Nevada Check Up (NCU) Application
Children's Health Insurance Program (CHIP)

Questions regarding this application? Call: 1-877-KIDS NOW (543-7669)

If previously on Nevada Check Up, please enter family identification number: _____

Note - We will review your application for possible Medicaid eligibility. If it appears your children may be eligible for Medicaid, we will deny NCU enrollment and may refer your case to the Division of Welfare and Supportive Services (DWSS) for a Medicaid eligibility review.

1) Do you want this application to be referred to Nevada Medicaid if applicable? ☐Yes ☐No
2) Are you currently applying for Medicaid medical assistance for any of the individuals listed? ☐Yes ☐No

Person or Head of the Household Applying for Child(ren): Please fill in all the information about the person applying for the child(ren).

(1) Last Name Male ☐ Female ☐		**First Name MI**	**Social Security Number**
Date of Birth / /	**Marital Status** Married ☐ Single ☐	**Race/Ethnicity (OPTIONAL)** ☐African American ☐ Asian ☐Caucasian/White ☐Other ☐ Hispanic ☐American Indian or Alaska Native	
Citizenship Status - Information received on citizenship status is not reported to INS ☐ U.S. Citizen ☐ Undocumented Alien ☐ Lawful Permanent Resident (LPR) as of (Date):			**Preferred Language** ☐ English ☐ Spanish
Home Address - Number, Apt/Space and Street		**City and State**	**Zip Code**
Mailing address (if different than home)		**City and State**	**Zip Code**
Home Number ( )	**Cell/Message** ( )	**Work Number** ( )	**How many people in this household?**

***Will this household continue to live in Nevada?** ☐Yes ☐No, explain_____
***Is your rent or mortgage subsidized by an agency?** ☐No ☐Yes, amount _____

Other Adults in Household: List all adults in the household regardless of relationship to child(ren) for which you are applying. If more adults reside in the household, please attach an additional sheet with the same information in the same order as listed below:

(1) Last Name Male ☐ Female ☐		**First Name MI**	**Social Security Number**
Date of Birth / /	**Marital Status** Married ☐ Single ☐	**Race/Ethnicity (OPTIONAL)** ☐African American ☐ Asian ☐Caucasian/White ☐Other ☐ Hispanic ☐American Indian or Alaska Native	
Citizenship Status- Information on citizenship is not reported to INS ☐ U.S. Citizen ☐ Undocumented Alien ☐ Lawful Permanent Resident (LPR) as of (Date):		**Relationship to applicant above** ☐ Spouse ☐Sibling ☐Child ☐ Parent ☐ Other Relative ☐ Other :	

(2) Last Name Male ☐ Female ☐		**First Name MI**	**Social Security Number**
Date of Birth / /	**Marital Status** Married ☐ Single ☐	**Race/Ethnicity (OPTIONAL)** ☐African American ☐ Asian ☐Caucasian/White ☐Other ☐ Hispanic ☐American Indian or Alaska Native	
Citizenship Status- Information on citizenship is not reported to INS ☐ U.S. Citizen ☐ Undocumented Alien ☐ Lawful Permanent Resident (LPR) as of (Date):		**Relationship to applicant above** ☐ Spouse ☐Sibling ☐Child ☐ Parent ☐ Other Relative ☐ Other :	

Children in Household: List all children even if they are not U.S. citizens. If more than four children reside in the household, please attach an additional sheet with the same information in the same order as listed below. If Birth Certificates are available, please provide a copy.

(1) Last Name Male ☐ Female ☐ | **First Name** | **MI** | **Social Security # (REQUIRED)**

Date of Birth (REQUIRED) ___/___/___

Marital Status
Single ☐ Married ☐

Race/Ethnicity (OPTIONAL)
☐African American ☐Asian ☐Caucasian/White ☐Hispanic
☐American Indian/Alaska Native ☐Other:

Citizenship Status (REQUIRED)
*Information on citizenship is not reported to INS
☐ U.S. Citizen ☐ Undocumented Alien
☐ Lawful Permanent Resident - **provide copy of card**

Is this child pregnant?
☐ Yes ☐ No
Due date:

Are you applying for NCU for this child?
☐ Yes ☐ No

Is this child disabled and receiving SSI?
☐ Yes ☐ No

Health Insurance
☐ On Nevada Medicaid
☐ No Coverage
Date coverage ended: _____
Reason:
☐ Yes, name of insurance: _____
Type of insurance:
☐Cancer ☐Dental/Vision ☐Pharmacy
☐Managed Care (HMO/PPO)
☐Major Medical ☐Medicare A, B, or D

Parental Relationship (REQUIRED)
Name of mother : _____
Name of father: _____
Relationship of child to applicant : ☐ Child ☐ Other:
☐ Step-Child ☐ None ☐ Niece/Nephew

Child Care Expenses - complete if applicable **Amount Paid:** **How often paid:**

(2) Last Name Male ☐ Female ☐ | **First Name** | **MI** | **Social Security # (REQUIRED)**

Date of Birth (REQUIRED) ___/___/___

Marital Status
Single ☐ Married ☐

Race/Ethnicity (OPTIONAL)
☐African American ☐Asian ☐Caucasian/White ☐Hispanic
☐American Indian/Alaska Native ☐Other:

Citizenship Status (REQUIRED)
*Information on citizenship is not reported to INS
☐ U.S. Citizen ☐ Undocumented Alien
☐ Lawful Permanent Resident - **provide copy of card**

Is this child pregnant?
☐ Yes ☐ No
Due date:

Are you applying for NCU for this child?
☐ Yes ☐ No

Is this child disabled and receiving SSI?
☐ Yes ☐ No

Health Insurance
☐ On Nevada Medicaid
☐ No Coverage
Date coverage ended: _____
Reason:
☐ Yes, Name of Insurance: _____
Type of insurance:
☐Cancer ☐Dental/Vision ☐Pharmacy
☐Managed Care (HMO/PPO)
☐Major Medical ☐Medicare A, B, or D

Parental Relationship (REQUIRED)
Name of mother : _____
Name of father: _____
Relationship of child to applicant: ☐ Child ☐ Other:
☐ Step-Child ☐ None ☐ Niece/Nephew

Child Care Expenses - complete if applicable **Amount Paid:** **How often paid:**

(3) Last Name Male ☐ Female ☐ | **First Name** | **MI** | **Social Security # (REQUIRED)**

Date of Birth (REQUIRED) ___/___/___

Marital Status
Single ☐ Married ☐

Race/Ethnicity (OPTIONAL)
☐African American ☐Asian ☐Caucasian/White ☐Hispanic
☐American Indian/Alaska Native ☐Other:

Citizenship Status (REQUIRED)
*Information on citizenship is not reported to INS
☐ U.S. Citizen ☐ Undocumented Alien
☐ Lawful Permanent Resident - **provide copy of card**

Is this child pregnant?
☐ Yes ☐ No
Due date:

Are you applying for NCU for this child?
☐ Yes ☐ No

Is this child disabled and receiving SSI?
☐ Yes ☐ No

Health Insurance
☐ On Nevada Medicaid
☐ No Coverage
Date coverage ended: _____
Reason:
☐ Yes, Name of Insurance: _____
Type of insurance:
☐Cancer ☐Dental/Vision ☐Pharmacy
☐Managed Care (HMO/PPO)
☐Major Medical ☐Medicare A, B, or D

Parental Relationship (REQUIRED)
Name of mother : _____
Name of father: _____
Relationship of child to applicant: ☐ Child ☐ Other:
☐ Step-Child ☐ None ☐ Niece/Nephew

Child Care Expenses - complete if applicable **Amount Paid:** **How often paid:**

(4) Last Name Male ☐ Female ☐	First Name MI	Social Security # (REQUIRED)

Date of Birth (REQUIRED) / /	Marital Status Single ☐ Married ☐	Race/Ethnicity (OPTIONAL) ☐African American ☐Asian ☐Caucasian/White ☐Hispanic ☐American Indian/Alaska Native ☐Other:

Citizenship Status (REQUIRED) *Information on citizenship is not reported to INS ☐ U.S. Citizen ☐ Undocumented Alien ☐ Lawful Permanent Resident - **provide copy of card**	Is this child pregnant? ☐ Yes ☐ No Due date:	Are you applying for NCU for this child? ☐ Yes ☐ No	Is this child disabled and receiving SSI? ☐ Yes ☐ No

Health Insurance	Parental Relationship (REQUIRED)
☐ On Nevada Medicaid ☐ No Coverage ☐ Yes, Name of Insurance: _____ Date coverage ended: _____ Reason: **Type of insurance**: ☐Cancer ☐Dental/Vision ☐Pharmacy ☐Managed Care (HMO/PPO) ☐Major Medical ☐Medicare A, B, or D	Name of mother : _____ Name of father: _____ Relationship of child to applicant: ☐ Child ☐ Other: ☐ Step-Child ☐ None ☐ Niece/Nephew

Child Care Expenses - complete if applicable	Amount Paid:	How often paid:

Employment Information: List employment information for each adult residing in the household. ***See insert for acceptable income verification (not more than 45 days old).**

(1) Person Employed - Last, First		Name of Employer
Employer Address		**Employer Telephone** ( )
Gross Pay - amount before taxes	**Tips per pay period**	**How Often Paid** ☐ Weekly ☐ Every 2 weeks ☐Twice a month ☐ Monthly ☐ Other:

(2) Person Employed - Last, First		Name of Employer
Employer Address		**Employer Telephone** ( )
Gross Pay - amount before taxes	**Tips per pay period**	**How Often Paid** ☐ Weekly ☐ Every 2 weeks ☐Twice a month ☐ Monthly ☐ Other:

Other Income: Please provide the most current proof (not more than 45 days old) for each income received. List all types of income received by anyone in the household (including children) and leave blank if not applicable.

Source of Other Income	Name of Recipient	Dollar Amount	How Often Paid
Child Support/Alimony			☐ Weekly ☐ Every 2 weeks ☐ Other: ☐Twice a month ☐ Monthly
Social Security Payments - select ☐ RSDI ☐ SSI			☐ Weekly ☐ Every 2 weeks ☐ Other: ☐Twice a month ☐ Monthly
Disability Payment Source			☐ Weekly ☐ Every 2 weeks ☐ Other: ☐Twice a month ☐ Monthly
Unemployment Benefits			☐ Weekly ☐ Every 2 weeks ☐ Other: ☐Twice a month ☐ Monthly
Pension Payment and Source			☐ Weekly ☐ Every 2 weeks ☐ Other: ☐Twice a month ☐ Monthly
Interest or Dividends (Stocks, Bonds, Trusts, Mutual Funds, Savings, etc.)			☐ Weekly ☐ Every 2 weeks ☐ Other: ☐Twice a month ☐ Monthly
Other (such as cash assistance, etc)			☐ Weekly ☐ Every 2 weeks ☐ Other: ☐Twice a month ☐ Monthly

Health Plan Selection: Please choose a health plan:_____
*Note: If you do not choose a health plan preference, we will choose a plan for you (see insert for choices).

Referral Information: How did you hear about Nevada Check Up? **(Please check the ONE that applies)**
☐ Covering Kids and Families ☐ Welfare ☐ School ☐ WIC ☐ Media (Newspaper, TV and Radio) ☐ Internet ☐ Friend/Family
☐ Doctor/Hospital ☐ Social Services/Health Dept ☐ Child Care Provider ☐ Tribal Resource ☐ Clinic ☐ Other:_____

Signature and Affirmation:

It is your responsibility to immediately report to Nevada Check Up any of the following status changes for your children:

- Change of address and phone number
- Moves out of the house or state
- Child(ren) becomes eligible for Medicaid or other health insurance
- A household member becomes deceased
- Child(ren) becomes a resident, inmate of a public institution or a ward of the state
- Child(ren) becomes emancipated and/or married

In signing this document, I hereby apply for health insurance coverage for the named children under the Nevada Check Up program. I agree to adhere to all the required responsibilities to report changes listed on this application. I certify that all information contained is true and accurate to the best of my knowledge and that no facts have been left out.

- I hereby release Nevada Check Up from liability, if any, resulting from the disclosure of information contained in this application.
- I understand and authorize Nevada Check Up and/or the Department of Health and Human Services to contact any party deemed necessary to verify information presented on the application.
- If any of my household members receive Nevada Check Up, 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 Nevada Check Up. I agree to cooperate with the division in obtaining payments for medical care from any third party or person who may be liable for the medical services paid for by Nevada Check Up. I also understand I must inform Nevada Check Up 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 Nevada Check Up.
- I understand the eligibility determination process may take 45 days. The 45 days starts when a complete application with all necessary, requested and required documentation is received. Once approved, I will be notified by mail of the date coverage begins and my premium amount. If the application is denied or Nevada Check Up makes any other decision with which I don't agree, including timeliness of the determination within established guidelines, I have the right to request a hearing. The request for hearing must be submitted in writing within 30 days of the date of the denial letter.
- A reproduced copy of this authorization constitutes an original copy.
- I declare under penalty of perjury under the laws of the State of Nevada that the foregoing is true and correct. (NRS 53.045, NRS 199.120 thru NRS 199.200 and NRS 41.365).
- I further understand that the law provides penalties for persons hiding facts or not being completely truthful.
- I understand that information provided to NCU may be verified or investigated by federal, state and local officials. If I do not cooperate in the investigation, my child(ren)'s benefits will be denied or terminated. If I make false or misleading statements; misrepresent, conceal or withhold facts; or alter any document necessary to make an accurate eligibility determination, my child(ren)'s benefits may be denied or terminated. I am responsible for repayment of all monies paid for services to which my child(ren) were not entitled and I may be subject to any criminal and/or civil penalties in accordance with state and federal law.

Applicant Signature:_____ **Date:**_____
(Mandatory) If not signed, application will be rejected.

Other Adult:_____ **Date:**_____

Send your completed application or any correspondence to:
Nevada Check Up Program
1000 E. William Street Ste 200
Carson City, Nevada 89701

Questions? Call us at (775) 684-3777 or toll free 1-877-KIDS-NOW (543-7669). Our fax number is (775) 684-8792. Spanish speaking staff is always available! You may also visit us on our website: http://nevadacheckup.nv.gov

If you believe someone has interfered with your right to register to vote, 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.

The Department of Health and Human Services, Division of Health Care Financing and Policy, provides services without discrimination of any kind due to race, national origin, color, gender, religion, age or disability (including AIDS and related conditions) as required by federal law.

1-877-KIDS-NOW (543-7669)
Fax (775) 684-8792

Nevada Check Up
1000 E Williams Street, Suite 200
Carson City, NV 89701

What is Nevada Check Up?

The state of Nevada Children's Health Insurance Program (CHIP) known as "Nevada Check Up" is a federal and state funded program that provides low-cost health care coverage to uninsured children from birth through 18 years of age who meet the program guidelines.

What health services are covered?

Most medically necessary services are covered. Nevada Check Up offers comprehensive medical, dental and medical vision care for children.

What are the eligibility qualifications for Nevada Check Up?

Children must meet the following conditions:

- Not be covered by or appear eligible for Medicaid
- Have no other health care coverage or had insurance in the last six months
- Not be covered by or have access to the Public Employee Benefits Program (PEBP)
- Be a citizen of the United States or a Lawful Permanent Resident (LPR) for five years
  - Please note that applying for Nevada Check Up will not affect your family's immigration status
- Meet federal income guidelines (be within 200% of the Federal Poverty Level)
  - Applicants that currently exceed the listed 200% FPL may still qualify for our program in the future as the Federal Poverty Levels can change
- Be younger than 18 years and 11 months at the time of the application

2011

Number of People in Household	200% FPL Max Income Level
2	$29,420
3	$37,060
4	$44,700
5	$52,340
6	$59,980

What about premium payments?

The only cost for Nevada Check Up is a quarterly premium which is determined by family size and income. The premium is charged per family, not per child. Below is a chart which shows the premium amount associated with the Federal Poverty Level (FPL). For American Indian families who are members of federally recognized tribes, or an Eskimo, Aleut or other Alaska Native enrolled by the Secretary of the Interior, quarterly premiums are waived when proof of status (copy of the tribal affiliation card) is provided.

Premium	FPL
$25	From 36% up to 150%
$50	From 151% up to 175%
$80	At or above 176%

Families are informed of their premium amount once they are enrolled. If families are enrolled during a quarter premiums will be prorated. If your child(ren) were previously on NCU and have an existing unpaid premium balance, children will not be enrolled until payment is received. Payment arrangements can be made which would not exceed 60 days.

Note - Failure to pay premiums will result in disenrollment

Quarters	Due Date
1st Quarter Oct, Nov, Dec	**October 1st**
2nd Quarter Jan, Feb, Mar	**January 1st**
3rd Quarter Apr, May, Jun	**April 1st**
4th Quarter Jul, Aug, Sept	**July 1st**

PLEASE KEEP FOR YOUR RECORDS

1-877-KIDS-NOW (543-7669)
Fax (775) 684-8792

Nevada Check Up
1000 E Williams Street, Suite 200
Carson City, NV 89701

How often must I re-qualify for Nevada Check Up?

Once a year, Nevada Check Up will send a request for updated information. Recipients will also be requested to send new income verification documents. If you do not respond by the deadline, your children will no longer be covered by Nevada Check Up. Families will only receive notification if their case will be disenrolled.

Health Plan

Families who live in urban Washoe County or urban Clark County are covered by a Managed Care Organization (MCO). You are asked to choose one of the following health plans on page four of the application under Health Plan Selection. If you do not indicate a health plan preference on your application, we will choose a plan for you. Your choice of health plan does not guarantee acceptance into the Nevada Check Up program. Once enrolled, families will receive a member handbook explaining the health plan benefits and can contact the numbers below for information regarding the health plans.

☐ **Amerigroup :** 1-800-600-4441 ☐ **Health Plan of Nevada :** 1-800-962-8074

For families living in the Fee-For-Service benefit area, services may be obtained from any Nevada Medicaid provider who will accept Nevada Check Up. If you need assistance in locating a provider, please call your local Medicaid District Office:

Carson City (775) 684-3653 Reno (775) 688-2811 Las Vegas (702) 486-1550 Elko (775) 753-1191

Third Party Liability

A condition of being eligible for Nevada Check Up is the agreement to assign all rights to any medical claims, medical support or other payments for medical care. Recipients must cooperate with the division in obtaining payments for medical care from any third party or person who may be liable for the medical services paid for by the Nevada Check Up Program. Recipients must inform Nevada Check Up if any legal action is taken against anyone or if any offer or settlement is received for the reimbursement of medical care and treatment that may be paid for by the Nevada Check Up Program.

Investigations and Referrals

Information provided to NCU may be verified or investigated by federal, state and local officials. If you do not cooperate in the investigation, which may include a home visit, your benefits will be denied or terminated. If you make false or misleading statements, misrepresent, conceal or withhold facts; or alter any document necessary to make an accurate eligibility determination, your benefits may be denied or terminated. You are responsible for repayment of all monies paid for services to which you were not entitled and you may be subject to any criminal and/or civil penalties in accordance with state and federal law.

ADDITIONAL DOCUMENTATION NEEDED FOR A COMPLETE APPLICATION:

Employed

✓ Proof of income - two current and consecutive pay stubs (not more than 45 days old from application date)
*If paycheck stubs are not available you need to contact Nevada Check Up for an Earnings Verification Form

Unemployed

✓Current unemployment award letter if receiving unemployment benefits

Self-employed

✓ Complete copy of last year's tax return
✓ Last 3 months of personal and business bank statements

Other Income

✓ Current year award letter for RSDI, SSI, Worker's Compensation, VA Benefits, Disability Benefits, Pension Payments, interest/dividends received, proof of money from property (rent received) and proof of any other income not listed
✓ Proof of child support including amount and frequency per child if applicable

PLEASE KEEP FOR YOUR RECORDS