Division of Welfare and Supportive Services

APPLICATION FOR ASSISTANCE

"Working for the Welfare of ALL Nevadans"

Programs You May Apply For

Food Stamps (FS) help people buy food.
Temporary Assistance for Needy Families (TANF) helps families with children meet their basic needs with cash/medical care.
Family Medical Coverage (FMC) helps families with dependent children with medical care.
Medical Assistance for the Aged, Blind and Disabled (MAABD) helps aged (65 years and older), blind and disabled individuals with medical care.

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. If any of these persons do not have a SSN, we can help you apply for one. Providing or applying for a SSN is voluntary. 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. If you are applying only for emergency Medicaid because of your immigration status, you do not need to give us information about your SSN if you do not have one.

SSNs are used to verify your family'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. 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. Qualified Alien status is verified with the Bureau of Citizenship and Immigration Services (BCIS) for eligibility purposes. Information on non-applicants or non-qualified aliens will not be shared with BCIS.

Non-Discrimination – No person shall be discriminated against for any reason (such as race, age, color, religion, sex, disability, political belief or national origin) in any program administered by the Nevada State Division of Welfare and Supportive Services (DWSS). To file a complaint for all programs, contact the Nevada State DWSS Administrator, 1470 College Parkway, Carson City, Nevada 89706-7924, (775) 684-0500 or 1-800-992-0900, extension 40500.

OR

For the Food Stamp Program, contact United States Department of Agriculture (USDA), Food and Nutrition Service – Western Region, 50 Seventh Street, Suite 10-100, San Francisco, California 94103, (415) 705-1353, TTY 1-800-735-2922 or you may write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independent Avenue, S.W., Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). For Braille, large print, audiotape, etc., contact USDA's TARGET Center at (202) 720-2600 (voice and TDD).

For Medicaid and/or TANF, contact the United States Office for Civil Rights (OCR), Department of Health and Human Services (HHS), 50 United Nations Plaza, Room 322, San Francisco, California 94102, 1-800-368-1019, TTY (415) 437-8311. USDA and HHS are equal opportunity providers and employers.

To get Food Stamps 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? ____________________ *(this service is 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)*

List everyone who lives in the home with you, whether you consider them household members or not. Please list any unborn children (if someone is pregnant). List the head of household first. You may choose the head of household, which will be the case name. Fill out as much of the application as you can; you may ask for help if you need it.

Race (optional) – please check one of the boxes ☐ Hispanic/Latino or ☐ Non-Hispanic or Latino.
Please list below the ethnicity* code for each household member: A – Asian; B – Black or African American; I – American Indian or Alaska Native; J – American Indian or Alaskan 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.
Please list marital status for each household member: D – Divorced; L – Legally Separated; M – Married; N – Never Married; P – Separated; W – Widowed

NAME LAST NAME, FIRST	RELATION TO YOU	SEX	SOCIAL SECURITY NUMBER OR ALIEN REGISTRATION NUMBER *(optional see cover page)*	STATE OR COUNTRY OF BIRTH	U.S. CITIZEN? Y/N	RACE/ETHNICITY*	DATE OF BIRTH	AGE	LAST GRADE COMPLETED	YEAR COMPLETED	MARITAL STATUS	FS	TANF	FMC	MAABD	NONE
	self															

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

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

Home Phone	Day/Message Phone	E-mail Address

If you are applying for Food Stamps, please answer questions 1 through 5 about your household. A Food Stamp 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. Has anyone received any benefits, including commodities, General Assistance, etc., either in another state or in Nevada? ☐ YES ☐ NO
   If "YES," where? ____________ Last month and year benefits were received ____________
   County and State

UNDER PENALTY OF PERJURY, I SWEAR MY ANSWERS ARE TRUE AND CORRECT.

____
Your Signature Date

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

6.	**Is anyone currently disqualified for an intentional program violation?**	☐ YES ☐ NO
7.	**List the most recent date you started living in Nevada:**	
8.	**Do you plan to continue living in Nevada?** If "NO," explain:	☐ YES ☐ NO
9.	**Is anyone, including a minor child, absent from the home?** If "YES," WHO?	☐ YES ☐ NO
10.	**Is anyone a member of an American Indian or Alaskan Native Tribe?** If "YES," WHO? What TRIBE?	☐ YES ☐ NO
11.	**Have you or anyone you live with been convicted of a felony drug offense?** If "YES," Who and When?	☐ YES ☐ NO
12.	**Is anyone in the household currently wanted by law enforcement?** WHO? ____________ Why? ____________	☐ YES ☐ NO
13.	**Does anyone have medical bills for the past three months that you want help with?** WHO? What months?	☐ YES ☐ NO

ALIEN / REFUGEE — ALIE

14. Is there anyone in the household who is NOT a U.S. CITIZEN? ☐ YES ☐ NO
If "YES," complete below.

List Non-citizens	Alien Number	If Alien Number is not known, explain why

SCHOOL ATTENDANCE — SCHL

15. Is any household member 16 years or older attending school? ☐ YES ☐ NO
If "YES," WHO? WHAT SCHOOL?

PREGNANCY — PREG

16. Is anyone pregnant? If "YES," complete below. ☐ YES ☐ NO
WHO? Expected Due Date:

DISABILITY — DISA

CHECK ALL THAT APPLY:

17. Is anyone in your home ☐ **Age 65 or Older** ☐ **Blind** ☐ **Disabled** ☐ **None of these**
If DISABLED, who is disabled? ____________
Date most recent disability began: ____________
What is the disability? ____________

18. Have you ever applied for, or received disability through Social Security Administration, including SSI and/or RSDI? ☐ YES ☐ NO
If "YES," complete below.

WHO	Applied (mo./yr.)	Approved (mo./yr.)	Denied (mo./yr.)	Appeal Denial (mo./yr.)

MEDICAL FACILITY	GRIN
19. Is a household member currently in a hospital, nursing home or other medical facility? If "YES," complete below. WHO?	☐ YES ☐ NO
Facility name and address	**Date entered**
Are they likely to stay 30 days or longer?	☐ YES ☐ NO

20. Was anyone, applying for assistance in a hospital, nursing home or other medical facility during the past three (3) months? ☐ YES ☐ NO

If "YES," WHO? ____________ Date Entered: ________ Date Left: ________

Facility Name: ____________

Address: ____________

21. Has anyone, applying for assistance, participated in a Drug Addiction or Alcohol Treatment Program? ☐ YES ☐ NO

If "YES," WHO? ____________ Date Entered: ________ Date Completed: ________

Facility Name: ____________

Address:

COMPLETE QUESTIONS 22 THROUGH 25 ONLY IF YOU ARE APPLYING FOR MEDICAID FOR THE AGED, BLIND OR DISABLED.

SPOUSE INFORMATION			SHST
22. Complete the following on your current or most recent spouse. If spouse is deceased, all possible information must still be completed.			
Spouse's name:			
Address:			
Social Security Number:		Date of birth:	Date of death:
Veteran? ☐ YES ☐ NO	Claim No.	Branch of Service:	
Employer name/address:		Medical insurance	Are you covered? ☐ YES ☐ NO

23. Has your spouse worked for a railroad company or for federal, state, county or city government? ☐ YES ☐ NO
If "YES," complete below.

Employer name/address:		
Dates employed:	Claim No.	Identification No.

24. Additional spouse information. List information on all other marriages.

Spouse's name: Last		First	Middle
Address:			
Social Security Number	Divorced? ☐ YES ☐ NO Date	Widowed? ☐ YES ☐ NO Date	Veteran? ☐ YES ☐ NO Claim No.
Railroad, federal or local government employee? ☐ YES ☐ NO			
RR or Gov claim No.		Years employed:	

Spouse's name: Last		First	Middle
Address:			
Social Security Number	Divorced? ☐ YES ☐ NO Date	Widowed? ☐ YES ☐ NO Date	Veteran? ☐ YES ☐ NO Claim No.
Railroad, federal or local government employee? ☐ YES ☐ NO			
RR or Gov Claim No.		Years employed:	

25. If you or your spouse live in a medical facility now, do you or your spouse intend to return to your residence? ☐ YES ☐ NO

OTHER INFO	QUIT	STRK

26. In the last 60 days did anyone leave a job, stop working or quit? ☐ YES ☐ NO

If "YES," WHO? ______________________ Explain: ______________________

27. Is anyone currently on strike? ☐ YES ☐ NO

If "YES," WHO?

BANK/CARS	RESOURCES	LIFE/PROP

ANSWER EVERY QUESTION: YES or NO

28. Does anyone in the home own or share ownership in any of the listed resources?

Be aware that by virtue of the provision of medical assistance for institutional care, annuities purchased on or after February 8, 2006 must name the State of Nevada as the remainder beneficiary.

YES	NO	TYPE	OWNER(S)	LOCATION	ACCT. NUMBER	VALUE
		Savings Account				
		Checking Account				
		Credit Union Account				
		Minor Savings				
		Business Accounts				
		Christmas Club Acct.				
		Available Trusts				
		Unavailable Trusts				
		Savings Bonds				
		Stocks or Bonds				
		Safe Deposit Box				
		Certificate of Deposit				
		IRA				
		Keogh Acct. (401K)				
		Individual Indian Money Account				
		Life Insurance				
		Burial Funds/Plan				
		Patient Trust Fund				
		Life Estates				
		Promissory Notes				
		Livestock				
		Land Mineral Rights				
		Business Equipment/Inventory				
		Mining Claims				
		Houses/Land or Buildings				
		Cash on Hand				
		Other				

29. Are any of the resources in question 28 money for burial? ☐ YES ☐ NO

If "YES," which items?

30. Does anyone own, or are they buying, a car, motorcycle, trailer, truck, camper, boat, motor home, etc.? Include vehicles that are not working. ☐ YES ☐ NO

OWNER	Type	Year, Make & Model	Value	Amount owed	Check if registered

TRANSFERRED RESOURCE — TRAN

31. Has anyone sold, traded or given away money, vehicles, property or other resources or closed any bank accounts, or purchased any annuities in the last 60 months? ☐ YES ☐ NO

If "YES," give date and complete below.

Name of person you sold or gave this to:		Relationship to you:
Address:		
Type of resource/gift:		
Explanation of why:		
Total sales price $	Are you getting time payments? ☐ YES ☐ NO How much? How often?	Value of resources/or gift $
Do you have a remaining interest in this property? ☐ YES ☐ NO	If property was sold, was it on the open market? ☐ YES ☐ NO	

For Official Use Resources:

EARNED INCOME / WORK HISTORY — JINC / SELF / OINC

32. List current and last employer for everyone in your household, including self-employment and odd jobs.

Dates Employed MM/YY	Name of Person Working	Name and Address of Employer	How Often Paid	Hours Worked per Week	Hourly Wage	Tips per pay period	If no longer employed, date and reason for leaving

33. Does anyone, applying for assistance, work in exchange for food, shelter or other? If YES," complete below. ☐ YES ☐ NO		
Person working in exchange	What do you receive for your work?	Value
		$
		$
		$

MORE INCOME

UNIN / GAGA / LSUM / RINC / RBIN / EDIN

ANSWER EVERY QUESTION: YES or NO

34. Has anyone applied for or is anyone currently receiving any money from the listed sources?

YES	NO	SOURCE	Person Receiving	Gross Amount Per Month
		Alimony		
		Boarders / Roomers		
		Child Support		
		Contribution / Gifts		
		Educational Assistance / Student Loans		
		Foster Care		
		Insurance Settlements		
		Interest / Dividends		
		Loans		
		Military Allotment		
		Mining Claims		
		Pan Handling		
		Pensions / Retirements		
		Property Rentals		
		Railroad Retirement		
		Royalties		
		Social Security Benefits (RSDI)		
		Strike Benefits		
		Subsidized Housing		
		Supplemental Security (SSI)		
		Supported Living Arrangement (SLA)		
		TANF Assistance		
		Trust Income		
		Unemployment Insurance		
		Utility Allowance / Rebate Check		
		Veteran's Benefits		
		Winnings		
		Worker's Compensation or Temporary Disability		
		Other		

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

36. Is anyone in your household a veteran? ☐ YES ☐ NO

If "YES," complete below.

Branch of Service	VA Claim Number	Serial Number	Dates of Service

37. Has any household member worked for the railroad company or for federal, state, county or city government? If "YES," complete below. ☐ YES ☐ NO		
Who: Name of employer:		
Address of employer:		
Dates you were employed:	Claim Number:	Identification Number:

For Official Use Income:

SUPPORT EXPENSE	SUDE

38. Does anyone pay court-ordered child support? ☐ YES ☐ NO

WHO? ______________________ How much? $ __________ per __________ (day/week/month)

For what children?

RENT/HOME	SHELTER EXPENSE	UTIL

39. List the monthly shelter expenses for your household or for your spouse's household if you are currently residing in a medical facility.

Rent or Space Rent	$	Electricity	$	Water	$
Mortgage (including 2nd)	$	Natural Gas	$	Garbage	$
Property Taxes	$	Propane	$	Sewer	$
Home Insurance	$	Heating Oil	$	Telephone	$
Association Fees	$	Wood	$	Other	$

40. How is your apartment/home heated/cooled? ☐ **Gas** ☐ **Electric** ☐ **Propane** ☐ **Wood** ☐ **Other:** __________

41. Does anyone else pay for a portion of your shelter expenses? ☐ YES ☐ NO

WHO? ______________________ How much? $ __________ How often? __________

42. Is your rent subsidized? (HUD, Section 8, Housing, Low-income, etc.) ☐ YES ☐ NO

List your landlord's / rental company's name, address and telephone number.

Name	*Address*	*Telephone*

MEDICARE — MEDI

43. Does anyone, applying for assistance, have medical benefits through either Medicare (Part A or B) or Railroad Retirement Coverage? If "YES." complete below. ☐ YES ☐ NO

WHO? ____________ What coverage? ____________ Claim # ____________

44. Did anyone, applying for assistance, refuse Medicare (Part A or B)? ☐ YES ☐ NO

If "YES," WHO? When? What Coverage?

MEDICAL INSURANCE — MINS

45. Does anyone, applying for assistance, have any health/dental insurance or Medicare Prescription Drug Card? If "YES," complete below. ☐ YES ☐ NO

(Include employer group insurance, CHAMPUS and insurance coverage through a spouse, ex-spouse, parent, etc.)

Insurance company name/address

Policy in name of

Policy Owner's Social Security No.	Group or policy number	Effective date of coverage

Amount Paid $	How often paid?

Persons covered:

MEDICAL EXPENSES — MEDX

46. Does anyone who is elderly or disabled have medical expenses? ☐ YES ☐ NO

If "YES," how much are the expenses each month? $ ____________

47. Does anyone else pay any of these expenses for you? ☐ YES ☐ NO

If "YES," what expenses? ____________

Name and Address of person/agency paying for expenses:

INJURIES / ACCIDENTS — SETT

48. Has anyone, applying for assistance, been injured in an accident? ☐ YES ☐ NO

If "YES," WHO? ____________ When? ____________

49. Is anyone, applying for assistance, receiving medical treatment for injuries caused by an accident? ☐ YES ☐ NO

If "YES," WHO? ____________ When? ____________

50. Was anyone, applying for assistance, injured in the custody of a law enforcement agency? ☐ YES ☐ NO

If "YES," WHO? ____________ When? ____________

51. Is there a pending lawsuit because of an injury or accident? ☐ YES ☐ NO

If "YES," give details: ____________

52. Does anyone, applying for assistance, expect an insurance reimbursement, payment or legal settlement? ☐ YES ☐ NO

If "YES," from whom? ____________

Attorney Name and Address:

DEPENDENT CARE EXPENSES	DCEX

53. Does anyone pay childcare or care for a disabled adult? ☐ YES ☐ NO

If "YES," how much are the expenses each month? $ ____________

54. Does anyone or agency help pay day care costs? ☐ YES ☐ NO

Who pays? ______________________________ How much? $ __________ per ___________ (day/week/month)

For Official Use Expenses and TPL:

ABSENT PARENT INFORMATION	NCPM

55. Is the father / mother of the child(ren) you are applying for benefits:

(check one) ☐ **living somewhere else** ☐ **disabled** **or** ☐ **deceased?**

56. If anyone in your household is expecting a child, is the father living in the home? ☐ YES ☐ NO

Who?

Complete the following information for the parents of your child(ren) who are not living with you (including the parent of an unborn child). If there are more than one possible parent, complete a form for each one. Also, list your parent if you are under 18 and are not living with them. Please provide as much information as possible.
*** Please make copies or request additional copies of this page for additional parents.**

JIM GIBBONS
Governor

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

NANCY KATHRYN FORD
Administrator

NON-CUSTODIAL PARENT (NCP) FORM

When applying for TANF and/or Medicaid assistance, the law requires you to cooperate with Child Support Enforcement (CSE) to establish paternity to get child support and/or medical 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 and medical support, reviews and adjusts existing child support orders, and collects and distributes financial and medical support payments. If you are requesting medical assistance only, you may request in writing you only want medical support services.

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, visitation or unpaid medical bills. 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 and you will be ineligible for Medicaid. 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 or health insurance 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)**	

Social Security Number of the Parent Who Does Not Live With You:	***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:

DATE LAST SEEN OR CONTACTED::	TELEPHONE / CELL PHONE:

RACE:	SEX:	HAIR COLOR:	EYE COLOR:	WEIGHT:	HEIGHT:	IS HE OR SHE DISABLED? ☐ YES ☐ NO

BIRTH CITY AND STATE:	DATE OF BIRTH:	DATE OF DEATH:
AT ANY TIME WAS THE MOTHER MARRIED TO THIS NON-CUSTODIAL PARENT? ☐ YES ☐ NO	DATE OF MARRIAGE:	DATE OF DIVORCE:

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) and medical programs where the adult and child(ren) receive Medicaid must be referred for Child Support Enforcement. I understand if there is no adult in my family receiving medical assistance, and I would like to receive Child Support Enforcement services, I must submit an application for assistance with the appropriate state or county child support agency.

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:

AUTHORIZED REPRESENTATIVE	AREP

57. Do you want someone other than yourself to apply for benefits or act on your behalf? ☐ YES ☐ NO
(This would include obtaining and using your EBT card for you. This person must be at least 18 and provide I.D.) If "YES," complete below.

Who? ____

Name *Address* *Telephone Number* *Age*

58. In Case of an Emergency, Contact:

____

Name, Relationship, Address and Telephone Number

IMPORTANT NOTICE
NEVADA CHECK ✓ UP PROGRAM INFORMATION

If you are denied Medicaid benefits, your child may be eligible for the Nevada Check ✓ Up Program. This program provides low-cost, comprehensive health care coverage to uninsured children up to age 19, who are not eligible for Medicaid and not covered by private insurance. To find out if you qualify or to request an application, call toll free 1-800-360-6044.

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.

Electronic Benefits Transfer (EBT) – Any Food Stamp benefits that are not used in an EBT account for 365 days will be removed from the account and returned to Food and Nutrition Service (FNS) as required by federal regulations. Any unused benefits can be applied (credited) to an outstanding Food Stamp claim (overpayment) the household may have. By signing this application, you are authorizing the Division of Welfare and Supportive Services (DWSS) to apply any unused EBT Food Stamp benefits to any unpaid or outstanding Food Stamp debt you or any adult member of your household may owe to the Food Stamp Program.

Time Frames – If eligible, Food Stamp benefits are issued from the date of the application, Medicaid benefits are issued from the 1st day of the month you apply and TANF benefits are paid from the date of approval or 30 days from the date of the application, whichever is sooner. If eligible, Food Stamp benefits are processed 30 days from the date of the application. If your household has little or no income, you could receive Food Stamps within 7 days from the date of your application. TANF and most Medicaid applications are processed within 45 days from the application date unless there are unusual circumstances. Denial of benefits of one program does not automatically affect the decision on other programs you may be applying for.

Important Information – If you are applying for TANF and Food Stamps with this application and your TANF benefits are approved, any adjustment to your Food Stamp 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 Food Stamp benefits resulting from the TANF approval. If your TANF benefit is less than $10.00, you will receive Medicaid only and 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.

Work Requirements: If you are approved for TANF and/or Food Stamps, 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.

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 for the Food Stamp Program. The 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.

Third Party Liability – If any of my household members receive Medicaid, I agree to assign all rights to any medical claims, medical support or other payments for medical care. I understand this is a condition of being eligible for Medicaid. I agree to cooperate with the Department of Health and Human Services in obtaining payments for medical care from any third party or person who may be liable for the medical services paid for by the Medicaid Program. I also understand I must inform the DWSS if any legal action is taken against anyone or if I receive any offer or settlement for the reimbursement of medical care and treatment that may be paid for by the Medicaid Program.

Initials ____________

Parental Financial Responsibility for Medicaid Services Provided to Disabled Children – I understand as a parent of a disabled minor child who receives services under the Medicaid Program, I may be responsible to contribute to the support of my child by reimbursing the Department of Health and Human Services for services paid on behalf of my child(ren) pursuant to NR 125B.020 and NRS 422.310. I agree to cooperate with the Department of Human Resources in providing all information regarding income, resources and medical insurance, necessary to determine the amount of the reimbursement. If I fail to cooperate or provide the information requested, I am responsible for a monthly reimbursement payment in the amount of $1,900.

Important Child Support Information – By signing this application and by receiving TANF and/or Medicaid 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 and/or Medicaid 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 and/or Medicaid assistance, the law requires you to cooperate with CSE to establish paternity to get child support and/or medical 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 to not cooperate has not been determined, your household will be ineligible for TANF and you will be ineligible for Medicaid.

If TANF and/or Medicaid assistance 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: http://www.welfare.state.nv.us/child.htm 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 and/or Medicaid? ☐ Yes ☐ No

Initials ____________

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.)

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 Food Stamps 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 Food Stamps 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 Division office or the administration office. For Food Stamps, you may request a hearing by calling your local district Division office. You may also request a hearing by signing and returning the Notice of Decision you receive. You must request a hearing for TANF, Food Stamps or Medicaid within 90 days of the notice date. For other Social Service Programs, you must request a hearing within 13 days from 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.

Your Responsibilities – You must report changes in your mailing address immediately. 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.

Changes must be reported immediately after you apply and before you are approved benefits. Once your Food Stamp benefits are approved, you must report within 10 days from the date the change happened, and once your TANF and/or Medicaid benefits are approved, proof of the change must be postmarked by the 5th of the following month. 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 Food Stamp 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 Food Stamps 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, this will be considered 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. This information may also include education records (including IEP records) maintained at the local school district that are necessary for Medicaid reimbursement purposes for health services provided to my child. 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 13 – 16 where indicated on this application, it does not release me or my household members from those requirements / obligations.

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 any changes in my household circumstances that may affect my benefits. I understand failure to report changes may cause an overpayment which I would be responsible to pay back and could even be prosecuted by the 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)** **Date**

Signature or Mark of Applicant **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**

Case Manager's Signature **Date**

Non-Discrimination – No person shall be discriminated against for any reason (such as race, age, color, religion, sex, disability, political belief or national origin) in any program administered by the Nevada State Division of Welfare and Supportive Services (DWSS). To file a complaint for all programs, contact the Nevada State DWSS Administrator, 1470 College Parkway, Carson City, Nevada 89706-7924, (775) 684-0500 or 1-800-992-0900, extension 40500.

OR

For the Food Stamp Program, contact United States Department of Agriculture (USDA), Food and Nutrition Service – Western Region, 550 Kearney Street, Suite 400, San Francisco, California 94108, (415) 705-1353, TTY 1-800-735-2922 or you may write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independent Avenue, S.W., Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). For Braille, large print, audiotape, etc., contact USDA's TARGET Center at (202) 720-2600 (voice and TDD).

For Medicaid and/or TANF, contact the United States Office for Civil Rights (OCR), Department of Health and Human Services (HHS), 50 United Nations Plaza, Room 322, San Francisco, California 94102, 1-800-368-1019, TTY (415) 437-8311. 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 Food Stamps, you may request a hearing by calling your local district DWSS office. You may also request a hearing for assistance programs such as TANF, Food Stamps or Medicaid within 90 days of the notice date. For Social Service programs, you must request a hearing within 13 days from 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.

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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 www.welfare.state.nv.us

This is Your Copy, Keep This Page for Your Records