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/medical care.
Medical Coverage under Family Medical Coverage (FMC) which helps families with dependent children with medical care or the Medical Assistance for the Aged, Blind and Disabled (MAABD) program which helps aged (65 years and older), blind and disabled individuals with medical care.

Time Frames

If eligible, SNAP 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, 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. 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 for which 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. 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 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	MEDICAL	NONE
				SELF											☐	☐	☐	☐
															☐	☐	☐	☐
															☐	☐	☐	☐
															☐	☐	☐	☐
															☐	☐	☐	☐
															☐	☐	☐	☐

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

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

Race (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 Phone	E-mail Address

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

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

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

Your Signature Date

FOR OFFICE USE ONLY – EXPEDITED SERVICE SCREENING: HOUSEHOLD ELIGIBLE FOR EXPEDITED SERVICE?

☐ YES ☐ NO Expedited service screener signature: ______________________ DATE: __________

AUTHORIZED REPRESENTATIVE	AREP

7. Do you want someone other than yourself, age 18 or older, to apply for benefits or act on your behalf? ☐ YES ☐ NO
If "YES," Who? ______________________ Age? _____ Telephone # (____) ______ – ______
Address ______________________

8. In case of emergency, who would you like us to contact? Name: ______________ Relationship ______
Daytime Telephone # ______________ Address ______________________

ADDITIONAL HOUSEHOLD INFORMATION

9. Do you plan to continue living in Nevada? ☐ YES ☐ NO
If "NO," Explain: ______________________

10. List the most recent date you started living in Nevada. ________/________ (MM/YYYY)

11. Are you or any person(s) in your household a member of an American Indian or Alaskan Native Tribe? ☐ YES ☐ NO
If "YES," Who? ______________________ What Tribe? ______________

12. Are you or any person(s) in your household currently disqualified for an Intentional Program Violation (IPV)? ☐ YES ☐ NO
If "YES," Who? ______________________ Where? ______________

13. Have you or any person(s) in your household been convicted of a felony drug offense on or after August 22, 1996? ☐ YES ☐ NO
If "YES," Who? ______________ When? __________ Where? __________

14. Are you or any person(s) in your household currently participating in or has participated in a Drug Addiction or Alcohol Treatment Program? ☐ YES ☐ NO
If "YES," Who? ______________ Date Entered ___/___/___ Date Completed ___/___/___
Facility Name: ______________ Facility Address ______________

15. Are you or any person(s) in your household currently wanted by Law Enforcement? ☐ YES ☐ NO
If "YES," Who? ______________________ Why? ______________

16. Are you or any person(s) in your household a veteran? If "YES," complete below. ☐ YES ☐ NO

Who	Branch of Service	From	To
		/	/
		/	/

17. Have you or any person(s) in your household worked for the railroad or been a city, county, state or federal government employee? ☐ YES ☐ NO
If "YES," Who? ______________ Dates of Employment. From ______/______ to ______/______
Employer's Name ______________ Employer's Address ______________
Employer's Telephone ______________________

PREGNANCY	PREG

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

DISABILITY	DISA

19. Are you or any person(s) in your household Blind, Disabled or unable to work due to illness or injury? ☐ YES ☐ NO
If "YES," Who? ______________ When did this condition begin? ___/___/___ (MM/DD/YYYY)
What is the disability? ______________________

20. Have you or any person(s) in your household ever applied for or received disability payments through the Social Security Administration, including SSI and/or RSDI? ☐ YES ☐ NO
If "YES," Who? ______________________ Date Benefits Applied for: ______/______ (MM/YYYY)
Status of application: ☐ Approved ☐ Denied ☐ In Appeal; If in appeal Date of Appeal ______/______/______

NON-CITIZEN INFORMATION	ALIE

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

SCHOOL ATTENDANCE	SCHL

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

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

23. Are you or any person(s) in your household **currently** working, including self employment? ☐ YES ☐ NO

If "YES," Who is employed? ____________ Hourly Wage? $________ Hours worked per week? ______

How often are they paid? ____________ Tips received per month? $____________

Start Date? ____/____/____

Employer's Name ____________ Employer's Telephone ____________

Employer's Address ____________

If "YES," for additional household members:

Who is employed? ____________ Hourly Wage? $ ________ Hours worked per week? ______

How often are they paid? ____________ Tips received 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.

24. 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 were 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 house members:

Who was employed? ____________ Hourly Wage? $ ________ Hours worked per week? ______

How often were 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

25. Are you or any person(s) in your household currently registered with a Temporary Employment Service/Agency? ☐ YES ☐ NO

If "YES," Who? ____________ Which Service/Agency? ____________

26. Are you or any person(s) in your household currently on Strike? ☐ YES ☐ NO

If "Yes," Who? ____________

27. 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? ____________

For Official Use – Earned Income

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

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

YES	SOURCE	Person Applied/Receiving	Gross Amount Per Month
☐	Alimony		$
☐	Boarder/Roomer Income		$
☐	Child Support		$
☐	Contribution/Gifts		$
☐	Educational Assistance/Student Loans		$
☐	Foster Care		$
☐	General Assistance		$
☐	Insurance Settlements		$
☐	Interest/Dividends		$
☐	Loans		$
☐	Military Allotment		$
☐	Mining Claims		$
☐	Pan Handling		$
☐	Pensions/Retirement		$
☐	Property Rentals		$
☐	Railroad Retirement		$
☐	Royalties		$
☐	Social Security Benefits (RSDI)		$
☐	Strike Benefits		$
☐	Subsidized Housing		$
☐	Supplemental Security Income (SSI)		$
☐	Supported Living Arrangement (SLA)		$
☐	TANF Assistance		$
☐	Trust Income		$
☐	Unemployment Insurance		$
☐	Utility Allowance/Rebate Check		$
☐	Veteran's Benefits		$
☐	Gambling Winnings		$
☐	Worker's Compensation or Temporary Disability		$
☐	Other: (please list)		$

INCOME MANAGEMENT

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

For Official Use Unearned Income & Income Management:

RESOURCES	BANK/LIFE/PROP

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

BANK ACCOUNTS

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

LIFE INSURANCE/TRUSTS/BURIALS

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

INVESTMENTS & RETIREMENT ACCOUNTS

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

PERSONAL PROPERTY

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

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

31. Are any of the resources in question 30 designated as money for burial? ☐ YES ☐ NO

If "YES," Which Resources? ______________________________

VEHICLES

CARS

32. Do you or any person(s) in your household own, or are they buying, a car, motorcycle, trailer, truck, camper, boat, motor-home, ATV, etc.? (Please include any vehicles that are not currently working.) ☐ YES ☐ NO

If "YES," Please complete the information below:

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

TRANSFERRED RESOURCE

TRAN

33. Have you or any person(s) in your household sold, traded or given away money, vehicles, property or other resources, closed any bank accounts or purchased any annuities in the last 60 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?

For Official Use Resources:

HOUSING EXPENSES — RENT/HOME/UTIL

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

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

36. What is your landlord's name? ____________________ Landlord's Telephone Number ( ) –
What is your landlord's address? ____________________

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

38. If "YES," By what agency? ____________________ How much is subsidized? $ ________

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

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

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

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

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

42. Does anyone outside your home pay a portion of your utility expenses? ☐ YES ☐ NO
If "YES," Who? ____________________ How Much? $ ________ How Often? ________

OTHER EXPENSES — SUDE/MEDX/DCEX

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

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

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

46. Does anyone age 60 or over, or any person(s) who is disabled have out-of-pocket medical expenses? ☐ YES ☐ NO
If "YES," Who? ____________________ How much per month? $ ________

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

For Official Use Expenses:

MEDICAL COVERAGE

48. Do you or any person(s) in your household have medical bills for the past three months that they want help with? ☐ YES ☐ NO
If "YES," Who? ______________ What months? ______________

MEDICAL FACILITY | GRIN

49. Are you or anyone in your household currently in a hospital, nursing home or other medical facility? ☐ YES ☐ NO
If "YES," please complete the following information:
Who? ______________ Date Entered ___/___/___ (MM/DD/YYYY)
Facility Name: ______________ Facility Address: ______________
Is this person expected to stay longer than 30 days? ☐ YES ☐ NO

50. Were you or any person(s) in your household in a hospital, nursing home or other medical facility during the last three (s) months? ☐ YES ☐ NO
If "YES," please complete the following information:
Who? ______________ Date Entered ___/___/___ Date Left ___/___/___
Facility Name: ______________ Facility Address: ______________

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

SPOUSE INFORMATION | SHST

Please complete the following information only if you are applying for Medicaid for the Aged, Blind or Disabled.

52. Complete the following information for your current or most recent spouse. If your current or most recent spouse is deceased, please provide as much information as possible.
Spouse's Name ______________
Spouse's Social Security Number ___–___–___ Date of Birth ___/___/___ Date of Death ___/___/___
Is/was your spouse a Veteran? ☐ YES ☐ NO If "YES," Branch of Service ______________
Spouse's Address ______________
Is your spouse currently employed? ☐ YES ☐ NO If "YES," Employer's Name ______________
Employers Address ______________
Does your spouse have medical insurance? ☐ YES ☐ NO

53. Has your current spouse or any previous spouse ever worked for the railroad or for a city, state, county or the federal government? ☐ YES ☐ NO
If "YES," Who? ______________ Employer's Name ______________
Employer's Address ______________
Dated Employed ___/___ to ___/___ Claim or Identification Number ______________

THIRD PARTY LIABILITY

MEDICARE | MEDI

54. Are you or any person(s) in your household eligible for or enrolled in Medicare? ☐ YES ☐ NO
If "YES," Who? ______________ Medicare Claim # ______________

MEDICAL INSURANCE | MINS

55. Do you or any person(s) in your household have any health/dental insurance? ☐ YES ☐ NO
If "YES," please complete the following questions' be sure to include employer group insurance, CHAMPUS and insurance coverage through a spouse, ex-spouse or parent. Person(s) Covered ______________
Insurance Company Name: ______________ Group/Policy Number ______________
Policy Holder's Name ______________ Policy Owner's Social Security Number ___/___/___
Effective date of coverage ___/___ (MM/YYYY) Type of Coverage
Do you or any person(s) in your household pay a premium for this coverage? ☐ YES ☐ NO
If "YES," How much per month? $ ______________

56. Do you or any person(s) in your household have insurance coverage available that has not been pursued? ☐ YES ☐ NO
If "YES," Who? ______________ From Where? ______________

INJURIES/ACCIDENTS	SETT

57. Have you or anyone in your household been injured or in an accident in the last 12 months? ☐ YES ☐ NO
If "YES," Who? ______________________ When? ______________________
Was medical treatment received for this injury/accident? ☐ YES ☐ NO If "YES," When? ______________
Is there a pending lawsuit because of the injury/accident? ☐ YES ☐ NO
If "YES," What is the Attorney's Name ______________________
Attorney's Address ______________________
Did the injury or accident occur while in the custody of law enforcement? ☐ YES ☐ NO

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

For Official Use Medical Coverage and TPL.

ABSENT PARENT INFORMATION	NCPM

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

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

Complete the following form with information about the absent parent9) 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. Also, please complete a form for your parent(s) 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.

For official Use Child Support

JIM GIBBONS
Governor

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

ROMAINE GILLILAND
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)**	

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

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	MODIFIER (Jr., Sr., etc.):
ADDRESS:			
CITY:	STATE:	ZIP:	
SOCIAL SECURITY NUMBER:	TELEPHONE / CELL PHONE:		
DATE OF BIRTH:	BIRTH CITY AND STATE:		
IF DECEASED, DATE OF BIRTH:	IF DECEASED, DATE OF BIRTH:		
DATE LAST SEEN OR CONTACTED:	IS HE OR SHE DISABLED? ☐ YES ☐ NO		

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

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

INFORMATION ON THE CHILDREN FOR THIS ABSENT PARENT:

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

All cases for Temporary Assistance for Needy Families (TANF) 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:

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, go to http://nevadacheckup.nv.gov, or call toll free 1-877-543-7669.

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)

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.

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.

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 SNAP. 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.

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 the 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.

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: 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 and/or Medicaid? ☐ Yes ☐ No

Initials ____________

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 NRS 125B.020 and NRS 422A.460. I agree to cooperate with the Department of Health and Human Services 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.

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 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, SNAP 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

If you are applying for TANF and/or Medicaid:

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 request for TANF and Medicaid.

If your household is designated as a *Simplified Reporting Household* you will only need to report if you move out of state or your household's income exceeds 130% of the federal poverty 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 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. 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 12-14 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 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)** **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

"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, SNAP 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.

Your Responsibilities

If you are applying for TANF and/or Medicaid:

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 request for TANF and Medicaid.

If your household is designated as a *Simplified Reporting Household* you will only need to report if you move out of state or your household's income exceeds 130% of the federal poverty 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 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.

Information regarding NPHF and available services can be located at http://www.nphf.org/ or contact NPHF at (775) 884-0392 or by fax at (775) 884-0274. To email specific NPHF staff, type in the first name of the staff person followed by @nphf.org.

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 2905 – EG/A (3/09)