



Application for Suspended Medicaid

This application is used to apply for Suspended Medicaid.

This application is used for individuals who are preparing to exit a correctional facility and will remain in a suspended status until the individual is released.

Social Security Number

We need Social Security Numbers (SSNs) for everyone applying for health insurance who has one. An SSN is optional for people not applying for insurance; however, providing one can speed up the application process.

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

American Indians or Alaska Natives (AI/AN)

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

Contact / Applicant Information

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

Currently incarcerated? Yes No Expected release date: (less than 6 months) ____ / ____ / ____

Facility Name: _____ Facility address: _____ City: _____ State: _____ Zip Code: _____

After release, list the Home and Mailing address below where you intend to reside. Must provide a valid mailing address.

Home Address: _____ Apartment Number: _____ Mailing Address: _____ Apartment Number: _____

City: _____ State: _____ Zip Code: _____ City: _____ State: _____ Zip Code: _____

Daytime Phone # _____ Ext. _____ Secondary Phone # _____ Ext. _____

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

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

Email: Yes No Email address: _____

Social Security Number (OPTIONAL) ____-____-____	Marital Status _____	Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Due Date: _____ If yes, how many babies are expected: _____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
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Are you legally blind or permanently disabled? Yes No

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

Are you a U.S. citizen? Yes No Have you lived in the U.S. since 1996? Yes No

If not a U.S. citizen, do you have eligible immigration status? Yes No

If yes, provide the following information: Type: _____ ID Number: _____

Are you, your spouse, domestic partner, or your parent (if you are a minor) an honorably discharged veteran or active-duty member of the military? Yes No

Current Income Information <input type="checkbox"/> Not employed	
Are you currently receiving income?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what type:	Gross amount: \$
How often are you paid?	<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually
RACE / ETHNICITY	
Are you an American Indian or Alaskan Native?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what tribe?	
Are you Hispanic, Latino or of Spanish origin? (optional)	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Hispanic/Latino (check all that apply - optional):	<input type="checkbox"/> Mexican <input type="checkbox"/> Mexican American <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Chicano/a <input type="checkbox"/> Other
Race (optional) - check all that apply	
<input type="checkbox"/> White	<input type="checkbox"/> Filipino
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Japanese
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Korean
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Chinese	<input type="checkbox"/> Other Asian
<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> Samoan	<input type="checkbox"/> Other Pacific Islander
<input type="checkbox"/> Other	<input type="checkbox"/> Other
HEALTH INSURANCE INFORMATION	
Do you currently have health insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what type?	
Authorized Representative	
You can give a trusted friend or partner permission to talk about this application with us, see your information and act for you on matters related to this application. This person is called an "authorized representative."	
Do you want to name someone as your authorized representative?	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, skip this section.
Name of Authorized Representative	Phone Number (____)____-____
Address	City State ZIP Code
By signing, you allow this person to sign your application, to get official information about this application and to act for you on all future matters with this agency.	
Your Signature _____	____/____/____ Date
Non-Discrimination	
Following federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity or disability. You can file a complaint either: online at: https://www.hhs.gov/civil-rights/filing-a-complaint/index.html ; by mail: Director, U.S. Department of Health and Human Services, Office for Civil Rights, Centralized Case Management Operations, 200 Independence Ave, S.W. Suite 515F, HHH Building, Washington, D.C. 20201. by phone: Customer Response Center: (800) 368-1019, Fax: (202) 619-3818, TDD: (800) 537-7697. by email: ocrmail@hhs.gov	

Medicaid Estate Recovery Program

Medicaid recipients who are 55 years or older or inpatients of a medical facility may be responsible for repayment of Medicaid expenses paid for them. Recovery of these payments made from the Medicaid Program would be pursued from the estate of the recipient after their death or after the death of their surviving spouse. (See Form 6160-AF, Program Operation.)

Third Party Liability

I understand the following is an eligibility requirement to receive Medicaid benefits:

- 1) If anyone on this application receives Medicaid benefits, I give the Medicaid agency the right to pursue and get any money from other health insurance, insurance, legal settlements, and any other third party that may be liable for the medical services paid by Medicaid; and
- 2) I give the Medicaid agency the right to pursue and get child and medical support from a spouse or a parent; and
- 3) I agree my household members will cooperate with the Medicaid agency to obtain any money from insurance companies, legal settlements and third parties and will give DHHS notice of any settlements or legal action.

Reviews and Investigations

By signing this application, you are authorizing the Department of Health and Human Services to make investigations concerning you, other members of your household and/or your child(ren)'s legal or natural parent(s) that may be necessary to determine eligibility for benefits you or your household receives under programs administered by the DWSS and Nevada Health Link. Information provided to the agency may be verified or investigated by federal, state, and local officials including quality control staff.

You must cooperate in the investigation, or your benefits may be denied or terminated. If you knowingly make a statement which is false or misleading; provide documents that have been altered; or conceal or withhold information that is necessary for the agency to make an accurate determination of the benefits for which you are eligible your benefits may be denied, terminated, or reduced. If you receive benefits for which you are not entitled, you must repay the agency for all money, services, and benefits you were not entitled to receive. You may also be disqualified from receiving future benefits and be criminally prosecuted or penalized according to state and federal law.

Privacy Policy

We keep your information private as required by law. Your answers on this application will only be used to determine eligibility for health coverage and to provide information on additional healthcare services available to your household. Nevada Health Link, Division of Welfare and Supportive Services and the Department of Health and Human Services will check your eligibility using our electronic databases and the databases of other federal agencies. If the information does not match, we may ask you to send us proof. We won't ask any questions about your medical history. Household members who don't want coverage won't be asked questions about citizenship or immigration status.

IMPORTANT: As part of the application process, we may need to retrieve your information from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security and/or a consumer reporting agency.

We need this information to check your eligibility for coverage and help paying for coverage if you want it and to give you the best service possible. We may also check your information at a later time to make sure your information is up to date. We'll notify you if we find something has changed.

I understand my information will be used and retrieved from data sources for this application. I have consent for all people I will list on the application that allows their information to be retrieved and used from the above- mentioned data sources.

Optional Text Messaging Opt-In/Opt-Out

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

(Check one of the following:) I consent to receive text messaging as described above.

I do not consent to receive text messaging as described above.

Initials _____

Health Plan Selection / Managed Care Organization Preference

Families who live in urban Washoe County or urban Clark County are covered by a managed care organization (MCO). You are being asked to choose one of the following health plans. If you do not select a preference, you will be assigned a plan randomly. Your choice does not guarantee enrollment into the Nevada Medicaid program. If you or any family members are already enrolled in one of the current MCOs, you might not be able to switch at this time. Enrolled families will receive a member handbook explaining their benefits.

Please Make A Selection	Contact Phone	Website
<input type="checkbox"/> Anthem Blue Cross and Blue Shield Healthcare Solutions	1-844-396-2329	mss.anthem.com/nevada-medicaid/home.html
<input type="checkbox"/> Molina Healthcare	1-844-327-7136	meetmolina.com/nv-medicaid
<input type="checkbox"/> SilverSummit Healthplan	1-844-366-2880	silversummithealthplan.com
<input type="checkbox"/> United Healthcare Health Plan of Nevada Medicaid	1-800-962-8074	myHPNmedicaid.com/Member

No Preference *(Note: If you do not choose a Managed Care option, you will be randomly assigned to one by Medicaid)*
For more information on the different MCO plans, visit <https://dhcfp.nv.gov/Members/BLU/MCOMain/>. If you need to find a provider, visit <https://www.medicaid.nv.gov/hcp/provider/Home/tabid/135/Default.aspx>, and search for a provider or you can call one of the local Medicaid district offices below:

Statewide Toll Free (800) 992-0900	TTY (800) 326-6888	Carson City (775) 684-3651	Reno (775) 687-1900	Las Vegas (702) 668-4200	Elko (775) 753-1191
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Your Rights

If you think we made a mistake or have not acted timely on your application, you can appeal. This means you can ask us to look at your case again. You must request an appeal in writing within 90 days of the date of the notice. The notice will tell you how to appeal. You may appoint a representative to act for you in the appeals process. Contact us, and we can help you with your appeal.

Your Responsibilities

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

Release of Information

I hereby authorize and consent to the release of all information concerning me or my household members to the Department of Health and Human Services by the holder of the information such as, but not limited to, wage information, information made confidential by law, as well as patient information privileged under NRS 49.225, or any other provision of law. I hereby release the holder of the information from liability, if any, resulting from the release (disclosure) of the required information.

If I am 60 years of age or older, I hereby consent to the disclosure of my identity and waive my right as an older person to have my identity kept confidential. I hereby release the holder of information from liability, if any, resulting from the disclosure of the required information.

Please read and sign this application.

- I'm signing this application under penalty of perjury, which means I've provided true answers to all of the questions to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.
- I swear I have honestly reported the citizenship status of myself and anyone I am applying for.

Signature or Mark of Applicant	Date	Signature or Witness* (Use if applicant cannot read, write, is blind.) <i>*The information in this application has been read to the applicant and I have witnessed their signature or mark.</i>	Date
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Submit This Application by: Email to welfwarmspringsdo@dwss.nv.gov , or, Fax to (702-631-4487).	Did you remember to: ✓ Sign this application?
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