OFFICE OF COMMUNITY LIVING PROGRAM APPLICATION

IF YOU NEED HELP COMPLETING ANY PART OF THIS FORM, LET US KNOW.

OFFICE OF COMMUNITY LIVING (OCL) PROGRAMS YOU MAY APPLY FOR:

COPE - Community Service Options Program for the Elderly

COPE provides services to seniors to help them maintain independence in their own homes as an alternative to a long-term care facility. COPE services include the following non-medical services: Case Management, Homemaker, Social Adult Day Care, Adult Companion, Attendant Care, Personal Emergency Response System, Chore and Respite.

ELIGIBILITY - Must be 65 years or older and be at risk of long-term care facility placement within 30 days without services to keep them in their home and community. Priority given to those meeting criteria of Nevada Revised Statute (NRS) 426 – unable to bathe, toilet and feed self without assistance.

PAS - Personal Assistance Services

PAS provides community-based, in home services to enable adult persons with severe physical disabilities to remain in their own homes and avoid placement in a long-term care facility. PAS services include authorizations for Personal Care Services assisting an individual with daily tasks such as bathing, dressing, grooming, toileting, transferring/ambulating, eating, housekeeping, shopping, laundry, and meal preparation. PAS recipients may share in the cost of their services, based upon a sliding scale formula.

ELIGIBILITY -- Applicants must be age 18 or over and have a severe physical disability as determined by a licensed medical professional outlined in NAC 427A. Note: PAS Services are for those that do not meet the financial criteria for Nevada Medicaid or are waiting for the Home and Community Based Services Waiver for the Frail Elderly (HCBS FE) or Home and Community Based Services Waiver for Persons with Physical Disabilities (HCBS PD). Per Nevada Administrative Code (NAC) 427A in order for an application to be considered complete, it must be submitted with a written statement from a licensed physician, physician assistant or registered nurse certifying the applicant's need for essential personal care. The applicant may submit a written statement, or, a completed CBC-423 form, both of which are required to be signed and dated by a medical professional as noted above. If this statement/CBC-423 form is not returned with the application, the application will not be considered a referral for the PAS program.

HCBS FE Waiver - Home and Community Based Services Waiver for the Frail Elderly

The HCBS FE Waiver authorizes services to seniors to help them maintain independence in their own homes and communities as an alternative to long-term care facility placement. HCBS FE Waiver services include the following: Case Management, Homemaker, Social Adult Day Care, Adult Companion, Home Delivered Meals, Personal Emergency Response System, Chore, Respite, Augmented Personal Care provided in residential care settings and access to State Plan Personal Care Services.

ELIGIBILITY -- Must be 65 years or older; at risk of long-term care facility placement within 30 days without services; and require at least one monthly HCBS FE Waiver service. Must apply for and be determined financially eligible for Medicaid through the Division of Welfare and Supportive Services (DWSS).

HCBS PD Waiver - Home and Community Based Services Waiver for Persons with Physical Disabilities

The HCBS PD Waiver authorizes services to individuals who have been diagnosed with a physical disability to help them maintain independence in their own homes and communities as an alternative to long-term care facility placement. HCBS PD Waiver services include the following: Case Management, Attendant Care, Homemaker, Chore, Respite, Assisted Residential Care, Environmental Accessibility Adaptations, Specialized Medical Equipment/Supplies, Personal Emergency Response System (PERS), Home Delivered Meals and access to State Plan Personal Care Services.

ELIGIBILITY -- Must be; at risk of long-term care facility placement within 30 days without services, must be certified as physically disabled by the Division of Health Care Financing and Policy (DHCFP) Central Office Physician Consultant; and require at least one monthly HCBS PD Waiver service. Must apply for and be determined financially eligible for Medicaid through the Division of Welfare and Supportive Services (DWSS).

Financial Eligibility

Must apply for and be determined financially eligible by ADSD for COPE, and PAS programs, and by DWSS for the HCBS FE and HCBS PD Waivers.
Please refer to adsd.nv.gov for more information.

To report suspected abuse, neglect, exploitation, isolation or abandonment of vulnerable adults, 18 years and older, please call:

- **Las Vegas/Clark County (702) 486-6930**
- **Statewide/All Other Areas (888) 729-0571**

If a vulnerable adult is in immediate danger, the local police, sheriff's office or emergency medical service should be contacted. If the person is not in immediate danger, the report should be made via one of the designated phone numbers.

READ THIS PAGE CAREFULLY BEFORE FILLING OUT THIS APPLICATION

Failure to answer ALL questions on this application may cause delay in processing time.
Willful Concealment of income or asset information and false or misleading statements could result in a denial or termination of program eligibility. Whether you are completing the form yourself or acting on behalf of the person who will receive the services, you are certifying the correctness of the answers.

1. The applicant must be the primary source of information to confirm they choose to apply for voluntary services. If the applicant chooses to have an authorized representative be the primary contact, one of the following must be submitted along with the OCL Application: Authorization to Release Information (included with OCL application), proof of guardianship, power of attorney, etc.
2. All OCL Applications must be signed by the applicant or their authorized representative to be accepted as a complete application. Remember, you are certifying the correctness of the answers whether you are completing the form yourself or acting on behalf of the person who will receive the services.
3. If you need help filling out the form, you may ask your family, a friend or contact your local OCL Intake and Operations unit for assistance; office location listed below.
4. Verifications of income and resources will be needed to process the application. Be prepared to obtain these documents promptly upon request.
5. **VETERANS**: If you or your spouse/ or both is/are a Veteran, verification that you have applied for VA Benefits is required.
6. **APPLICANTS UNDER 65 applying for Medicaid waiver services**: Medical records that support your reported disability are required to be submitted 30 DAYS from the date the OCL Application was submitted to continue the intake progress. Medical records must include sufficient evidentiary information to support your reported disability and may include primary care office visit notes; clinical findings including medical history, diagnosis, physical and/or discharge summary; or treatment and prognosis. If insufficient records are submitted, a denial of waiver services will be issued. NOTE: Applicants who do not meet the financial criteria for HCBS PD Waiver services may be required to have a statement or provided form signed and dated by a medical professional to apply for the PAS program.

PLEASE RETURN THE COMPLETED APPLICATION TO THE APPROPRIATE OFFICE LOCATION BELOW

ADSD Carson City Office
3208 Goni Road, Suite I-181
Carson City, NV 89706
(775) 687-4210 Main
(775) 688-2969 Fax

ADSD Elko Regional Office
1010 Ruby Vista Drive, Suite 104
Elko, NV 89801
(775) 738-1966 Main
(775) 688-2969 Fax

ADSD Las Vegas Regional Office
3320 W Sahara Ave, Suite 100
Las Vegas, MV 89102
(702) 486-3545 Main
(702) 486-3569 Fax

ADSD Reno Regional Office
9670 Gateway Drive, Suite 100
Reno, NV 89521
(775) 687-0800 Main
(775) 688-2969 Fax

STATEWIDE INTAKE EMAIL
CBCSouthIntake@adsd.nv.gov

We encourage all emails to be sent encrypted to protect the applicant's personal health and personally identifiable information. We will gladly send you an encrypted message upon request that will prompt you to follow the web instructions to open the protected email and then reply.

OFFICE OF COMMUNITY LIVING PROGRAM APPLICATION

Race (optional) - please check one of the boxes ☐ Hispanic/Latino or ☐ Non -Hispanic or latino

Please list below the ethnicity code in Race/Ethnicity: A - Asian; B - Black or African American; I - American Indian or Alaska Native; J - American Indian or Alaskan Native and White; L - Asian and White; M - Black or African American and White; N - Native Indian/Alaskan Native and Black/African American; U - Native Hawaiian or other Pacific Islander; W - White; NA -North African; ME - Middle Eastern; Z - 2 or more combinations not listed above.

Demographic Information

Name of Applicant (Last, First, Middle):	Social Security Number:	Race/Ethnicity (See codes above):	
Preferred Language of Applicant: English ☐ Spanish ☐ Other:			
Physical Address:	Medicare Number:	Age:	Sex:
City, State, Zip Code:	Marital Status:	Date of Birth:	
Mailing Address:	City, State, Zip Code:		
Telephone Number:	Email Address:		
Secondary Phone Number:	What is the best time to contact you or your designated representative?		
Referring Party and Relationship:	Phone Number:		

Current Living Situation: Alone ☐ Living with Family ☐ Own Home ☐ Living With Roommate ☐ Apartment ☐
Skilled Nursing Facility ☐ Group Home/Assisted Living ☐ Other: ☐
Name of Facility/Group Home/Assisted Living:

Is the Applicant Currently in a Hospital or Nursing Facility?: Yes ☐ No ☐
If Yes, Name and Address of Facility:
Anticipated Discharge Date (If known):

Does the Applicant have a Power of Attorney (POA), Guardian, or chosen designated representative? Yes ☐ No ☐
If Yes, Name, Phone Number, and Email:

Applied for Medicaid benefits before? Yes ☐ No ☐	Medicaid Number:
Has Applicant ever been disqualified for Medicaid? Yes ☐ No ☐ Reason:	Veteran/Spouse of Veteran: Yes ☐ No ☐ Claim #: Dates of Service:

Other Medical Insurance: Yes ☐ No ☐ If Yes, Name and Policy Number:

All Persons Residing With Applicant (SSN and Marital Status needed for Applicant and Spouse Only)

Name:	Social Security #:	DOB:	Sex:	Marital Status:	Relationship to Applicant:

HOUSEHOLD

The applicant/recipient, their spouse, and any minor dependent child(ren), under the age of 18 residing in the home more than ½ time.

Income – List Anyone in the Household including Applicant				
Income Type:	Source:	Received by Whom?	Gross Amount:	Frequency:
Social Security (RSDI)			**$**	
Social Security (RSDI)			**$**	
Supplemental Security Income (SSI)			**$**	
Supplemental Security Income (SSI)			**$**	
Veterans Benefits			**$**	
Job Income			**$**	
Pension			**$**	
IRA/401K Distributions			**$**	
OTHER:			**$**	
OTHER:			**$**	
OTHER:			**$**	

Has applicant applied for but not yet received any other income? Yes ☐ No ☐

Date Applied: _____

If Yes, who will be receiving and from what source?

Resources – List all Owned or Shared Ownership			
Resource Type:	Owner(s):	Source/Company:	Value:
Savings Account			$
Savings Account			$
Checking Account			$
Checking Account			$
Trust			$
Savings Bond			$
Safe Deposit Box			$
IRA			$
401K			$
Burial Insurance			$
Life Insurance			$
Cash on Hand			$
Vehicle			$
Vehicle			$
Vehicle			$
Other			$
Other			$

Has the applicant, within 60 months of the date of this application, divested or transferred his or her assets in an attempt to qualify for services from the program for which they are applying? Yes ☐ No ☐

If Yes, where were the assets divested or transferred from?

If Yes, date

Medical Expenses - Personal Assistance Services ONLY Include Expenses Paid For By Applicant Only			
Medical Expense:	Company/ Source:	Amount paid:	Frequency of Payments:
Prescriptions		$	
Medical Insurance/ Premiums		$	
Other		$	
Other		$	
Other		$	

Social/Health Information

Diagnosis:

Physician Name/Phone Number:

Does the Applicant have Decision Making Difficulties?: Yes ☐ No ☐ Unknown ☐ _____

Does the Applicant have Short Term Memory Difficulties?: Yes ☐ No ☐ Unknown ☐ _____

Other Care Needs:

Current Services Receiving (Hospice, Home Health etc.):

Does the Applicant Need Help With Any of the Following? (check all that apply)

- ☐ Bathing
- ☐ Dressing
- ☐ Grooming
- ☐ Toileting
- ☐ Eating
- ☐ Mobility
- ☐ Transfers

Does the Applicant Use Any of the Following Equipment? (check all that apply)

- ☐ Cane
- ☐ Wheelchair
- ☐ Walker
- ☐ Other: _____

Service Needs

Is the Applicant in need of any of the following services (check all that apply):

- ☐ Group Home or Assisted Living Placement
- ☐ Personal Emergency Response System (PERS)
- ☐ Adult Day Care/Companion services home
- ☐ Durable Medical Equipment
- ☐ Homemaker services
- ☐ Respite
- ☐ Accessibility Adaptations for the Home Durable
- ☐ Home Delivered Meals

Voluntary Questions

1. What sex were you assigned at birth, such as on your original birth certificate? (Mark one answer)
   ☐ Male ☐ Female ☐ Prefer Not To Disclose
2. How do you describe yourself? (Mark one answer)
   ☐ Male ☐ Female ☐ Transgender Man/Trans Male ☐ Transgender Woman/Trans Female ☐ Gender queer/gender non-comforming
   ☐ Different Identity, Please Specify _____ ☐ Prefer Not To Disclose
3. Which of the following best represents your sexual orientation identity? (Mark one answer)
   ☐ Straight or Heterosexual ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Not, listed: Please specify _____
   ☐ Prefer Not To Disclose

Signature and Affirmation

I hereby apply for services through Aging and Disability Services Division (ADSD). I certify all the information is true and correct to the best of my knowledge and no facts have been omitted.
I make this application with the understanding:

- I authorize and consent to the release of any and all information concerning me and my family to ADSD by the holder of the information, regardless of the manner or form held (including, without limitation, information made confidential by law or otherwise). I release the holder of such information from any liability resulting from the disclosure of the required information.
- I will report any changes in circumstances within 10 days, including changes in my income, assets, living situation, or abilities.
- I will report any additional income or assets I receive within 30 days of receipt.
- I authorize ADSD to contact my employer to obtain wage information.
- I will furnish any additional information which may be required to determine eligibility.
- I will notify ADSD when I no longer need services.
- I understand, if I am eligible for Medicaid, I must pursue eligibility through them and depending on the outcome, my services and eligibility through the ADSD State Programs (PAS and COPE) may be affected.

By signing this application, you are authorizing the Department of Health and Human Services to make investigations necessary to determine eligibility for benefits you receive or will receive under FE/PD/COPE/PAS program. You understand that information gathered during the assessment process may be shared with ADSD sister state agencies and contracted service providers to ensure adequate care is authorized and received. Information provided to ADSD may be verified or investigated by state officials including Quality Control staff. If you do not cooperate in the investigation, your benefits may be denied or terminated. If you make false or misleading statements, misrepresent, conceal or withhold facts necessary to ADSD to make an accurate determination of benefits, or alter any documents, your benefits may be denied, terminated, or reduced. You may be held responsible for repayment of all monies, services and benefits for which you were not entitled. Additionally, you may be disqualified from receiving benefits in the future and criminally prosecuted. You understand the law provides penalties for persons hiding facts or not telling the truth.

This authorization constitutes a full and complete release from any liability from disclosure of such information. A reproduced copy of this authorization legally constitutes an original copy.

ADSD 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 regulations.

Signature or Mark of Applicant Date

Authorized Representative Print and Sign Date

Authorized Representative Relationship to Applicant (Power of Attorney, Guardian etc.)
Please provide proof of guardianship, POA, etc.

ADSD Case Manager Date

Joe Lombardo
Governor

Richard Whitley, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES

AGING AND DISABILITY SERVICES DIVISION

Helping people. It's who we are and what we do.

Dena Schmidt
Administrator

Authorization to Release Information

☐**Aging and Disability Services Division (ADSD) Administration**	☐**Adult Protective Services (APS)**	☐**Autism Treatment Assistance Program (ATAP)**	☐ **Communication Access Services (CAS)**	☐**Developmental Services (DS)**
☐**Intermediate Care Facility (ICF)**	☐**Long-Term Care Ombudsman Program (LTCOP)**	☐**Nevada Early Intervention Services (NEIS)**	☐**Office of Community Living (OCL)** - **Community Options Program from the Elderly (COPE)** - **Home and Community Based Services Waiver for the Frail Elderly (HCBS FE)** - **Home and Community Based Services Waiver for Person's with Physical Disabilities (PD)** - **Personal Assistance Services (PAS)**	
☐**Office for Consumer Health Assistance (OCHA)**	☐**Senior Rx/Dx**	☐**Taxi Assistance Program (TAP)**	☐**Other (Specify below)**	

(Individual Legal Name Printed) (Date of Birth)

(Individual Mailing Address) (City, State, Zip Code)

I authorized ADSD to: ☐Release information to: ☐Receive information from:

Name of person/provider/organization/facility/program:

Phone: Fax:

Reason for Request: To determine the individual's eligibility and/or to coordinate services.

☐Other (specify):

This consent is provided in accordance with 42 CFR 2.31 regarding the confidentiality of alcohol and drug treatment patient records; 34 CFR 99.30 – 99.39 regarding disclosure of educational or early intervention records; 45 CFR 164.508 regarding the disclosure of mental health information; and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is to be used only to facilitate treatment, payment, and/or health care operations (45 CFR 164.506). The Participant's service, payment, enrollment, or eligibility for benefits will not be conditioned on the provision of the authorization, except as permitted by law.

Specific Information Authorized to Be Released: Use/Disclosure of information is authorized below by selection box.

Records Date Range: From: To:

TYPE OF INFORMATION			
☐	Assessments	☐	History and Physical
☐	Developmental Screeners	☐	Lab / X rays /Imaging Studies/ Test results
☐	Intake Evaluations and Records	☐	Consultation Reports
☐	Legal Records	☐	Educational Records+
☐	Medical information including but not limited to medical and hospital records; including but not limited to HIV/ AIDS related information**	☐	Progress Notes and Treatment Plans including but not limited to Individual Family Support Plan (IFSP), Care Plans, Service Plans
☐	Mental Health information including psychological testing and psychiatric evaluations***	☐	Financial Records
☐	Other		

* ADSD has elected not to disclose or release information relating to drug and alcohol treatment.

With some exceptions, HIV/AIDS – related health information, or mental health treatment information may be re-disclosed by the recipient. **The recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without the specific written consent of the person to whom it pertains, unless permitted to do so under federal or state law.

***Information from mental health clinical records may be released if there is a **demonstrable need for the information**, provided that the disclosure will not reasonably be expected to be detrimental to the participant or another person.

+ If the authorized information is protected by the Family Educational Rights and Privacy Act it may not be disclosed without the written consent of the person to whom it pertains unless otherwise provided for in federal or state law. This authorization serves as written consent for the release of the aforementioned information.

I understand that:
I may request and obtain a copy of the Division's confidential information policy.
I do not have to sign this authorization; I understand that I may be denied treatment in some circumstances if I do not sign this consent because information may be required to determine my eligibility for services.
I may cancel this authorization at any time by submitting a written request to the Aging and Disability Services Division, except where a disclosure has already been made with my prior authorization.
A photocopy or fax of this form is as valid as the original.
If I experience discrimination because of the release or disclosure of HIV/AIDS – related information, I may contact the Office of Civil Rights to file a complaint.
ADSD releases information in the scope of their duties to make determinations necessary for eligibility and on-going service requirements.
Information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.
I release ADSD employees from any liability arising from the release of information to the person/entity designated on page 1.

☐ I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program identified as often as necessary.

My authorization will expire:

☐ If I am no longer receiving services from the Aging and Disabilities Services Division or it's programs

☐ One (1) year from the date of signature, unless otherwise specified by a condition or event, whichever is earlier

☐ Other: _____
(Please describe)

Relationship: ☐Parent ☐Legal Guardian/Designee ☐Custodian ☐Self ☐Other

_____
(Parent/Guardian/Custodian/Self Printed Name)

_____
(Parent/Guardian/Custodian/Self Signature) (Signature Date)

_____
(Signature of ADSD Employee) (Signature Date)

Aging and Disability Services Division

Voter Registration Inquiry Form

New Applicant/Certification ☐ Recert ☐ Change of Address ☐ Other ☐

(eligibility redeterm; annual review, etc.) (not applying for ADSD services)

If you are not registered to vote where you live now, would you like to apply to register to vote?

Yes ☐ Application mailed as requested via phone ☐ No ☐ Already registered ☐

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the County Clerks and Registrars where you reside.

_____ _____

Signature Date

_____ _____

Please print name ADSD Representative

(when individual does not sign)

DIVISION USE ONLY

OUTCOME: (Required if participant gave a "YES" response above)

☐ Individual completed application in office or assistance was provided by staff during home visit and brought back to the office for submission to Elections Dept.

☐ Individual took application with them to complete and submit to Elections Dept.

☐ Application mailed to individual with other Agency forms or at the request of the individual.

Submission: Upon completion of this form immediately submit to your Site Voter Registration Coordinator.

Please submit immediately for accurate and timely reporting

STATE OF NEVADA VOTER REGISTRATION APPLICATION

Application No. IA52216

Clear Form

USE BLACK OR BLUE INK ONLY – PLEASE PRINT CLEARLY

WARNING: GIVING FALSE INFORMATION IS A FELONY AND INCLUDES A CIVIL PENALTY OF UP TO $20,000.

All fields are required unless marked Optional. If you do not provide all of the required information, your application to register to vote will not be complete.

1. Are you a citizen of the United States of America? ☐ Yes ☐ No
If you checked "No" to the above question, do not complete this form.
Will you be at least 18 years of age on or before election day? ☐ Yes ☐ No
If you checked "No" to the above question but are at least 17 years of age, do you wish to preregister to vote? ☐ Yes ☐ No
If you checked "No" to both of the prior questions, do not complete this form.

2. Last Name | First Name | Middle Name | Suffix

3. Nevada Residential Address – See Instructions on Back (No P.O. Box/Business Address) | Apt. # | City | State (NV) | Zip Code

4. Mailing Address – If Different From Above (P.O. Box or Mail Service Address Acceptable) | Apt. # | City | State | Zip Code

5. Birth Date (MM/DD/YYYY)

6. Place of Birth (State or Country)

7. Telephone Number (Optional)

8.
☐ I have a valid NV Driver's License or ID Card and that number is: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
☐ I have not been issued a NV Driver's License or ID Card. The last 4 digits of my Social Security Number are: XXX – XX – ___ ___ ___ ___
☐ I have not been issued a NV Driver's License or ID Card, and I do not have a Social Security Number. If you select this option, you will be contacted by your County Election Department for more information once your application is received.
Note: ID numbers provided above are confidential and not available for public inspection.

9. If applicable, check one of the following:
☐ Military Domestic (or military spouse or dependent) – Only check if you are on active duty and will be absent from your place of registration
☐ Military Overseas (or military spouse or dependent)
☐ U.S. Citizen Overseas
Clear Military Information

10. Email Address (Optional) – Email Address is Confidential

11. ☐ **CHECK THIS BOX TO RECEIVE A SAMPLE BALLOT IN LARGER TYPE**

12. Party Registration – Check Only One Box
☐ Democratic Party
☐ Independent American Party
☐ Libertarian Party of Nevada
☐ Nonpartisan (No Political Party)
☐ Republican Party
☐ Other Party – Write in below
_____

13. I swear or affirm I am a U.S. citizen. I will be at least 18 years old by the date of the next election, or if I indicated in Box 1 above that I am preregistering to vote, I am at least 17 years old. I will have continuously resided in Nevada at least 30 days in my county and at least 10 days in my precinct before the next election at which I intend to vote. The residential address listed herein is my sole legal place of residence and I claim no other place as my legal residence. If I am preregistering to vote, I understand and acknowledge that I will be deemed to have registered to vote as of the date of my 18th birthday unless my preregistration is cancelled by any of the means or for any of the reasons for cancelling voter registration pursuant to Chapter 293 of the Nevada Revised Statutes. I am not currently serving a term of imprisonment for a felony conviction. I declare under penalty of perjury that the foregoing is true and correct.

SIGNATURE OF APPLICANT (REQUIRED)

PRINT

(MM / DD / YYYY)

14. Your name and residential address where you were last registered to vote (Optional) – (Name Used, Address, State, etc.)

15. Important! If you are assisting a person to register to vote and you are not a Field Registrar appointed by a County Clerk / Registrar of Voters or an employee of a voter registration agency, you MUST complete the following. Your signature is required. Failure to do so is a felony.

Full Name | Mailing Address | City/State/Zip Code | Signature

OFFICIAL USE ONLY. DO NOT WRITE IN THE SHADED AREA BELOW.

DATE STAMP	☐ AGENCY ☐ FIELD REGISTRAR ☐ MAIL ☐ IN PERSON ☐ OTHER	CANCELLED INACTIVE PRECINCT	**APPLICATION NO.** IA52216 RECEIVED BY:

✂ Detach Here ✂ ✂ Detach Here ✂ ✂ Detach Here ✂

NAME OF PERSON RETAINING THIS APPLICATION
(Agency Stamp or Name of Agent, Election Official or Person Retaining Application)

ELECTION OFFICIAL OR AGENCY
(Contact Information, Address, Telephone, Fax)

VOTER APPLICATION RECEIPT
(Please Retain Receipt)
Your voter registration information has been transmitted to your County Election Office for processing. Within 10 days after receiving your information, your County Election Office will mail your Nevada Voter Registration Card or a notice that additional information is required to complete your registration.

APPLICATION NO. IA52216

PRINT

INSTRUCTIONS

Box 1 – PREREGISTRATION: Every citizen of the United States who is 17 years of age or older but less than 18 years of age and has continuously resided in this state for 30 days or longer may preregister to vote by any of the means available for a person to register to vote pursuant to Nevada law. If a person preregisters to vote, he or she shall be deemed to be a registered voter on his or her 18th birthday unless the person's preregistration has been cancelled or he or she does not satisfy the voter eligibility requirements.

Box 2 – NAME: Required. Please write your name exactly as it appears on your Nevada Driver's License, ID Card, or Social Security Card.

Box 3 – ADDRESS WHERE YOU LIVE: Required. Your home address is the street address assigned to the location at which you actually reside. If you reside at a location that has not been assigned a street address, a description of the location at which you actually reside must be provided. A P.O. Box or business address cannot be listed as a home address.

Box 4 – ADDRESS WHERE YOU RECEIVE MAIL: Optional. Include your mailing address if it is different than your physical address. Include P.O. Boxes and Mail Service Addresses, if applicable.

Box 8 – IDENTIFICATION: Required. Include your Nevada Driver's License or Nevada Identification Card number. If you do not have a driver's license or identification card issued by a Nevada DMV, include the last four digits of your Social Security Number. If you do not have a Nevada Driver's License or Social Security Number, you will be contacted by your County Election Department for more information once your application is received.

Box 9 – MILITARY: Required, if applicable. Mark the applicable box.

Box 12 – POLITICAL PARTY AFFILIATION: Required. Mark your choice of a qualified political party, "Nonpartisan" or "Other." If you mark "Other," you may print the name of an unlisted political party. If you register with a minor political party or as a nonpartisan, you will receive a nonpartisan ballot for the Primary Election.

Box 13 – DECLARATION: Required. Sign and date. Voting Rights are immediately restored for all felony convictions upon release from prison.

Box 14 – UPDATING INFORMATION: Optional. You may include the last address where you were registered to vote. This helps the County Clerk / Registrar of Voters identify you as the applicant.

Box 15 – ASSISTANCE: Required, if applicable. If you are assisting a person to preregister or register to vote, you must complete Box 15. *FAILURE TO DO SO IS A FELONY.*

DEADLINES FOR SUBMITTING APPLICATION:

- By Mail – Postmarked by the fourth Tuesday preceding the primary or general election.
- In Person at your local County Clerk's or Registrar of Voters Office – By the fourth Tuesday preceding the primary or general election.
- Online – By the Thursday preceding the primary or general election. Online Registration available at www.RegisterToVoteNV.gov
- For Special / Recall Elections – Contact your County Clerk or Registrar of Voters.

SAME-DAY VOTER REGISTRATION: Eligible Nevada voters can register to vote or update existing voter registration information in person at the polling place either during early voting or on Election Day.

INTERESTED IN BEING A POLL WORKER? Please contact your local County Clerk or Registrar of Voters Office.

NOTICE: You are urged to return your application to the County Clerk or Registrar of Voters in person or by mail. If you choose to give your completed application to another person to return to the County Clerk or Registrar of Voters on your behalf, and the person fails to deliver the application to the County Clerk or Registrar of Voters, you will not be preregistered or registered to vote, as applicable. Please retain the duplicate copy or receipt from your application to preregister or register to vote.

COUNTY	ELECTION DEPARTMENT ADDRESS	COUNTY	ELECTION DEPARTMENT ADDRESS
Carson City Clerk (775) 887-2087	885 East Musser Street, Suite 1025, Carson City, NV 89701	**Lincoln Clerk** (775) 962-8077	181 North Main Street, Suite 201, Pioche, NV 89043
Churchill Clerk (775) 423-6028	155 North Taylor Street, Suite 110, Fallon, NV 89406	**Lyon Clerk** (775) 463-6501	27 South Main Street, Yerington, NV 89447
Clark Registrar (702) 455-8683	965 Trade Drive, Suite A, North Las Vegas, NV 89030 P.O. Box 3909, Las Vegas, NV 89127	**Mineral Clerk** (775) 945-2446	105 South A Street, Suite 1, Hawthorne, NV 89415 P.O. Box 1450, Hawthorne, NV 89415
Douglas Clerk (775) 782-9014	1616 8th Street, 2nd Floor, Minden, NV 89423 P.O. Box 218, Minden, NV 89423	**Nye Clerk** (775) 482-8127	101 Radar Road, Tonopah, NV 89049 P.O. Box 1031, Tonopah, NV 89049
Elko Clerk (775) 753-4600	550 Court Street, 3rd Floor, Elko, NV 89801	**Pershing Clerk** (775) 273-2208	398 Main Street, Lovelock, NV 89419 P.O. Box 820, Lovelock, NV 89419
Esmeralda Clerk (775) 485-6309	233 Crook Avenue, Goldfield, NV 89013 P.O. Box 547, Goldfield, NV 89013	**Storey Clerk** (775) 847-0969	26 South B Street, Drawer D, Virginia City, NV 89440
Eureka Clerk (775) 237-5262	10 South Main Street, Eureka, NV 89316 P.O. Box 694, Eureka, NV 89316	**Washoe Registrar** (775) 328-3670	1001 East Ninth Street, Bldg A, Rm 135A, Reno, NV 89512
Humboldt Clerk (775) 623-6343	50 West 5th Street, #207, Winnemucca, NV 89445	**White Pine Clerk** (775) 293-6509	801 Clark Street, Suite 4, Ely, NV 89301
Lander Clerk (775) 635-5738	50 State Route 305, Battle Mountain, NV 89820		

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