



## DEPARTMENT OF HUMAN SERVICES

DIVISION OF SOCIAL SERVICES Helping people. It's who we are and what we do.



Robert H. Thompson *Administrator* 

**Medicaid Application for Justice Involved Individuals** 

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

#### Re-Entry Medicaid Coverage

Individuals must meet specific program requirements to be considered for this program.

Carceral facilities must attest to the individual meeting these requirements by submitting a completed DSS Form 2971, Justice Involved Medicaid Transition Request to DSS.

#### Suspended Medicaid

Individuals currently not on a Medicaid program may apply and have DSS evaluate them for a Medicaid or CHIP program.

If determined eligible, the individual will have their eligibility suspended until their release from the carceral facility or their circumstances change, and they no longer qualify for Medicaid or CHIP.

Applicant Information					
First Name: Middle Name:	Last Name:		Suffix:	Date of Birth	n:
Cumontly in concented?			Evnantad ralan	go doto:	
Currently incarcerated? ☐ Yes			Expected refea	se date:	
Facility Name:	Facility Address:		City:	State: 2	Zip Code:
List the current Physical and Mailing	address below.				
Physical Address:	Apartment Number:	Mailing Address:		Apartment	Number:
City: State:	Zip Code:	City:	State:	Zip Code:	
				•	
Daytime Phone #:	Ext.:	Secondary Phone 3	#:	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:					
DSS needs Social Security Numbers	(SSNs) (if one has been as	ssigned) for individuals	s applying for hea	alth insurance.	
Please ensure the name is listed the same as it is displayed on your Social Security Card.					
Social Security Number/Tax ID (REQUIRED):	Marital Status:	Pregnant?	es 🗆 No		Sex:
		Due Date:			☐ Male
		If yes, how many ba	bies are expected	l:	☐ Female
Are you legally blind or permaner	ntly disabled?	•		□ Ve	s □ No

Do you plan to file a federal income tax return NEXT YEAR	□ Yes □ No	
If <b>no</b> , are you being claimed as a dependent on someone els	□ Yes □ No	
If <b>yes</b> , name of tax filer:	Relationship to You:	
Are you a U.S. citizen? ☐ Yes ☐ No Hav	ve 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 veteran or active-duty member of the military?	u are a minor) an honorably discharged	□ Yes □ No
If under age 26, have you ever been in foster care?	Yes □ No If yes, what state?	-
Did you receive health care through a state Medicaid pro	ogram? □ Yes □ No	
Age when you left the program?		
Current Income Information	Not employed	
Are you currently receiving income?		□ Yes □ No
If yes, what type:	Gross amount: \$	
How often are you paid? ☐ Weekly ☐ Every 2	weeks $\square$ Semi-Monthly $\square$ Monthly	☐ Annually
Racial and Ethnicity Information		
Are you Hispanic, Latino or of Spanish origin? (optional)		☐ Yes ☐ No
Race (optional) - check all that apply		
☐ White ☐ Native Hawa	iian 🗆 Asian Indian	
☐ African American or Black American Ind	ian or Alaska Native 🗆 Middle Easterr	n or North African
☐ Other Pacific Islander ☐ Other Asian	☐ Other:	
American Indians or Alaska Natives (AI/AN)  American Indians or Alaska Natives (AI/AN) who enroll in Malso get services from the Indian Health Services, tribal health		
Are you an American Indian or Alaska Native?		☐ Yes ☐ No
If yes, what tribe?		
Health Insurance Information		
Do you currently have health insurance?		☐ Yes ☐ No
If yes, what type?	Insurance Company Name:	

#### **Non-Discrimination**

Following federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity or disability. You can file a complaint either:

online at: <a href="https://www.hhs.gov/civil-rights/filing-a-complaint/index.html">https://www.hhs.gov/civil-rights/filing-a-complaint/index.html</a>

by mail: Director, U.S. Department of Health and Human Services, Office for Civil Rights, Centralized Case Management

Operations, 200 Independence Ave, S.W. Room 509F, HHH Building, Washington, D.C. 20201

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

by email: ocrmail@hhs.gov

#### **Medicaid Estate Recovery Program**

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

#### **Third Party Liability**

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

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

#### **Reviews and Investigations**

By signing this application, you are authorizing the Department of 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 DSS 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 Social Services and the Department of 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.

<b>Optional Text Messaging Opt</b>	-In/Opt-Out			
The information provided on this a	application, including you	r phone number(s),	will be shared with any D	epartment of
Human Services (DHS) Division a				
calls and/or texts from DHS, MCC	•	_		•
application, now or in the future, in				
benefits, eligibility, renewal and/or				
DHS or the MCO concerning healt				
automatic telephone dialing system	n or artificial or prerecord	ed voice message.	Standard message and dat	a rates may apply.
(Check one of the following;)		D., f 1 Dl		
☐ I consent to receive text messa				.1
☐ I do not consent to receive tex	t messaging as described	above.	Initia	ıls:
Health Plan Selection / Manag	ged Care Organization	Preference		
Families who live in urban Washo			hy a managed care organi	zation (MCO)
You are being asked to choose one				
plan randomly. Your choice does n				
you or any family members are alr				
Enrolled individuals will receive a				
Please Make a Selection	Available Regions	<b>Contact Phone</b>	Website: (Visit for more Information)	
	Urban Clark			
☐ Anthem Blue Cross and Blue Shield Healthcare Solutions	Urban Washoe	1-844-396-2329	mss.anthem.com/nevada-m	nedicaid/home.html
Siliela Healthcare Solutions	Oldan Washuc			
_				
☐ Health Plan of Nevada	Urban Clark	1-844-962-8074	myHPNmedicaid.com/Men	<u>mber</u>
☐ Molina Healthcare	Urban Clark	1-844-327-7136	meetmolina.com/nv-medicaid	
	Urban Washoe	1 011 027 7100		
☐ SilverSummit Healthplan	Urban Clark Urban Washoe	1-844-366-2880	silversummithealthplan.com	
□ 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 <a href="https://dhcfp.nv.gov/Members/BLU/MCOMain/">https://dhcfp.nv.gov/Members/BLU/MCOMain/</a> . If you need to find				
a provider, visit <a href="https://www.medicaid.nv.gov/hcp/provider/Home/tabid/135/Default.aspx">https://www.medicaid.nv.gov/hcp/provider/Home/tabid/135/Default.aspx</a> , and search for a provider or you				
can call one of the local Medicaid district offices below:				
Statewide Toll Free TTY	Carson City	Reno	Las Vegas	Elko
(800) 992-0900 (800) 992-0	•	(775) 687-1900	•	(775) 753-1191
Your Rights	(773) 004-3031	(775) 007-1700	(702) 000-4200	(110) 100-1171
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.

I hereby authorize and consent to the release of all information concerning me or my household members to the Department of 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.

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

Signature or Mark of Signature or Witness\*: Date: Date: (Use if applicant cannot read, write, is blind.) Applicant: \*The information in this application has been read to the applicant and I have witnessed their signature or mark.

<b>Submit This Application by:</b>	
Email to justicemed@dss.nv.gov, or; Fax to 702-631-3387	Did you remember to:  ✓ Sign this application?
Disclaimore	

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

<b>Designation of Authorized Represen</b>	tative		
Applicants may designate an individual or ndividual's application for assistance, rene designation must include the applicant's signalso agree in writing to act responsibly on The rights and obligations of an authorized of the applicant/recipient's financial ability	ewals of eligibility and other or gnature. For a valid designation behalf of the applicant/recipient I representative are the same as	going communications n, the designated autho t.	with the agency. This rized representative must
Do you want to name an individual as you	r authorized representative?	□ Yes □ No	If no, skip this section.
Name of Authorized Representative:		Phone Number:	
Mailing Address: (Required)	City:	State:	ZIP Code:
By signing, you agree to allow this person to a individual will receive copies of all official not Medicaid eligibility period unless you inform I	tifications about your case with D	SS. NOTE: This authorize	
Your Signature:			Date:
If you wish to designate a facility as your Arthe applicant and facility staff member:	uthorized Representative, the se	ction below must be con	npleted and signed by
I, (PRINT NAME OF APPLICANT/ RECIPIENT)		_, request the following	(CECK ONE)
(PRINT NAME OF PERSON OR AGENCY)			•
Primary representative (Receives the same responsibility as the cust and they are the only one authoriz to case information as a customer.	tomer in securing information for ed to sign on behalf of the custom )	determining eligibility, re er. Primary representative	eporting responsibilities es have the same access
<ul> <li>Secondary representative (Receiresponsible for securing or reporting information to the DSS. A secondary sign on behalf of the customer.)</li> </ul>	ng information; however, if they ch	oose to, they may secure	and report the requested
I understand I may terminate this designati	on in writing at any time and that	the authorization for the	facility to act as an
authorized representative ceases upon release	ase from the public institution.		
SIGNATURE OF APPLICANT	DATE OF BIRTH		DATE
STATEMENT OF DESIGNATED FACIL	ITY REPRESENTATIVE		
I believe the above-named applicant/recipie his/her own will. I certify the above-name under no threat or duress of any kind.	ent understands the nature and cor		
☐ As primary representative, I agree providing all necessary informatio are the same as if I were the applic	n to determine eligibility for assis	tance. I understand my ri	ghts and obligations
<ul> <li>As secondary representative, I und applicant/recipient's initial and on process. I understand I have no a</li> </ul>	going eligibility and may provide	any information to assist	in the eligibility
I certify under penalty of perjury; the information	mation I provide is correct and cor	nplete to the best of my k	nowledge.
	PRINT NAME)	POSITION/RELATIONSHIP	DATE
ADDRESS			TELEPHONE NUMBER

### Medicaid Estate Recovery Notification of Program Operation

Please be advised that if you are applying for or receiving benefits from the Medicaid Program, this is important information that could affect your decision to receive benefits from Medicaid.

Pursuant to State and Federal law, the State of Nevada administers a Medicaid Estate Recovery Program whereby correctly paid Medicaid assistance is recovered from the undivided estate of the person who

received Medicaid benefits. Medicaid recipients aged 55 or older and certain inpatients in nursing facilities or institutions<sup>1</sup> are affected by this program. When those individuals pass away, Medicaid requires that the undivided estates of those individuals pay back any benefits paid by Medicaid.

"Undivided estate" is defined broadly in Nevada. It includes all real and personal property and other assets in or to which an individual had any interest or legal title at the time of death. This includes assets conveyed to someone else through joint tenancy, life estate, living trust, annuity, homestead or other arrangement. A Medicaid claim cannot be defeated by a homestead exemption or by the operation of bankruptcy or insolvency law.

Certain individuals are protected from Medicaid recovery. Medicaid cannot recover if the Medicaid recipient has a surviving spouse, a child under the age of 21 or a blind and/or disabled child of any age. If Medicaid is prevented from recovering because of a surviving spouse, blind or disabled child or a child under the age of 21, Medicaid may place a lien on the deceased recipient's interest in real and/or personal property.

However, Medicaid must release the lien if the spouse, blind or disabled child or child under the age of 21 sells the property to a bona fide purchaser for fair market value. If the exempted individual chooses to refinance the property, Medicaid will subordinate its lien.

In addition, certain income, resources and property of American Indians and Alaska Natives are exempt from Medicaid estate recovery. Please reference the Medicaid Operations Manual at <a href="www.dhcfp.nv.gov">www.dhcfp.nv.gov</a> for a detailed explanation of the property exempt from recovery for these groups.

The above language refers to benefits that are correctly paid to eligible Medicaid recipients. When benefits are paid to persons who are not otherwise eligible, those benefits are considered as incorrectly paid. Medicaid may recover incorrectly paid benefits immediately upon discovery and without the restrictions that apply to correctly paid benefits.

Medicaid recovery may be waived, compromised or delayed if it would cause undue hardship for the heirs. Heirs may submit a hardship waiver request at the time of Medicaid recovery. The denial of a hardship waiver or compromise may be appealed through the appropriate legal system. Medicaid will provide hardship waiver application information to the known heirs at the time of recovery.

#### Please share this form with all family members and potential heirs.

If you have questions or need additional clarification, please contact the Medicaid Estate Recovery Program at (775) 687-8416, email mer@nvha.nv.gov or visit its website at www.dhcfp.nv.gov under "Programs."

<sup>&</sup>lt;sup>1</sup>Certain inpatients in nursing Facilities or institutions refers to individuals with respect to whom the State determines, after notice and opportunity for hearing, that the inpatient cannot reasonably be expected to be discharged from the medial institution and return home.