

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 whose 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											<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
															<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
															<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
															<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
															<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
															<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.

- Do you usually buy, prepare and eat with others you live with? YES NO
If "NO", list who buys their food separately _____
- List the total gross amount of money your household received or expects to receive this month. \$ _____
- How much do all persons have in cash, checking and savings accounts? \$ _____
- How much is your current monthly cost for housing (rent/mortgage) and utilities. \$ _____
- Are you or any person(s) in your household a migrant or seasonal farm worker? YES NO
- 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?	
<input type="checkbox"/> YES <input type="checkbox"/> 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? If "YES" Who? _____ Age? _____ Telephone # () _____ - _____ Address _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	
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? If "NO", Explain: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	
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? If "YES," Who? _____ What Tribe? _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	
12. Are you or any person(s) in your household currently disqualified for an Intentional Program Violation (IPV)? _____ If "YES", Who? _____ What State? _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	
13. Have you or any person(s) in your household been convicted of a felony drug offense on or after August 22, 1996? If "YES", Who? _____ When? _____ Where? _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	
14. Are you or any person(s) in your household currently participating in or have participated in a Drug Addiction or Alcohol Treatment Program? If "YES", Who? _____ Date Entered ____ / ____ / ____ Date Completed ____ / ____ / ____ Facility Name: _____ Facility Address _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	
15. Are you or any person(s) in your household currently wanted by Law Enforcement? If "YES", Who? _____ Why? _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	
PREGNANCY		PREG
16. Are you or any person(s) in your household pregnant? If "YES" Who? _____ Expected Due Date? ____ / ____ / ____ (MM/DD/YYYY)	<input type="checkbox"/> YES <input type="checkbox"/> NO	
DISABILITY		DISA
17. Are you or any person(s) in your household blind, disabled or unable to work due to illness or injury? If "YES", Who? _____ When did this condition begin? ____ / ____ / ____ (MM/DD/YYYY) What is the disability? _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	
NON-CITIZEN INFORMATION		ALIE
18. Are you or any person(s) in your household NOT a U.S. Citizen? 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)	<input type="checkbox"/> YES <input type="checkbox"/> NO	
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? If "YES" Who? _____ School Name? _____ If additional persons "YES" Who? _____ School Name? _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	
EARNED INCOME/WORK HISTORY		JINC/SELF/OINC/QUIT/STRK
20. Are you or any person(s) in your household currently working, including self-employment? 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? _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	

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 YES NO

Service/Agency? _____
 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
<input type="checkbox"/>	Alimony		\$
<input type="checkbox"/>	Boarder/Roomer Income		\$
<input type="checkbox"/>	Child Support (Voluntary or Court Ordered)		\$
<input type="checkbox"/>	Contributions/Gifts		\$
<input type="checkbox"/>	Educational Assistance/Student Loans		\$
<input type="checkbox"/>	Foster Care		\$
<input type="checkbox"/>	General Assistance		\$
<input type="checkbox"/>	Insurance Settlements		\$
<input type="checkbox"/>	Interest/Dividends		\$
<input type="checkbox"/>	Loans		\$
<input type="checkbox"/>	Military Allotment		\$
<input type="checkbox"/>	Mining Claims		\$
<input type="checkbox"/>	Pan Handling		\$
<input type="checkbox"/>	Pensions/Retirement		\$
<input type="checkbox"/>	Property Rentals		\$
<input type="checkbox"/>	Railroad Retirement		\$
<input type="checkbox"/>	Royalties		\$
<input type="checkbox"/>	Social Security Benefits (RSDI)		\$

UNEARNED/OTHER INCOME (CONT)			UNIN/GAGA/LSUM/RINC/RBIN/EDIN
<input type="checkbox"/>	Strike Benefits		\$
<input type="checkbox"/>	Subsidized Housing		\$
<input type="checkbox"/>	Supplemental Security Income (SSI)		\$
<input type="checkbox"/>	Supported Living Arrangement (SLA)		\$
<input type="checkbox"/>	TANF Assistance		\$
<input type="checkbox"/>	Trust Income		\$
<input type="checkbox"/>	Unemployment Insurance		\$
<input type="checkbox"/>	Utility Allowance/Rebate Check		\$
<input type="checkbox"/>	Veteran's Benefits		\$
<input type="checkbox"/>	Gambling Winnings		\$
<input type="checkbox"/>	Worker's Compensation or Temporary Disability		\$
<input type="checkbox"/>	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)
<input type="checkbox"/>	Savings Account			\$	
<input type="checkbox"/>	Checking Account			\$	
<input type="checkbox"/>	Credit Union Account			\$	
<input type="checkbox"/>	Minor Savings			\$	
<input type="checkbox"/>	Business Account			\$	
<input type="checkbox"/>	Christmas Club Account			\$	
<input type="checkbox"/>	Educational Savings Account			\$	
<input type="checkbox"/>	Patient Trust Fund			\$	
<input type="checkbox"/>	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)
<input type="checkbox"/>	Life Insurance			\$ /CSV\$	
<input type="checkbox"/>	Available Trusts			\$	
<input type="checkbox"/>	Unavailable Trusts			\$	
<input type="checkbox"/>	Burial Funds/Plans			\$ /CSV\$	
<input type="checkbox"/>	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)
<input type="checkbox"/>	Savings Bonds				
<input type="checkbox"/>	Stocks or Bonds				
<input type="checkbox"/>	Certificates of Deposit				
<input type="checkbox"/>	Individual Retirement Accounts (IRA)				
<input type="checkbox"/>	Keogh Account (401K)				
<input type="checkbox"/>	Annuities				

PERSONAL PROPERTY					
YES	TYPE OF PROPERTY	OWNER(S)	LOCATION	CONTENTS OR TYPE OF RESOURCE	CURRENT OR MARKET VALUE
<input type="checkbox"/>	Safe Deposit Box				\$
<input type="checkbox"/>	Livestock				\$
<input type="checkbox"/>	Land Mineral Rights				\$
<input type="checkbox"/>	Mining Claims				\$
<input type="checkbox"/>	Business Equipment/ Inventory				\$
<input type="checkbox"/>	Houses/Land or Buildings			Is this property currently for sale? <input type="checkbox"/> Yes <input type="checkbox"/> No	\$

MISCELLANEOUS			
YES	TYPE OF RESOURCE	OWNER(S)	CURRENT VALUE
<input type="checkbox"/>	Promissory Notes		\$
<input type="checkbox"/>	Cash on Hand		\$
<input type="checkbox"/>	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
			<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	\$
			<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	\$
			<input type="checkbox"/> YES <input type="checkbox"/> 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. <input type="checkbox"/> RENT <input type="checkbox"/> MORTGAGE/RELATED EXPENSES <input type="checkbox"/> 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?			<input type="checkbox"/> YES <input type="checkbox"/> 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?			<input type="checkbox"/> YES <input type="checkbox"/> 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?			<input type="checkbox"/> YES <input type="checkbox"/> NO
If "YES", does this utility expense include costs for heating or cooling?			<input type="checkbox"/> YES <input type="checkbox"/> NO
If "NO", please choose the utilities your household is responsible for paying:			
Electricity	<input type="checkbox"/>	Wood	<input type="checkbox"/>
Natural Gas	<input type="checkbox"/>	Propane	<input type="checkbox"/>
Water	<input type="checkbox"/>	Garbage	<input type="checkbox"/>
Sewer	<input type="checkbox"/>	Telephone	<input type="checkbox"/>
Other	<input type="checkbox"/>		<input type="checkbox"/>
40. Does anyone outside your household pay a portion of your utility expenses?			<input type="checkbox"/> YES <input type="checkbox"/> 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?			<input type="checkbox"/> YES <input type="checkbox"/> 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?			<input type="checkbox"/> YES <input type="checkbox"/> 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?			<input type="checkbox"/> YES <input type="checkbox"/> 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?			<input type="checkbox"/> YES <input type="checkbox"/> NO
If "YES", Who? _____			How much per month? \$ _____
45. Does anyone outside the household pay for any of these medical expenses?			<input type="checkbox"/> YES <input type="checkbox"/> 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?			<input type="checkbox"/> YES <input type="checkbox"/> NO
If "YES", Who? _____			When? _____
47. Is there a pending lawsuit because of the injury or accident?			<input type="checkbox"/> YES <input type="checkbox"/> 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?			<input type="checkbox"/> YES <input type="checkbox"/> 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) <input type="checkbox"/> living somewhere else <input type="checkbox"/> disabled or <input type="checkbox"/> deceased			
50. If anyone in your home is pregnant, is the father of the unborn in the home?			<input type="checkbox"/> YES <input type="checkbox"/> NO
If "YES", Who is the father? _____			
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? <input type="checkbox"/> YES <input type="checkbox"/> NO				If YES, where? (City, State)			
<i>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.</i>							
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? <input type="checkbox"/> YES <input type="checkbox"/> NO			
RACE:		SEX:	HAIR COLOR:	EYE COLOR:	WEIGHT:	HEIGHT:	
AT ANY TIME WAS THE MOTHER MARRIED TO THIS NON-CUSTODIAL PARENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				DATE OF MARRIAGE:		PLACE OF MARRIAGE:	
IF MARRIED ARE THEY DIVORCED? <input type="checkbox"/> YES <input type="checkbox"/> NO				DATE OF DIVORCE:		PLACE DIVORCE FILED:	
WAS THE MOTHER MARRIED TO SOMEONE ELSE? <input type="checkbox"/> YES <input type="checkbox"/> NO				ARE THERE OTHER POSSIBLE FATHERS? <input type="checkbox"/> YES <input type="checkbox"/> NO			
EXISTING CHILD SUPPORT COURT ORDER? <input type="checkbox"/> YES <input type="checkbox"/> 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	
					<input type="checkbox"/> YES <input type="checkbox"/> NO		
					<input type="checkbox"/> YES <input type="checkbox"/> NO		
					<input type="checkbox"/> YES <input type="checkbox"/> NO		
<p>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.</p> <p>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.</p>							
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
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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
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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
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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? Will you be 18 years of age or over on or before Election Day? If you checked "no" in response to either of these questions, do not complete this form.	<input type="checkbox"/> Yes <input type="checkbox"/> No	2 Check boxes that apply and complete items 3-13 <input type="checkbox"/> New Registration <input type="checkbox"/> Party Affiliation Change <input type="checkbox"/> Name Change <input type="checkbox"/> Address Change
3	Last Name (Only) _____ First Name (Only) _____ Middle Name (Only) _____ Jr. Sr. 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 <input type="checkbox"/> Democratic Party <input type="checkbox"/> Independent American Party <input type="checkbox"/> Libertarian Party <input type="checkbox"/> Republican Party <input type="checkbox"/> Other Party – Write In Below _____ <input type="checkbox"/> 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 <input type="checkbox"/> AGENCY <input type="checkbox"/> FIELD REGISTRAR <input type="checkbox"/> MAIL <input type="checkbox"/> OTHER	CANCELLED INACTIVE PRECINCT	APPLICATION NO. HA RECEIVED BY: _____ DATE: _____
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NAME OF PERSON RETAINING THIS APPLICATION AGENCY STAMP OR NAME OF AGENCY, 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
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(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: <ul style="list-style-type: none"> your spouse, if married your children who live with you your partner who lives with you (but only if you have children together who need health insurance) anyone you include on your federal tax return, whether they live with you or not If you don't file a tax return, remember to still add family members who live with you. 				
Do you or anyone in your household plan to file a federal income tax return NEXT YEAR?				
<input type="checkbox"/> Yes If yes, who? _____ and answer questions 1 - 3 <input type="checkbox"/> No If no, skip to question 3				
1. Filing Status <input type="checkbox"/> Single _____ Check only one box. <input type="checkbox"/> Married filing jointly <input type="checkbox"/> Married filing separately Name of spouse/partner: _____				
2. Dependents	First Name	Last Name	Relationship	Resides in Household
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you being claimed as a dependent on someone else's tax return? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			If pregnant, how many babies are expected:	
If under age 26, has anyone ever been in foster care? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, who? what state?	
Age when they left the program?			Did they receive health care through a state Medicaid program? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does anyone need help with activities of daily living through personal assistance services or a medical facility? <input type="checkbox"/> Yes <input type="checkbox"/> 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
(775) 684-3651

Reno
(775) 687-1900

Las Vegas
(702) 668-4200

Elko
(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:

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?
- ✓ 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