.

Important Information

If you are applying for TANF and SNAP with this application and your TANF benefits are approved, any adjustment to your SNAP benefits will be made at the same time. With this application, you are waiving your right to 13 days advance notice of any change in your SNAP benefits resulting from TANF approval. If your TANF benefit is less than $10.00, you will receive no cash payment.

The DWSS may mail information to you that may require you to respond by a certain date. If you are away from home, you are still responsible to respond by the required date. You may wish to make arrangements for your mail while you are away.

Your Responsibilities

If you are applying for TANF:

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, the birth of a child, 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 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 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 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, 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 your household is designated as a ***Simplified Reporting Household*** you must report if you move out of state or your household's income exceeds 130% of the federal poverty level for your household size. If SNAP benefits are approved you will be notified of the income 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 (age 60 or over) or disabled person applying for benefits. **If you do not report or verify any of the expenses listed on the application, it will be considered that you do not want to receive a deduction for the unreported or unverified expense.**

Initials	*Initials*

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.

Initials _____

I understand if I fail to initial pages 10-12 where indicated on this application, it does not release me or my household members from those requirements / obligations. If I am under age 18 and applying for TANF assistance I understand I must have an additional signature of an adult over age 18 to complete the application.

I understand the questions on this application and the penalty for hiding or giving false information. I agree to notify the Nevada State Division of Welfare and Supportive Services of any changes in my household circumstances that may affect my benefits. I understand failure to report changes may cause an overpayment that I would be responsible to pay back and could even be prosecuted by a court of law. I certify under penalty of perjury, my answers are correct and complete to the best of my knowledge and ability. I swear I have honestly reported the citizenship of myself and anyone I am applying for.

Signature or Mark of Applicant	**Date**	**Signature or Mark of Spouse/ Second Parent of Child(ren)/Adult Representative**	**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**

Your completed application may be submitted to your local Welfare office or mailed to PO Box 15400, Las Vegas, NV 89114.

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.

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 89710.

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 TANF or SNAP within 90 days of 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 TANF:
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 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 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 TANF reporting requirements listed above.
If your household is designated as a *Simplified Reporting Household* you must report if you move out of state or your household's income exceeds 130% of the federal poverty level for your household size. Your household will be notified of this amount at approval. 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 will 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

SECRETARY OF STATE ROSS MILLER
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, I.D. 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 10 - 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 13 - ASSISTING IN THE COMPLETION OF THIS FORM If you are assisting a person to register to vote, you must complete Box 13. 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.
- ★ 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 3-13
☐ 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 or NV ID Card Number (If neither, last 4 digits of your SSN)

9 Telephone No.(Opt.)

10 Party Registration—Check Only One Box
- ☐ Democratic Party
- ☐ Independent American Party
- ☐ Libertarian Party
- ☐ Republican Party
- ☐ Other Party – Write In Below

_____

- ☐ Nonpartisan (no party affiliation)

11 "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) ___/___/___

12 Your name and residence address where you were last registered to vote. (Name Used, Street, Apt. #, City, State & Zip Code of Former Residence)

13 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.

AGENCY STAMP HERE

- ☐ AGENCY
- ☐ FIELD REGISTRAR
- ☐ MAIL
- ☐ OTHER

CANCELLED | INACTIVE | PRECINCT | APPLICATION NO. HA | RECEIVED BY:

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

(Revised 8.2012)

Medical Assistance Addendum

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

Case Information

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

Who needs to be included on this application:

- 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.**

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

☐Yes **If yes**, who? _____ **and** answer questions 1 - 3

☐ No **If no**, skip to question 3

1. Filing Status — Check only one box.
   - ☐ Single
   - ☐ Married filing jointly
   - ☐Married filing separately — Name of spouse/partner: _____

2. Dependents

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

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

   If yes, please list the name of the tax filer:

   How are you related to the tax filer?

Please list all members requesting medical assistance:

Do any children, under the age of 19, have access to public employee coverage? ☐Yes ☐ No

If pregnant, how many babies are expected:

If under age 26, has anyone ever been in foster care? ☐Yes ☐ No

If yes, who? what state?

Age when they left the program?

Did they receive health care through a state Medicaid program? ☐Yes ☐ No

Does anyone need help with activities of daily living through personal assistance services or a medical facility?

☐Yes ☐ No **If yes**, who?

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

If yes, who? what months?

DEDUCTIONS (Only list deductions reported on 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.

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

Type:

HEALTH INSURANCE INFORMATION

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

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

If yes, provide the following information:

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

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.

Referral Information:

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

☐	Covering Kids & Families	☐	School
☐	Tribal Resources	☐	WIC
☐	Clinic	☐	Other
☐	Friend/Family		

Health Plan Selection:

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

Families who live in urban Washoe County or urban Clark County are covered by a managed care organization (MCO). You are being asked to choose one of the following health plans. If you do not indicate a health plan preference on your 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.

Please choose a health plan:

Amerigroup: 1-800-600-4441 **Health Plan of Nevada**: 1-800-962-8074

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

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

Privacy Policy

We keep your information private as required by law. Your answers on this 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 agree to allow my information to 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.

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

_____ ____/____/_____
Signature of Case Manager Date

Mail Your Completed Application.

Submit your application to the local Welfare Office or, mail your application to:	**Did you remember to:**
PO BOX 15400 Las Vegas, NV 89114	✓ Tell us about everyone in your family & household, even if they don't need insurance? ✓ Attach verification of current monthly income? ✓ Attach copy of insurance card (front & back)? ✓ Sign this application?

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

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION	
☐ Paper Application	☒ Online Application
TRANSMITTAL NUMBER:	**STATE:**
13-0026-MM	Nevada

Through September 30, 2014, the state is using an interim alternative single streamlined application. After September 30, 2014, 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.

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION

☒Paper Application ☐Online Application

TRANSMITTAL NUMBER:	STATE:
13-0026-MM	Nevada

Through September 30, 2014, the state is using an interim alternative single streamlined application. After September 30, 2014, 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.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

General Eligibility Requirements Eligibility Process	S94

42 CFR 435, Subpart J and Subpart M

Eligibility Process

☑ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

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 for all insurance affordability programs, 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 in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

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.

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

☐ The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

☒ An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

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 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

◉ Yes ○ No

Indicate the other electronic means below:

	Name of Method	Description	
+	Fax	Application may be submitted via fax	X

☑ The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

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 435.916:

■ 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.

■ Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

☒ Once every 12 months

☐ Once every 6 months

☐ Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

☑ The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

PRA Disclosure Statement