Medicaid Application for Justice Involved Individuals

This application can be used for Justice Involved Individuals to request a Medicaid determination of eligibility for one of the following programs:

Re-Entry Medicaid Coverage	Suspended Medicaid
Individuals must meet specific program requirements to be considered for this program. *Carceral facilities must attest to the individual meeting these requirements by submitting a completed DWSS Form 2971, Justice Involved Medicaid Transition Request to DWSS.*	*Individuals currently not on a Medicaid program may apply and have DWSS evaluate them for a Medicaid or CHIP program.* *If determined eligible, the individual will have their eligibility suspended until their release from the carceral facility or their circumstances change, and they no longer qualify for Medicaid or CHIP.*

Applicant Information

First Name: Middle Name: Last Name: Suffix: Date of Birth:

Currently incarcerated? ☐ Yes ☐ No Expected release date: ____ / ____ / ____

Facility Name: Facility Address: City: State: Zip Code:

List the current Physical and Mailing address below.

Physical Address:	Apartment Number:	Mailing Address:	Apartment Number:
City: State:	Zip Code:	City: State:	Zip Code:

Daytime Phone #: Ext.: Secondary Phone #: Ext.:

Preferred language (if not English): ☐ Spanish ☐ Other: _____ Interpreter needed? ☐ Yes ☐ No

Currently, notifications are sent by mail. In the future, if available, would you like to receive information by:

Email: ☐ Yes ☐ No Email address:

Social Security Number:

DWSS needs Social Security Numbers (SSNs) (if one has been assigned) for individuals applying for health insurance.

Please ensure the name is listed the same as it is displayed on your Social Security Card.

Social Security Number/Tax ID (**REQUIRED**):	Marital Status:	Pregnant? ☐ Yes ☐ No Due Date: _____ If yes, how many babies are expected: _____	**Sex:** ☐ Male ☐ Female
_____-_____-_____			

Are you legally blind or permanently disabled? ☐ Yes ☐ No

Do you plan to file a federal income tax return NEXT YEAR? ☐ Yes ☐ No

If **no**, are you being claimed as a dependent on someone else's federal income tax return? ☐ Yes ☐ No

If **yes**, name of tax filer: Relationship to You:

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

Current Income Information ☐ Not employed

Are you currently receiving income? ☐ Yes ☐ No

If yes, what type: Gross amount: $

How often are you paid? ☐ Weekly ☐ Every 2 weeks ☐ Semi-Monthly ☐ Monthly ☐ Annually

American Indians or Alaska Natives (AI/AN)

American Indians or Alaska Natives (AI/AN) who enroll in Medicaid and/or the Silver State Health Insurance Exchange can also get services from the Indian Health Services, tribal health programs or urban Indian health programs.

Racial and Ethnicity Information

Are you an American Indian or Alaska Native? ☐ Yes ☐ No

If yes, what tribe?

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	☐ Native Hawaiian	☐ Asian Indian	☐ Korean
☐ African American or Black	☐ Guamanian or Chamorro	☐ Chinese	☐ Other Asian
☐ American Indian or Alaska Native	☐ Samoan	☐ Filipino	☐ Vietnamese
☐ Middle Eastern or North African	☐ Other Pacific Islander	☐ Japanese	☐ Other:_____

Health Insurance Information

Do you currently have health insurance? ☐ Yes ☐ No

If yes, what type? Insurance Company Name:

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 either:

online at: https://www.hhs.gov/civil-rights/filing-a-complaint/index.html

by mail: Director, U.S. Department of Health and Human Services, Office for Civil Rights, Centralized Case Management Operations, 200 Independence Ave, S.W. Room 509F, HHH Building, Washington, D.C. 20201

by phone: Customer Response Center: (800) 368-1019, Fax: (202) 619-3818, TDD: (800) 537-7697

by email: ocrmail@hhs.gov

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.)

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.

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.

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 and to provide information on additional healthcare services available to your household. 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.

Optional Text Messaging Opt-In/Opt-Out

The information provided on this application, including your phone number(s), will be shared with any Department of Health and Human Services (DHHS) Division and Managed Care Organization (MCO) to which you are assigned. Consent authorizes calls and/or texts from DHHS, MCO, or any contractors acting on their behalf, at any phone number(s) you provide on this application, now or in the future, including information regarding healthcare needs and treatment, wellness services, plan benefits, eligibility, renewal and/or redetermination, and for any other communication relating to your relationship with DHHS or the MCO concerning health coverage. These calls/texts may be made using automated technology, such as with an automatic telephone dialing system or artificial or prerecorded voice message. Standard message and data rates may apply.

(Check one of the following;)

☐ I consent to receive text messaging as described above. Preferred Phone (____) _____-_____

☐ I do not consent to receive text messaging as described above. Initials:_____

Health Plan Selection

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 select a preference, you will be assigned a plan randomly. Your choice does not guarantee enrollment into the Nevada Medicaid or Nevada Check Up programs. If you or any family members are already enrolled in one of the current MCOs, you might not be able to switch at this time. Enrolled individuals will receive a member handbook explaining their benefits.

Please Make a Selection:	Contact Phone:	Website: (Visit for more Information)
☐ **Anthem Blue Cross and Blue Shield Healthcare Solutions**	**1-844-396-2329**	mss.anthem.com/Nevada-medicaid.home.html
☐ **Molina Healthcare**	**1-844-327-7136**	meetmolina.com/nv-medicaid
☐ **SilverSummit Healthplan**	**1-844-366-2880**	silversummithealthplan.com
☐ **UnitedHealthcare Health Plan of Nevada Medicaid**	**1-844-962-8074**	myHPNmedicaid.com/Member

☐ **No Preference** *(Note: If you do not choose a Managed Care option, you will be randomly assigned to one by Medicaid)*

For more information on the different MCO plans, visit https://dhcfp.nv.gov/Members/BLU/MCOMain/. If you need to find a provider, visit https://www.medicaid.nv.gov/hcp/provider/Home/tabid/135/Default.aspx, and search for a provider or you can call one of the local Medicaid district offices below:

Statewide Toll Free	TTY	Carson City	Reno	Las Vegas	Elko
(800) 992-0900	(800) 992-0900	(775) 684-3651	(775) 687-1900	(702) 668-4200	(775) 753-1191

Your Rights

If you think we made a mistake or have not acted timely on your application, you can appeal. This 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.

Your Responsibilities

I know that I must tell the program I'll be enrolled in if information I listed on this application changes. I know I can make changes by calling customer service and that I must report by the fifth (5th) of the following month. I understand that a change in my information could affect my eligibility for member(s) of my household.

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.

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.

Signature or Mark of Applicant: Date: **Signature or Witness*:** (Use if applicant cannot read, write, or is blind.) Date:

**The information in this application has been read to the applicant and I have witnessed their signature or mark.*

Submit This Application by:

Email to justicemed@dwss.nv.gov, or;
Fax to 702-631-3387

Did you remember to:

✓ Sign this application?

Disclaimer:

Upon release from the public institution, you must provide the address of where you intend to reside. All important documents, such as eligibility determinations, Medicaid card, etc., will be mailed to the last address you provided.

Designation of Authorized Representative

Applicants may designate an individual or facility to act responsibly on their behalf. This includes assisting with the individual's application for assistance, renewals of eligibility and other ongoing communications with the agency. This designation must include the applicant's signature. For a valid designation, the designated authorized representative must also agree in writing to act responsibly on behalf of the applicant/recipient.
The rights and obligations of an authorized representative are the same as if they were the applicant/recipient to the extent of the applicant/recipient's financial ability to pay.

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

Name of Authorized Representative:	Phone Number: (_____)_____- _____

Mailing Address: *(Required)* City: State: Zip Code:

By signing, you agree to allow this person to act and speak on your behalf with all DWSS matters regarding your Medicaid eligibility. This individual will receive copies of all official notifications about your case with DWSS. NOTE: This authorization is only valid for the current Medicaid eligibility period unless you inform DWSS to terminate the authorization sooner.

_____ / /

Your Signature Date

If you wish to designate a facility as your Authorized Representative, the section below must be completed and signed by the applicant and facility staff member:

I, _____, request the following person/agency: ☐ ☐
(PRINT NAME OF APPLICANT/ RECIPIENT) (CIRCLE ONE)

_____ to be my:
(PRINT NAME OF PERSON OR AGENCY)

- ☐ Primary representative (Receives all requests for information along with any attachments plus all notices. They hold the same responsibility as the customer in securing information for determining eligibility, reporting responsibilities and they are the only one authorized to sign on behalf of the customer. Primary representatives have the same access to case information as a customer.)
- ☐ Secondary representative (Receives the same requests for information and notices as the customer but are not responsible for securing or reporting information; however, if they choose to, they may secure and report the requested information to the DWSS. A secondary representative has the same access to case information as a customer, but cannot sign on behalf of the customer.)

I understand I may terminate this designation in writing at any time and that the authorization for the facility to act as an authorized representative ceases upon release from the public institution.

_____ _____
SIGNATURE OF APPLICANT DATE OF BIRTH DATE

STATEMENT OF DESIGNATED FACILITY REPRESENTATIVE

I believe the above-named applicant/recipient understands the nature and consequences of his/her acts and is able to exercise his/her own will. I certify the above-named applicant/recipient made the decision to designate me as his/her representative under no threat or duress of any kind.

- ☐ As primary representative, I agree to act responsibly on behalf of the above-named applicant/recipient by providing all necessary information to determine eligibility for assistance. I understand my rights and obligations are the same as if I were the applicant/recipient to the extent of the applicant/recipient's financial ability to pay.
- ☐ As secondary representative, I understand I will receive all notifications regarding the above-named applicant/recipient's initial and ongoing eligibility and may provide any information to assist in the eligibility process. **I understand I have no authority to sign on behalf of the above-named applicant/recipient.**

I certify under penalty of perjury, the information I provide is correct and complete to the best of my knowledge.

_____ _____ _____ _____
SIGNATURE OF REPRESENTATIVE (PRINT NAME) POSITION/RELATIONSHIP DATE

_____ _____
ADDRESS TELEPHONE NUMBER

_____
NAME OF JUSTICE INVOLVED FACILITY