



For more information call:
1-877-KIDS-NOW (543-7669)
1 (775) 684-3777 In-State
1-800-360-6044 Out-of-State
www.nevadacheckup.nv.gov

Nevada Check Up Application

Children's Health Insurance Program (SCHIP)

Have you ever applied for, or been enrolled in Nevada Check Up? If so, please enter your Family Identification Number _____

Return application with income verification (See instructions) to:
Nevada Check Up
1000 E. William Street, Suite 200
Carson City, NV 89701

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. Person or Head of the Household Applying for Child or Children

Last Name	First Name	MI	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Social Security Number (optional)	Race/Ethnicity (optional)	*Citizenship Status (optional)			
							* Information received on adults' citizenship status is not reported to INS			
							<input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian or Alaska Native Tribal Affiliation: _____ <input type="checkbox"/> Other: _____			
Marital status (optional)			Married <input type="checkbox"/>	Single <input type="checkbox"/>	Date of Birth			<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Undocumented Alien <input type="checkbox"/> Qualified Alien with Legal Immigration Status		
If married, name of spouse:										
Are you pregnant?			Yes <input type="checkbox"/>	No <input type="checkbox"/>	Are you employed?	Home Phone	Work Phone	Cell/Message Phone		
If yes, enter due date:					Yes <input type="checkbox"/> No <input type="checkbox"/>					
Home Address - Number and Street					Apt./Space	City		State	Zip Code	
Mailing Address					How many people are in this household?			Preferred language?		

2. Other Adults in Household: If more adults reside in the household, please attach an additional sheet with the same information in the same order as listed below:

Last Name	First	Gender	Date of Birth	Are you Employed?	Social Security Number (optional)	Relationship to Applicant Above	*Citizenship Status (optional)	Marital Status (optional)	Is this adult pregnant? If yes, enter due date	Race/Ethnicity (optional)
		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Undocumented Alien <input type="checkbox"/> Qualified Alien with Legal Immigration Status	Married <input type="checkbox"/> Single <input type="checkbox"/> If married, name of spouse	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, enter due date	<input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian or Alaska Native Tribal Affiliation: _____ <input type="checkbox"/> Other: _____
		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Undocumented Alien <input type="checkbox"/> Qualified Alien with Legal Immigration Status	Married <input type="checkbox"/> Single <input type="checkbox"/> If married, name of spouse	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, enter due date	<input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian or Alaska Native Tribal Affiliation: _____ <input type="checkbox"/> Other: _____

3. Children in Household: List all children in your home 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.

Last Name	First	MI	Date of Birth	Gender	Social Security Number	Health Insurance	Citizenship Status (Required)	Marital Status	Parental Relationships	Race/Ethnicity (optional)
				<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> On Nevada Medicaid <input type="checkbox"/> Covered by other insurance <input type="checkbox"/> No coverage Date coverage ended: _____ Reason: _____	<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Undocumented Alien <input type="checkbox"/> Qualified Alien with Legal Immigration Status	Married <input type="checkbox"/> Single <input type="checkbox"/>	Mother (name): _____ Father (name): _____ Relationship of the Child to the Head of the Household: _____	<input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian or Alaska Native Tribal Affiliation: * _____ <input type="checkbox"/> Other: *Please provide copy of your tribal affiliation card
Are you applying for Nevada Check Up for this child? Yes <input type="checkbox"/> No <input type="checkbox"/>			Is this child pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, enter due date: _____		Is this child disabled & receiving SSI? Yes <input type="checkbox"/> No <input type="checkbox"/>					
				<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> On Nevada Medicaid <input type="checkbox"/> Covered by other insurance <input type="checkbox"/> No coverage Date coverage ended: _____ Reason: _____	<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Undocumented Alien <input type="checkbox"/> Qualified Alien with Legal Immigration Status	Married <input type="checkbox"/> Single <input type="checkbox"/>	Mother (name): _____ Father (name): _____ Relationship of the Child to the Head of the Household: _____	<input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian or Alaska Native Tribal Affiliation: * _____ <input type="checkbox"/> Other: *Please provide copy of your tribal affiliation card
Are you applying for Nevada Check Up for this child? Yes <input type="checkbox"/> No <input type="checkbox"/>			Is this child pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, enter due date: _____		Is this child disabled & receiving SSI? Yes <input type="checkbox"/> No <input type="checkbox"/>					
				<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> On Nevada Medicaid <input type="checkbox"/> Covered by other insurance <input type="checkbox"/> No coverage Date coverage ended: _____ Reason: _____	<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Undocumented Alien <input type="checkbox"/> Qualified Alien with Legal Immigration Status	Married <input type="checkbox"/> Single <input type="checkbox"/>	Mother (name): _____ Father (name): _____ Relationship of the Child to the Head of the Household: _____	<input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian or Alaska Native Tribal Affiliation: * _____ <input type="checkbox"/> Other: *Please provide copy of your tribal affiliation card
Are you applying for Nevada Check Up for this child? Yes <input type="checkbox"/> No <input type="checkbox"/>			Is this child pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, enter due date: _____		Is this child disabled & receiving SSI? Yes <input type="checkbox"/> No <input type="checkbox"/>					
				<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> On Nevada Medicaid <input type="checkbox"/> Covered by other insurance <input type="checkbox"/> No coverage Date coverage ended: _____ Reason: _____	<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Undocumented Alien <input type="checkbox"/> Qualified Alien with Legal Immigration Status	Married <input type="checkbox"/> Single <input type="checkbox"/>	Mother (name): _____ Father (name): _____ Relationship of the Child to the Head of the Household: _____	<input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian or Alaska Native Tribal Affiliation: * _____ <input type="checkbox"/> Other: *Please provide copy of your tribal affiliation card
Are you applying for Nevada Check Up for this child? Yes <input type="checkbox"/> No <input type="checkbox"/>			Is this child pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, enter due date: _____		Is this child disabled & receiving SSI? Yes <input type="checkbox"/> No <input type="checkbox"/>					

Do the above adults and children, including applicant, plan to continue to live in Nevada?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If no, explain: _____
Are any or all of the above adults applying for Medicaid medical assistance?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

4. Child Care Expense

Child Name (Please list the name of every child for whom you are paying child care)	Amount Paid for Each Child	How Often Paid?

5. Employment Information – List employment information for each working adult residing in the household. You must provide verification of income by submitting **copies of at least two most current consecutive pay stubs from each job (stubs need to be no older than 45 days before the date of the application)**. (If you are self-employed, you must submit a **complete** copy of your most current income tax return including Schedule C; additional information may be requested.)
Note: If pay stubs do not represent your normal hours worked and pay received, please explain on a separate sheet of paper.

Persons Employed	Name and Address of Employer	Employer Telephone Number	Tips (amount earned each pay period)	Gross Pay (amount earned for each pay period before taxes)	How Often Paid (weekly, every two weeks, twice a month, monthly)

6. Other Income – Please provide proof for each income received - List all types of income received by anyone in the household (including children).

(✓ one) Yes/No	Source of Other Income	Name of Recipient	Dollar Amount	How Often Paid? (weekly, every two weeks, twice a month, monthly)
	Child Support/Alimony (Please show name of each child and their amount received)			
	Social Security Payments & Type: <input type="checkbox"/> RSDI <input type="checkbox"/> SSI			
	Disability Payment Source:			
	Unemployment Benefits:			
	Pension Payments & Source:			
	Interest or Dividends (Stocks, Bonds, Trusts, Mutual Funds, Savings Accounts, etc.)			
	Other (such as cash assistance, etc):			

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

Do you want this application to be referred to Nevada Medicaid? Yes No

7. 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) Friend/Family Doctor/Hospital Social Services/Health Dept Child Care Provider Tribal Resource Clinic Other: _____

8. Health Plan: Please indicate your health plan preference. If you live in an area where this health plan provides coverage for Nevada Check Up, you will be assigned to your chosen health plan. If this plan does not provide coverage in the area where you live, you will be assigned to the correct plan or to the Fee-For-Service benefit plan. This choice of health plan does not guarantee acceptance into the Nevada Check Up program. Once you have been enrolled, you will receive a member handbook explaining your benefits. 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.

Please choose one of the following health plans:

Anthem Blue Cross Blue Shield Partnership Plan
Ph: 1- 866-474-6138

Health Plan of Nevada
 Northern Nevada **Ph: 1-800-962-8074**
 Southern Nevada Ph: 1-800-777-1840 or 702-242-7317

(If you do not indicate a health plan preference, we will choose a plan for you. You may change plans at any time by contacting Nevada Check Up . The change will be effective as of the next enrollment month)

9. Third Party Liability

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 Department of Health and Human Services in obtaining payments for medical care from any third party or person who may be liable for the medical services paid for by the Nevada Check Up Program. 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 the Nevada Check Up Program.

10. Verification

- I understand that verification of the information is necessary and may be requested and obtained.
- I further understand that the law provides penalties for persons hiding facts or not being completely truthful.

11. Signature and Affirmation

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 the last page of 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 authorize Nevada Check Up and/or the Department of Health and Human Services to contact my employer to obtain wage and health insurance information.
- 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 I have been 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 case review. The request for review must be submitted in writing within 30 days of the date of the Notice of Action.
- 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)

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

Date: _____

Other Adult: _____

Date: _____

Did you?

Sign the application? Yes <input type="checkbox"/> No <input type="checkbox"/>	Send proof of ALL income received? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Choose an MCO? Yes <input type="checkbox"/> No <input type="checkbox"/>	Provide each Child's Social Security Number? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Answer all questions? Yes <input type="checkbox"/> No <input type="checkbox"/>	If available, send copy of Birth Certificate for each citizen child? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Nevada Check Up

Instructions and important information

(Please detach, keep for your records and future reference)

1-877-KIDS-NOW

(1-877-543-7669) In-State

1-800-360-6044 Out-of-State

Instructions

- Section 1. Please fill in all the information about the person or head of the household who is applying for the child or children. Citizenship, Social Security and Ethnic Group fields are optional for the adults only.
- Section 2. This section asks you to fill in the information on other adults living in the household. Citizenship, Social Security and Ethnic Group fields are optional for the adults only.
- Section 3. In the children section, all fields must be completed except Ethnic Group (optional). Empty fields could cause the application to be returned to you to complete.
- Section 4. Please list any and all child care expense you may have.
- Section 5. Employment information - you need to send in at least 2 of your most current consecutive pay stubs in order for us to determine eligibility on your case. Self employed applicants must include a complete copy of the most current income tax return. Please also note for all households, especially self-employed households, additional information may be requested to better assess your total annual gross income.
- Section 6. Other Income - please list all types of income received by anyone in the household and provide proof of each income received.
- Section 7. Referral source - please check the one that applies.
- Section 8. Health Plan - please choose one of the Managed Care Organizations (MCO) from the choices provided.
- Section 11. Signature and Affirmation - please sign your application. **All applications missing the signature will be returned, which will delay processing.**

What is Nevada Check Up?

Nevada Check Up is a state and federally funded program that provides low-cost, health care coverage to uninsured children from birth through 18 years of age, who are not covered by private insurance or Medicaid and who meet the program guidelines.

What are the eligibility qualifications for Nevada Check Up?

A child must:

- be between birth through 18 years of age at the date of application;
- have no other creditable health care coverage;
- be a Citizen of the United States, or be a Qualified Alien who has Legal Immigration Status;
- not be covered by or have access to the Public Employee Benefits Program (PEBP) through an employer;
- meet federal income guidelines (be within 200% of the Federal Poverty Level);
- not be covered by or appear eligible for Medicaid.

INCOME GUIDELINES As published in February 2008

Number of People in Household	200 % FPL Max Income Level*
2	\$ 28,000
3	35,200
4	42,400
5	49,600
6	56,800

Premium Due Dates

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

Applying for Nevada Check Up will not affect your family's immigration status. If not born in the United States, the child must be a qualified alien who has legal immigration status to be eligible for Nevada Check Up or Nevada Medicaid.

*Applicants that currently exceed the above listed 200% FPL may still qualify for our program in the future. The Federal Poverty Levels change every year in February.

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

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

Once a year, you must respond to our request for updated information. You must respond to this request on time. Our form will include all our current information about your household. Send new income verification documents and, if needed, tell us who is now in your household. **If you do not respond on time, your children will no longer be covered by Nevada Check Up.**

What about premium payments? - The only cost for Nevada Check Up is a quarterly premium which is determined by family size and income and is charged per family, not per child. For incomes at or above 176% of the Federal Poverty Level (FPL), the premium is \$80, for incomes at or above 151% FPL but at or below 175% FPL, the premium is \$50 and for incomes at or above 36% FPL but at or below 150% FPL, the premium is \$25 per quarter. 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. The due date and amount of your premiums is shown on your notice of enrollment. You will be sent a notice showing the premium amount due for the first quarter. Please remember to write your family ID number on your check or money order. This number can be found on the notice of enrollment. Payment is due within 10 days of receipt of the notice of enrollment. **If premiums are not paid, your children will lose health care coverage, and you will still be responsible for any remaining balance!** Please do not send premiums with your application.

NEVADA CHECK UP APPLICANT RESPONSIBILITIES

It is your responsibility to immediately report to Nevada Check Up any of the following:

- Change of address and phone number.
- If my child (ren) moves out of the house or state.
- If my child (ren) becomes eligible for Medicaid or other health insurance.
- If my child (ren) dies.
- If my child (ren) becomes a resident or inmate of a public institution, or a ward of the state.
- If my child (ren) becomes emancipated/married.
- If I have lost my Nevada Check Up card and need a new one.
- I understand that if I don't pay premiums, my children will lose their health care coverage.
- I understand that if I don't respond to the annual renewal, my children will lose their health care coverage.
- I understand that if my application is not complete, Nevada Check Up will return my incomplete application and the processing of my application may be delayed.
- If a member of my household becomes pregnant, I will notify Nevada Check Up within 14 days of the baby's birth. Failure to comply with this condition will result in delayed coverage for the newborn child if the child is eligible for Nevada Check Up.

Any Questions? Call:

1-877-KIDS-NOW
(1-877-543-7669) In-State
1-800-360-6044
Out-of-State

If you fail to report any of the information listed above your child/children may lose their coverage with Nevada Check Up.

Send your completed **Application** or any **Correspondence** to:

Nevada Check Up Program
1000 E. William Street Ste 200
Carson City, Nevada 89701

Send your **Payments Only** to:

Nevada Check Up Program c/o Bank of America
File 56708
Los Angeles, CA 90074-6708

Bank of America will only process payments. Please write your family identification number on your check or money order.

More Questions?

Call us at (775) 684-3777 or toll free (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> or write to Nevada Check Up, Division of Health Care Financing and Policy (DHCFP), 1000 East William Street, Suite 200, Carson City, Nevada 89701.

If you need help with your application, call Nevada Check Up at (877) KIDS-NOW (543-7669).

If you have any questions about providers, bills or would like to know where you can take your children for services, please contact your Managed Care Organization (MCO) at the following numbers:

Health Plan of Nevada-South 1(702) 242-7317 - Health Plan of Nevada-North 1(800) 962-8074

Anthem Blue Cross Blue Shield Partnership Plan 1(866)474-6138

If you are enrolled in Fee-For-Service 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.