



APPLY FASTER ONLINE AT: www.nevadahealthlink.com

Application for Health Coverage & Help Paying Costs



Use this application to see what coverage you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well.
- A tax credit that can immediately help pay your premiums for health coverage.
- Free or low-cost coverage from Medicaid or Nevada Check Up - CHIP.
- Certain income levels may qualify for free or low-cost programs.



Who can use this application?

- Use this application for anyone in your household.
- Apply even if you, your spouse or your child have health coverage. You may be eligible for free or lower-cost coverage.
- Households that include eligible immigrants can apply. You can apply for your child even if you aren't eligible for coverage.
- If someone is helping you fill out this application, you may need to complete the attached appendix.



What you may need to apply

- Your Social Security Number (or document number if you're an eligible immigrant).
- Employer and income information for everyone in the household (for example, from pay stubs, W-2 forms, or wage statements).
- Policy numbers for any current health insurance.
- Information about any job-related health insurance available to your household.



Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. We'll keep all the information you provide private and secure, as required by law. To view the Privacy Policy, visit

<https://nevadahealthlink.com/about-nevada-health-link/privacy-policy/>.



What happens next?

Send your completed, signed application to:

Nevada Health Link Processing Center
PO Box 2128
Birmingham, AL 35201

If you don't have all the information we ask for, sign and submit your application anyway. We'll follow up with you within 1–2 weeks and you may receive a call from Nevada Health Link if we need more information. You will receive an eligibility determination letter after your application is processed. Filling out this application doesn't mean you have to buy health coverage.



Get help with this application

- **Online:** nevadahealthlink.com
- **Phone:** Call Nevada Health Link Call Center at 1-800-547-2927. TTY users should call 711.
- **In person:** There may be professionals in your area who can help. Visit nevadahealthlink.com, or call the Nevada Health Link Call Center at 1-800-547-2927 for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al 1-800-547-2927.
- **Other languages:** If you need help in a language other than English, call 1-800-547-2927 and tell the customer service representative the language you need. We'll get you help at no cost to you.

You have the right to get the information in this document in an alternate format. You also have the right to file a complaint if you feel you've been discriminated against. Visit www.cms.gov/about-cms/agency-information/aboutwebsite/cmsnondiscriminationnotice.html or call the Nevada Health Link Customer Service Center at 1-800-547-2927 for more information. TTY 711. Please visit <https://nevadahealthlink.com/about-nevada-health-link/privacy-policy/> for information about our Privacy Policy and Non-Discrimination Policy.

Privacy of Your Information

The privacy of your information is our top priority. We will keep your information private as required by federal and state law. Your answers on this form will only be used to determine eligibility for health coverage. We will verify your answers using the information in our electronic databases and the databases of federal and state agencies. If the information does not match, we may ask you to send us additional documentation. If you have questions about a request for information or suspect that the request is not from us, please contact our call center.

Important

As part of the application process, we may need to retrieve your information from the Social Security Administration, the Department of Homeland Security, the Internal Revenue Service, a consumer reporting agency, and/or other services available through other federal agencies. We need this information to check your ability to enroll in coverage. After your initial application, we may also periodically check the information received against these sources to make sure it is up to date. If we find that your information has changed, we will notify you with a request to verify or update your information.

Primary Contact Information

First name		M.I.		Date of birth (mm/dd/yyyy)		/		/		
Last name									Suffix	

Home Address

Address 1																				
Address 2																				
City		State		ZIP code																
County, parish, or township																				

☐ I do not have a home address.

If you do not have a home address, where do you usually stay?

Please describe the specific area, intersection, or landmark where you can most often be found.

Please select all that apply to your Nevada residency.

- | | |
|--|--|
| ☐ I live in Nevada. | ☐ I am visiting Nevada to get medical care or for personal reasons. |
| ☐ I am planning to make Nevada my home. | ☐ None of the above. |
| ☐ I entered Nevada with a job commitment or to seek employment. | |

Mailing Address
☐ Check if same as Primary Contact Home Address

Address 1																				
Address 2																				
City		State		ZIP code																
County, parish, or township																				
Email address																				
Mobile	()		-		Home	()		-		Ext. (optional)										

☐ By checking this box, I consent to receiving phone calls and text messages. I understand that data rates and fees from my telephone provider may apply. Your phone number helps us keep your account secure. Your phone number may be used to deliver a secure code to verify your identity in certain special circumstances. Please provide a number where you can be reached if we need additional information or if we need to contact you about your enrollment.

Preferred method of communication:
☐ Go Paperless (email) ☐ Postal Mail

How would you like to receive your 1095-A form?
☐ Go Paperless (email) ☐ Postal Mail

Preferred Spoken Language: ☐ English ☐ Spanish ☐ Other
Preferred Written Language: ☐ English ☐ Spanish ☐ Other
Help Filling Out This Application

Is anyone helping you with this application?

- ☐ I am filling out this application for myself and/or my family.
- ☐ I am being assisted by a certified professional (broker or assister).
- ☐ I am being assisted by a friend, family member, or an authorized representative.

Help Paying for Coverage

Do you want to find out if you can get help paying for health coverage?

☐ Yes ☐ No

If you indicate you do not want help paying for coverage, you will not need to provide financial information and can skip the Income Information section. However, you will not be considered for subsidies that could lower your cost of health insurance. You will be applying for full-cost insurance.

The primary applicant is the individual who is the primary person applying for insurance. The primary applicant should answer all of the questions on pages 3-6 about themselves first. Use subsequent pages to answer the questions for other family members.

Primary Applicant Information

In this section, we will ask for more detailed information on the primary applicant. Following this section, we will ask for more detailed information about everyone in your household.

First name M.I. Date of birth (mm/dd/yyyy) / /

Last name Suffix

Address 1

Address 2

City State ZIP code

County, parish, or township

Sex assigned at birth ☐ Male ☐ Female

Is this person seeking coverage?

☐ Yes ☐ No

Do you plan to continue living in Nevada?

☐ Yes ☐ No

Social Security Number: Please provide the applicant's Social Security Number (SSN) if they have one. If no SSN is provided, the applicant will be required to provide additional documentation. Providing an SSN can help verify your eligibility to enroll in health coverage. If the applicant does not have an SSN, please visit www.ssa.gov/ssnumber to apply. If this person does not have a Social Security Number, please leave this blank and see the section below to provide further information.

- -

Is the name provided on this application the same as the name shown on the Social Security card?

☐ Yes ☐ No

If no, please enter the name as shown on the Social Security card.

First name M.I.

Last name Suffix

Help Paying for Coverage

Do you want to find out if you qualify for help paying for health coverage? This includes an evaluation for Medicaid and Nevada Check Up - CHIP.

☐ Yes ☐ No

If you indicate you do not want help paying for coverage, you will not need to provide financial information and can skip the Income Information section. However, you will not be considered for subsidies that could lower the cost of your health insurance, and you will not be considered for Medicaid coverage. You will be applying for full-cost insurance.

Citizenship and Immigration Status

If the applicant is not seeking coverage, please do not fill out this section (Citizenship and Immigration Status).

Is the applicant a U.S. citizen or U.S. national?

☐ Yes ☐ No

Is the applicant a naturalized or derived citizen?

☐ Yes ☐ No

If the applicant is not a U.S. citizen or U.S. national, do you have eligible immigration status?

☐ Yes ☐ No

Immigration document type

Expiration date (mm/dd/yyyy) / / Status type (optional)

Is the name you provided the same on this person's immigration document?

☐ Yes ☐ No

If no, write your name as it appears on your immigration document.

First name M.I.

Last name Suffix

Alien or I-94 number SEVIS ID (optional)

Permanent Resident Card or Foreign Passport Number

Other (category code or country of issuance)

- ☐ Certification from U.S. Department of Health and Human Services (HHS)
- ☐ Certificate from the Office of Refugee Resettlement
- ☐ Office of Refugee Resettlement (ORR) Eligibility Letter (if Under 18)
- ☐ Cuban/Haitian Entrant
- ☐ Resident of American Samoa
- ☐ Battered spouse, child or parent under Violence Against Women Act
- ☐ Document indicating member of federally recognized Indian tribe or American Indian born in Canada
- ☐ Document indicating withholding of removal
- ☐ None of these

☐ Yes ☐ No

Please complete income information for the applicant. We ask for current information for everyone in the applicant's household to make sure they get the most benefits possible. Before you start, please take a moment to gather the information listed below. You may need:

- Note: Do not include income from child support, veterans payments or supplemental security income (SSI).*

☐ No Income[illegible][illegible]

Pension

Tribal Income Amount

Frequency

Weekly

Every two weeks

Twice a month

Monthly

Yearly

Single payment

Do you expect to earn this income for the whole year?

Yes

No

If no, enter:

Start date

/

/

End date

/

/

☐ Rental or Royalty Amount \$ [][][][][] . [][] ☐ Tribal Income Amount \$ [][][][][] . [][]

Frequency ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ Single payment

Do you expect to earn this income for the whole year? ☐ Yes ☐ No

If no, enter: Start date [][] / [][] / [][][][] End date [][] / [][] / [][][][]

[illegible]

☐ Other Income	Amount \$			☐ Tribal Income Amount \$		
Type of Income	☐ Canceled Debts	☐ Cash Support	☐ Court Awards	☐ Gambling, Prizes & Awards		
	☐ Jury Duty Pay	☐ Other				
Frequency	☐ Weekly	☐ Every two weeks	☐ Twice a month	☐ Monthly	☐ Yearly	☐ Single payment
Do you expect to earn this income for the whole year?						☐ Yes ☐ No
If no, enter:		Start date		/		/
		End date		/		/

Deductions

Telling us about the things that can be deducted on an income tax return could lower the cost of your health insurance.

☐ Alimony (If divorce finalized before January 1, 2019.)	Amount \$			Frequency	☐ Weekly	☐ Every two weeks	☐ Twice a month	☐ Monthly	☐ Yearly
☐ Student loan interest	Amount \$			Frequency	☐ Weekly	☐ Every two weeks	☐ Twice a month	☐ Monthly	☐ Yearly
☐ Other deductions (i.e. moving expenses, HSA deduction, educator expenses, etc.)	Description								
	Amount \$			Frequency	☐ Weekly	☐ Every two weeks	☐ Twice a month	☐ Monthly	☐ Yearly

Marital Status

Is the applicant married? ☐ Yes ☐ No

Who is the applicant's spouse? ☐ Someone already on the application ☐ Someone else who isn't applying for health coverage

First name **M.I.**

Last name **Suffix**

Parent/Caretaker Information

Is the applicant the main person taking care of any of the children named in the About Your Household section? ☐ Yes ☐ No

Optional Questions

These questions are optional, and you do not need to answer them to apply for health insurance. If you choose to answer them, Nevada Health Link will use this information to get a better understanding of the demographics and health needs of Nevadans. This information will also be shared with the US Department of Health and Human Services to support a broader understanding of health needs across the U.S.

Hispanic/Latino Ethnicity? ☐ Yes ☐ No

Race (check all that apply):

☐ American Indian or Alaska Native	☐ Japanese	☐ Other Pacific Islander
☐ Asian Indian	☐ Korean	☐ Samoan
☐ Black or African American	☐ Middle Eastern or North African	☐ Vietnamese
☐ Chinese	☐ Native Hawaiian	☐ White or Caucasian
☐ Filipino	☐ Other Asian	☐ Other
☐ Guamanian or Chamorro		

Which gender does the applicant most closely identify with?

☐ Male	☐ Female	☐ Transgender male	☐ Transgender female
☐ Non-binary	☐ Not sure	☐ A gender not listed	☐ Prefer not to answer

What is the applicant's sexual orientation?

☐ Lesbian or gay	☐ Straight	☐ Bisexual
☐ Not sure	☐ A sexual orientation not listed	☐ Prefer not to answer

In this section, we will ask for more detailed information about everyone in your household. **If more than one applicant is applying in addition to the primary applicant, please print extra copies of this section to include with the paper application.** The primary applicant should use pages 3-6 to answer questions about themselves and then use subsequent pages to answer questions for each additional household member.

First name		M.I.		Date of birth (mm/dd/yyyy)		/		/		
Last name									Suffix	

If you indicate you do not want help paying for coverage, you will not need to provide financial information and can skip the Income Information section. However, you will not be considered for subsidies that could lower your cost of health insurance. You will be applying for full-cost insurance.

[illegible]

Is the applicant the main person taking care of any of the children named in the About Your Household section? ☐ Yes ☐ No

Optional Questions

These questions are optional, and you do not need to answer them to apply for health insurance. If you choose to answer them, Nevada Health Link will use this information to get a better understanding of the demographics and health needs of Nevadans. This information will also be shared with the US Department of Health and Human Services to support a broader understanding of health needs across the U.S.

Hispanic/Latino Ethnicity?

☐ Yes

☐ No

Race (check all that apply):

☐ American Indian or Alaska Native

☐ Japanese

☐ Other Pacific Islander

☐ Asian Indian

☐ Korean

☐ Samoan

☐ Black or African American

☐ Middle Eastern or North African

☐ Vietnamese

☐ Chinese

☐ Native Hawaiian

☐ White or Caucasian

☐ Filipino

☐ Other Asian

☐ Other

☐ Guamanian or Chamorro

Which gender does the applicant most closely identify with?

☐ Male

☐ Female

☐ Transgender male

☐ Transgender female

☐ Non-binary

☐ Not sure

☐ A gender not listed

☐ Prefer not to answer

What is the applicant's sexual orientation?

☐ Lesbian or gay

☐ Straight

☐ Bisexual

☐ Not sure

☐ A sexual orientation not listed

☐ Prefer not to answer

Household Information

If you do not have enough space to provide information for all members of the household to which these questions apply, please print additional pages and submit them with your application.

Military Service

Are you an honorably discharged veteran or active duty member of the military?

☐ Yes ☐ No

If yes, please provide the name of the person:

First name M.I.

Last name Suffix

Tax Information

Who plans to file a federal income tax return next year?

First name M.I.

Last name Suffix

First name M.I.

Last name Suffix

(If married): Do you plan on filing a joint federal income tax return next year?

☐ Yes ☐ No

Please indicate which of the tax filers should be considered the primary applicant for this application (if filing joint return, this is the Primary Tax Filer).

First name M.I.

Last name Suffix

Who are the dependents who will be claimed by the tax filer(s) on their income tax return?

First name M.I.

Last name Suffix

First name M.I.

Last name Suffix

First name M.I.

Last name Suffix

First name M.I.

Last name Suffix

American Indian/Alaska Native

Are any of the members of your household American Indian/Alaska Natives?

☐ Yes ☐ No

If yes, please provide the name of the person:

First name M.I.

Last name Suffix

Please provide the tribe name and state.

Tribe name State

Is the tribe federally recognized?

☐ Yes ☐ No

Is the applicant eligible to get health services from the Indian Health Service, a tribal health program or an urban Indian health program, or through referral from one of these programs?

☐ Yes ☐ No

Has the applicant ever gotten a health service from the Indian Health Service, a tribal health program or urban Indian health program, or through a referral from one of these programs?

☐ Yes ☐ No

Medicaid Information

Was anyone on this application found not eligible for Medicaid or the Nevada Check Up - CHIP in the past 90 days?

☐ Yes ☐ No

If yes, please provide the name of the person:

First name

M.I.

Last name

Suffix

When was the applicant denied Medicaid or Nevada Check Up - CHIP coverage?

/

/

(mm/dd/yyyy)

Was the applicant found not eligible for Medicaid or Nevada Check Up - CHIP based on immigration status during the last five years, including the current year?

☐ Yes ☐ No

Has the applicant had a change in their immigration status during the last five years, including the current year?

☐ Yes ☐ No

Has the applicant had a change in their immigration status since they were found not eligible for Medicaid or Nevada Check Up - CHIP?

☐ Yes ☐ No**Pregnancy Information**

Are any of the members of your household pregnant?

☐ Yes ☐ No

If yes, please provide the name of the person:

First name

M.I.

Last name

Suffix

Expected due date: / / (mm/dd/yyyy)

How many babies are expected in this pregnancy?

Were any of the members of your household pregnant in the last 3 months and applying for Medicaid or applying for coverage?

☐ Yes ☐ No

If yes, please provide the name of the person:

First name

M.I.

Last name

Suffix

Did the person experience pregnancy loss with this pregnancy?

☐ Yes ☐ No

When did the pregnancy end, if applicable?

/

/

(mm/dd/yyyy)

Disability Information

Do any of the members of your household have a physical disability or mental health condition that limits their ability to work, attend school or take care of their daily needs?

☐ Yes ☐ No

If yes, please provide the name of the person:

First name

M.I.

Last name

Suffix

Do any of the members of your household need help with activities of daily living (such as bathing, dressing and using the bathroom), or live in a nursing home or other medical facility?

☐ Yes ☐ No

If yes, please provide the name of the person:

First name

M.I.

Last name

Suffix

Are any of the members of your household receiving Supplemental Security Income (SSI)?

☐ Yes ☐ No

If yes, please provide the name of the person:

First name

M.I.

Last name

Suffix

Student Information

Are any of the members of your household full-time students?

☐ Yes ☐ No

If yes, please provide the name of the person(s):

First name

M.I.

Last name

Suffix

First name

M.I.

Last name

Suffix

First name

M.I.

Last name

Suffix

First name

M.I.

Last name

Suffix

Foster Care Information

Were any of the members of your household ever in foster care?

☐ Yes ☐ No

If yes, please provide the name of the person:

Household Member #1

First name

M.I.

Last name

Suffix

In what state(s) was this applicant in the foster care system?

State

State

State

How old was the applicant when he/she/they left the foster care system?

Was this applicant getting health care through Medicaid?

☐ Yes ☐ No**Household Member #2**

First name

M.I.

Last name

Suffix

In what state(s) was this applicant in the foster care system?

State

State

State

How old was the applicant when he/she/they left the foster care system?

Was this applicant getting health care through Medicaid?

☐ Yes ☐ No

Employer Phone Number () - **Ext. (optional)**

☐ Yes ☐ No

Are any of the incarcerated persons awaiting disposition of their charges? ☐ Yes ☐ No

Qualifying Life Event / Special Enrollment Period Questions (Not applicable to Medicaid only application)

Qualified Health Plan & APTC Program Eligibility Questions

If you are applying for health coverage outside of an Open Enrollment Period, you will need to report a qualifying life event to be eligible to enroll in coverage using a Special Enrollment Period. If you believe you have a qualifying life event, but you do not see it listed on this application, please call the Nevada Health Link Call Center at 1-800-547-2927. TTY users should call 711.

Reporting a Qualifying Life Event

If you have experienced a change in circumstance, such as adding a dependent or losing health coverage within the last 60 days, or in some cases, if you will experience such an event within the next 60 days, you may be eligible to enroll in coverage using a Special Enrollment Period.

Have you experienced one of the following Qualifying Life Events?

Please mark the checkbox below that best describes your change in circumstance and include the date on which the event occurred:

- | | |
|---|---|
| ☐ Adoption | ☐ Gain of ICHRA (Individual Coverage Health Reimbursement) |
| ☐ Birth | ☐ Gain of QSEHRA (Qualified Small Employer Health Reimbursement Arrangement) |
| ☐ Change in American Indian/Alaska Native Status | ☐ Legal Separation |
| ☐ Change in Household Size | ☐ Loss of Coverage Through Employer |
| ☐ Change in Incarceration Status | ☐ Loss of Medicaid |
| ☐ Change in Legal Presence | ☐ Loss of Minimum Essential Coverage |
| ☐ Change in US Citizenship Status | ☐ Marriage |
| ☐ Divorce | ☐ Moved into State |
| ☐ Exemption Cancelled | |

Date the event occurred (or will occur):

/ / (mm/dd/yyyy)

Please list all household members for whom you are seeking coverage.

First name		M.I.		
Last name				Suffix
First name		M.I.		
Last name				Suffix
First name		M.I.		
Last name				Suffix
First name		M.I.		
Last name				Suffix

Additional Household members please include on attached sheet of paper.

Please answer the following questions if you experienced one of the following qualifying life events, as you will need to provide additional information to verify your eligibility for coverage using a Special Enrollment Period:

- Change in Address within Nevada
- Divorce (removing someone from a plan)
- Gaining eligible immigration status
- Income reduction, with gain in eligibility for financial help
- Marriage
- New Nevada Resident
- Newly eligible for employer health reimbursement arrangement (HRA)

Is anyone applying for coverage due to a marriage?

☐ Yes ☐ No

Which household members are applying for coverage, due to a marriage, as listed above?

First name

M.I.

Last name

Suffix

First name

M.I.

Last name

Suffix

First name

M.I.

Last name

Suffix

First name

M.I.

Last name

Suffix

Did at least one spouse listed above have qualifying health coverage at any time within the 60 days before the marriage?

☐ Yes ☐ No

Is anyone applying for coverage based on a permanent move to Nevada from another state, a foreign country, a U.S. territory, or within Nevada?

☐ Yes ☐ No

Which household member(s) are applying based on a permanent move?

First name

M.I.

Last name

Suffix

First name

M.I.

Last name

Suffix

First name

M.I.

Last name

Suffix

First name

M.I.

Last name

Suffix

Additional Household members please include on attached sheet of paper.

If moved to Nevada from another state: indicate the city and state you moved from below:

City

State

If moved to Nevada from another country or U.S. territory: indicate the country or territory you moved from below:

Country

If moved within Nevada: what's the county and ZIP code of your previous address?

County

Zip Code

Did the above household members have qualifying health coverage at any time in the 60 days before they moved?

☐ Yes ☐ No

Is anyone in the household applying due to gaining an eligible immigration status?

☐ Yes ☐ No

Which household members are applying based on gaining an eligible immigration status?

First name M.I. Last name Suffix First name M.I. Last name Suffix First name M.I. Last name Suffix First name M.I. Last name Suffix

Additional Household members please include on attached sheet of paper.

Is any household member being removed from coverage due to a divorce?

☐ Yes ☐ No

Which household member(s) is being removed from coverage due to a divorce?

First name M.I. Last name Suffix First name M.I. Last name Suffix First name M.I. Last name Suffix First name M.I. Last name Suffix

Additional Household members please include on attached sheet of paper.

Is anyone in the household applying due to becoming eligible for financial help due to a reduction in income?

☐ Yes ☐ No

Which household member(s) experienced a reduction in income?

First name M.I. Last name Suffix First name M.I. Last name Suffix First name M.I. Last name Suffix First name M.I. Last name Suffix

Additional Household members please include on attached sheet of paper.

☐ Yes ☐ No

Last name																															Suffix				
-----------	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--------	--	--	--	--

Additional Household members please include on attached sheet of paper.

Qualifying Life Event / Special Enrollment Period Documents for Verification **(Not applicable to Medicaid only application)**

If you are applying for coverage based on a qualifying life event, you may be required to submit additional documentation. Please see below for a sample list of documents you may need to include with your application. If you have questions about what you need to submit, please call the Nevada Health Link Call Center at 1-800-547-2927. TTY users should call 711.

Change of Address within Nevada/New Nevada Resident

- Copy of deed and record of most recent mortgage payment (if mortgage is paid in full, provide a copy of property tax bill from the most recent year)
- Copy of lease and record of most recent rent payment
- Mortgage showing primary residence address
- Nursery school or daycare records (if school is private, additional documentation may be requested)
- Current utility bill or work order dated within the past 60 days
- Statement from a homeless shelter
- School records (if school is private, additional documentation may be requested)
- Section 8 agreement
- Homeowner's insurance declaration page
- Proof of enrollment of custodial dependent in public school

Change to Employer Plan, Newly Eligible for Financial Help

- Completed Employer Coverage Tool (PDF) and a cover letter signed by the employer
- "Letter or other documentation from an employer or other documentation with this information:
 - o Statement that the employer doesn't currently offer you (or your family member) coverage
 - o Statement that the employer doesn't provide coverage that is qualifying health coverage
 - o Statement showing the cost of your share of the premium for the lowest-cost self-only plan that meets the minimum value standard (factoring in wellness incentives), if offered
- Health insurance letter that contains confirmation of health coverage and expiration dates for coverage received outside of the Marketplace

Divorce

- Divorce Decree

Income Reduction, newly Eligible for Financial Help

- Paycheck stubs showing employee information, pay date or pay period, and gross amount of pay, for the 4 weeks prior to the date listed on your notice.
- 1040 federal or state tax return from the previous year if representative of attested income.
- Wages and tax statement (W-2 and/or 1099, including 1099 MISC, 1099G, 1099R, 1099SSA, 1099DIV, 1099SS, 1099INT) showing first/last name, income amount, year, and employer name (if applicable).
- A signed earning statement from your employer showing first/last name, company contact information and gross pay information, signed by the employer and dated.

NOTE: If you are seasonally employed, any of the proofs above should include information about the duration of your employment.

- Self-Employment ledger documentation showing first/last name, company name, and income amount. If you're submitting a self-employment ledger, include the dates covered by the ledger, and the net income from profit/loss (can be a Schedule C, the most recent quarterly or year-to-date profit and loss statement, or a self-employment ledger).
- 1040 SE with Schedule C, F, or SE (for self-employment income)
- 1065 Schedule K1 with Schedule E
- Tax return
- Bookkeeping records
- Receipts for all allowable expenses
- Signed time sheets and receipt of payroll, if you have employees
- Most recent quarterly or year-to-date profit and loss statement
- Award letter/certificate dated within the last year
- Annual benefit statement
- Correspondence from the Social Security Administration with your award status (denied, award amount, still pending)
- Monthly benefits statement from the Department of Employment, Training, and Rehabilitation
- Copy of Direct Payment Card with statement
- Letter from the Department of Employment, Training, and Rehabilitation with reason for denial
- Filed tax return if representative of attested rental income
- Agricultural income certificate
- Alimony received: court order stating alimony amount or signed statement from individual providing alimony with amount and frequency.
- Annuity statement
- Bank or investment fund statement

- Cost of living adjustment letter and other benefit verification notices
- Farm Income (See acceptable proof of “Self-Employment Income” listed above)
- Foreign-Earned Income (See acceptable proof of “Income from a Job” listed above)
- Gambling Income: Form W-2G
- Interests and dividends income statement
- Letter, deposit, or other proof of deferred compensation payments
- Letter, deposit, or other proof of travel/business reimbursement pay
- Loan statement showing loan proceeds
- Military Leave and Earnings statement
- Pay stub indicating sick pay
- Pay stub indicating substitute/assistant pay
- Pay stub indicating vacation pay
- Prizes, settlements, and awards, including court-ordered awards letter
- Proof of bonus/incentive payments
- Proof of gifts and contributions
- Proof of inheritances in cash or property
- Proof of residuals
- Proof of severance pay
- Proof of strike pay and other benefits from unions
- Rental, real estate, royalties, partnerships, S-Corps, trusts: rent checks or rental payment receipts, current lease, signed letter from tenant with monthly rental amount, royalty checks, or financial record of payment from trusts
- Royalty income statement or 1099-MISC
- Sales receipts or other proof of money received from the sale, exchange, or replacement of things you own
- Statement of pension distribution from any government or private source
- Worker’s compensation letter

Marriage

- Marriage certificate
- Marriage license
- Official public record of marriage
- Marriage affidavit or affidavit of support that’s signed and dated by the person who officiated the marriage or the official witness of the marriage
- Religious document

Newly eligible for employer health reimbursement arrangement (HRA)

- Notice from your employer showing when your individual coverage HRA or QSEHRA can begin

Permissions and Sign

Read and check the box next to each statement if you agree

Are any applicants incarcerated (in prison or jail)? You are not considered incarcerated if you are in jail or imprisonment pending the disposition of charges; In other words, if someone is detained but not convicted of a crime, that person is not considered incarcerated.

☐ Yes. Provide the name of the applicant that is incarcerated (in prison or jail) below.

First name

M.I.

Last name

Suffix

☐ No. No one listed on this health insurance application is incarcerated (in prison or jail).

To make it easier to reduce the cost of my health insurance coverage in future years, I agree to allow Nevada Health Link to use computer sources, such as the Internal Revenue Service (IRS), to check my income. I also agree to allow Nevada Health Link to use my income data, including information from my tax returns, to determine whether I am eligible to continue to receive financial assistance. If those sources show I am still eligible for continued financial assistance, my insurance coverage and financial assistance will be renewed for another 12 months. I understand Nevada Health Link will send me a notice explaining that I have been renewed in coverage and allow me to make any changes needed for the following coverage year. I acknowledge if I elect not to give this consent, my insurance will be renewed without financial assistance for the following year. I also acknowledge I can discontinue or change this consent at any time.

☐ I agree.

☐ I disagree, but allow Nevada Health Link to check my information and use it for (check one) :

☐ 5 years (the maximum number of years allowed)

☐ 2 years

☐ 4 years

☐ 1 year

☐ 3 years

☐ I do not give Nevada Health Link consent to use my income data at renewal.

By signing below, if anyone on this application enrolls in Medicaid, I'm giving the Medicaid agency the right to pursue and recover payments from other health insurance, legal settlements, or other liable third parties. I'm also giving the Medicaid agency the right to pursue and obtain medical support from a spouse or parent. I authorize the Department of Human Services to verify the information I provide and conduct any reviews or investigations necessary to determine or maintain Medicaid eligibility. I understand I must cooperate with requests for information. Knowingly providing false information, withholding information, or submitting altered documents may result in the denial or termination of benefits, recovery of Medicaid benefits paid on my behalf, and civil or criminal penalties as allowed by state and federal law.

By signing below, I know I must report any changes that might affect my health coverage, like if I or a member of my household move, have any income changes, get married, get divorced, become pregnant, or have a child. If I or a member of my household is enrolled in Medicaid or Nevada Check Up (Nevada's Children's Health Insurance Program), I know I must report these changes by the fifth (5th) day of the month following the month the change occurred by contacting the Nevada Division of Social Services (DSS) at 1-800-992-0900. If I am enrolled in a Nevada Health Link plan and need to report a change, I know I can log in to my account on Nevada Health Link or call the Nevada Health Link Call Center at 1-800-547-2927 (TTY: 711).

By signing below, I acknowledge that the information provided on this application, including my phone number(s) and other contact information, will be shared with the Nevada Department of Human Services (DHS), Division of Social Services (DSS), and any Managed Care Organization (MCO) to which I am assigned as part of Medicaid or Nevada Check Up eligibility. I consent to receive calls and/or text messages from DHS, DSS, MCOs, and any contractors acting on their behalf, at any phone number(s) I provide on this application, now or in the future. These calls or text messages may include information regarding healthcare needs and treatment, wellness services, plan benefits, eligibility, renewal and/or redetermination, and other information relating to my relationship with DHS, DSS, or MCOs concerning my health coverage. These calls and text messages may be made using automated technology, such as an automatic telephone dialing system, or artificial or prerecorded voice message. Standard message and data rates may apply.

By signing my name in the box below, 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 I may be subject to penalties under federal law if I intentionally provide false information.

Signature of PRIMARY APPLICANT

Date Signed (mm/dd/yyyy)

 / /

Appendix: Appoint an Authorized Representative

You have the right to choose an authorized representative to help you. This is a trusted person who has your permission to talk about your application with Nevada Health Link, see your information, and act for you on matters related to your application, including receiving information about you and signing documents on your behalf. If you want to appoint an authorized representative, you must complete and submit this form. Your authorized representative can be an attorney but does not have to be.

Please Note: Your authorized representative will be able to sign your application as if they were you, submit updates and respond to eligibility redeterminations for you, as well as receive copies of your notices and other communications from Nevada Health Link. In addition, your authorized representative can act on your behalf in all other matters before Nevada Health Link until you rescind this appointment (or it expires). If you ever need to change your authorized representative, including removing your authorized representative, please contact Nevada Health Link Consumer Assistance center at 1-800-547-2927.

If you are a legally appointed authorized representative for someone, please submit proof with this application.

Make a copy for your records and mail the completed form to: Nevada Health Link PO Box 2128, Birmingham, AL 35201.

Step 1: Enter information for the customer who is appointing a representative.

First name		M.I.		Date of birth (mm/dd/yyyy)		/		/			
Last name									Suffix		
Address 1											
Address 2											
City								State		ZIP code	
County, parish, or township											
Email Address											
Nevada Health Link Account # (if you have one)											

Step 2: Enter information for the authorized representative.

By appointing an authorized representative, you are requesting that Nevada Health Link send all communications to your representative.

First name		M.I.		Date of birth (mm/dd/yyyy)		/		/			
Last name									Suffix		
Address 1											
Address 2											
City								State		ZIP code	
County, parish, or township											
Email Address											
Organization name (if applicable)											
Title (if applicable)		Daytime Phone Number	(		)		-				

Step 3: Customer Signature

By signing this form, the undersigned hereby empowers their authorized representative to act on their behalf with respect to any part of their application until the authorization is otherwise rescinded or it expires.

☐ Up to: / / (mm/dd/yyyy)

☐ Until I, the applicant, indicate that the representative is no longer authorized to act on my behalf.

First name		M.I.	
Last name			
Signature of PRIMARY APPLICANT	Date Signed (mm/dd/yyyy)		
	/ /		
	Suffix		

Qualified Health, Dental, and Vision Plan

If you are eligible for coverage in a qualified health plan (QHP), qualified dental plan, or qualified vision plan, you have the option to select those plans. Below are the plans that may be available to you. If you are eligible for a QHP, a Nevada Health Link Call Center representative will call you to complete plan selection. If you have questions about plans available to you, please call the Nevada Health Link Call Center at 1-800-547-2927. TTY users should call 711.

Qualified Health Plan	Contact Phone	Website (Visit for more information)
Health Plan of Nevada (HPN)	1-800-777-1840	https://www.healthplanofnevada.com
Silver Summit (Centene)	1-844-366-2880	https://www.silversummithealthplan.com/
Anthem (HMO Nevada)	1-866-755-2680	https://www.anthem.com/contact-us/nevada/
Select Health	1-800-538-5038	https://selecthealth.org/
CareSource	1-833-230-2099	https://www.caresource.com/
Hometown Health Plan	1-775-982-3232	https://www.hometownhealth.com/nvhealthlink/
Imperial Health Plan	1-800-595-0619	https://exchange.imperialhealthplan.com/nevada/
Molina Healthcare	1-833-671-0051	https://www.molinahealthcare.com/members/nv/en-us

Qualified Dental Plan	Contact Phone	Website (Visit for more information)
Alpha Dental	1-888-857-0337	https://www1.deltadentalins.com/individuals-and-families/healthcare-reform-for-individuals.html
Anthem - Rocky Mountain	1-855-877-4373	https://www.anthem.com/individual-and-family/dental-insurance
Best Life	1-800-433-0088	https://www.bestlife.com/dental.html
Delta Dental	1-888-857-0314	https://www1.deltadentalins.com/individuals-and-families/healthcare-reform-for-individuals.html

Qualified Vision Plan	Contact Phone	Website (Visit for more information)
VSP Individual Vision Plans	1-844-641-6718	https://www.vspdirect.com/4NV/welcome

Medicaid Health Plan Preference

If you are eligible for Medicaid, you may be covered by a Managed Care Organization (MCO). Please select one of the following MCOs. If you do not select a preference, you will be assigned an MCO randomly. Your choice does not guarantee enrollment into the Nevada Medicaid or Nevada Check Up - CHIP programs.

Which Managed Care Option Would You Like?

Managed Care Option	Available Region	Contact Phone	Website (Visit for more information)
☐ Anthem Blue Cross and Blue Shield Healthcare Solutions	Urban Clark Urban Washoe	1-844-396-2329	mss.anthem.com/nevada-medicaid/home.html
☐ CareSource	Urban Clark Urban Washoe	1-833-230-2058	caresource.com/nv/plans/medicaid/
☐ Health Plan of Nevada	Urban Clark	1-800-962-8074	myHPNmedicaid.com/Member
☐ Molina Healthcare	Urban Clark Urban Washoe	1-844-327-7136	meetmolina.com/nv-medicaid
☐ SilverSummit Healthplan	Rurals 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 assigned to one by Medicaid)			

Optional Text Messaging Opt-In/Opt-Out

The information provided on this application, including your phone number(s), will be shared with Nevada Department of Human Services (DHS) - Division of Social Services (DSS), Nevada Health Authority (NVHA), and health plan to which you are assigned. Consent authorizes calls and/or texts from Nevada DHS - DSS, NVHA, 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 your healthcare needs and treatment, wellness services, plan benefits, eligibility, renewal and/or redetermination, and for any other communication relating to your relationship with DHS - DSS, NVHA or any health plans concerning your 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.

Preferred Phone Number

() -

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