Joe Lombardo
Governor

NEVADA HEALTH AUTHORITY
DIRECTOR'S OFFICE
4070 Silver Sage Drive
Carson City, NV 89701
NVHA.NV.GOV

Stacie Weeks
Director

Provider Application for Waiver of NRS 439.589(4)

Please complete the following information requested below for **the health care provider** requesting a waiver of the provisions of NRS 439.589(4).

Legal business name:

Business address:

Business phone:

Email:

Applicant legal name:

Applicant National Provider Identifier (NPI) number:

License Number:

Licensure Board/Authority Name:

License expiration date (mm/dd/yyyy):

License type and state where issued:

Name of point of contact for application:

Phone:

Email:

Provider Eligibility

Please answer all of the following questions:

1. Does your practice have access to the internet? _____ Yes _____ No
2. If you do not have access to the internet, why not? (Provide detailed explanation in the box below)

3. Please describe the infrastructure related to maintaining electronic health records currently available to you and your practice in the box below:

4. What additional infrastructure do you need to have to be able to comply with the provisions of NRS 439.589, subsection 4? (Provide description of infrastructure needs in the box below)

5. Explain why obtaining such infrastructure is not reasonably practicable, including cost considerations, in the box below:

6. Should you be granted a waiver of the provisions of NRS 439.589(4), how will you provide health records to your patients and other health care providers in a secure, accessible format? Please explain in the box below:

7. Did you apply for grant funding available through the Nevada Health Authority (formally the Department of Health and Human Services - Division of Health Care Financing and Policy) to health care providers in 2024 and 2025 for the purposes of complying with the requirements of subsection 4 of NRS 439.589? ☐ Yes ☐ No

8. If you did not apply for the funding that was available, why not? Provide an explanation in the box below:

9. What is the average number of patients your practice sees annually? _____

Provider Verification for Waiver Application

I, _____, associated with the health care practice name, _____ _____, located at, _____ _____, hereby declare and affirm that I am applying for a waiver to the Nevada Health Authority from the provisions of NRS 439.589(4) because (***initial next to each***):

_____ I do not currently have the infrastructure necessary to comply with the provisions of NRS 439.589, subsection 4, including, without limitation, because my practice lacks access to internet due to its geographic location in the state; ***and***

_____ Obtaining such infrastructure is not reasonably practicable, including, without limitation, because the cost of such infrastructure would make it difficult for my health care practice to continue to operate.

I, the undersigned, affirm that the contents of this application are true and accurate to the best of my knowledge.

_____

Applicant Signature Date

_____

Printed Name

STATE OF NEVADA)
) : ss.
COUNTY OF _____)

SUBSCRIBED AND SWORN to before me this
_____ day of _____, 20__.

By: _____

_____

NOTARY PUBLIC in and for said
County and State